PRELIMINARY FINDINGS

From

Social Capital, Health & Neighbourhood Renewal in the City of Kingston Upon Hull: A Baseline Assessment

April 2005

Contents

Abbreviations

AGC Andrew Gibson Consulting Ltd
ANOVA Analysis of Variance
CI Confidence Interval
DF Degrees of Freedom (associated with statistical tests and used in footnotes)
HAZ Health Action Zone
HDA Health Development Agency
HRQL Health Related Quality of Life
IMD Index of Multiple Deprivation
KC Kingston Communications
LS Least square (means)
MP Member of Parliament
MRS Market Research Society
NRS Neighbourhood Renewal Strategy
NVQ National Vocational Qualification
SMR Standardized Mortality Ratio
UK United Kingdom
VAS Visual Analogue Scale

Symbols

+ commonly used in this report as an abbreviation for 'greater than or equal to'
> denotes 'greater than'
< denotes 'less than'
≤ denotes 'less than or equal to'
≥ denotes 'greater than or equal to'

Terms

Analysis of Variance – A statistical test used to compare means between different groups.

Area Partnerships – Geographical areas dividing the City of Hull into seven different areas used by Hull City Council.

Bonding Social Capital – Social Capital between similar types of people.

Boxplot – A graphical method for presenting continuous responses to questions (e.g. Health Thermometer and Mental Health Inventory scores) which gives the quartiles.

Bridging Social Capital – Social Capital between diverse types of people.

Civic Engagement – The degree to which people participate in community life, and the extent to which they feel empowered to change their society.

Confidence Interval – The 95% confidence interval (CI) gives a range of values for which we are 95% confident that the interval will contain the true, underlying statistic (e.g. mean or difference between two means) of the entire population.

Econometric Analysis – An analysis which examine the relationships between a number of variables relating to social capital, personal factors (such as age, gender, economic status, deprivation, etc) and health outcomes. The advantage of this approach is that we may examine the relationships as they are with all other factors / variables held constant, thereby controlling for confounding effects and biases due to different age, gender, social class, and other variations between areas.

EuroQol – Commonly- used health related measure of quality of life. It produces a score derived from the responses of five questions rating mobility, self-care, ability to perform usual activities, pain/discomfort and anxiety/depression. A score of 1 represents perfect health related quality of life and a score of 0 represents death, but negative scores are also possible which denote extremely poor quality of life.

Health Thermometer / **Visual Analogue Scale** – Self-reported measure of health status today ranging from 0 (worst state you can imagine) to 100 (best state you can imagine).

Least square means – Means adjusted for particular factor(s) so means can be compared between groups more readily.

Median– Value for which half of the group have a value below this for a particular question response and half of the group have a value above this.

Mental Health Inventory – Commonly- used score to measure mental health. The Mental Health Inventory is derived from five questions from the SF-36 questionnaire. The questions form a score which ranges from 5 to 30 with a higher score denoting better mental health.

Neighbourliness – Examines the extent of interaction, trust and reciprocity between neighbours.

Quartile – Value for a particular question response which divides the responses into four approximately equal group. The median is a special case of a quartile (50%). For the lower quartile, one quarter of responders have a value below the lower quartile and three-quarters have a value above this. The upper quartile similarly divides the responders into the bottom 75% and top 25% based on their response to a particular question.

SF-36 – A set of 36 questions which are used in self-completed questionnaires to assess health status. For this particular study, only some of these questions were used.

Social Capital – 'Social Capital….refers to the features of social organisation, such as trust, norms and reciprocity, that can improve the efficiency of society by facilitating coordinated action' (Putnam, 1993).

Social Networks – They are defined as the personal relationships which are accumulated when people interact with each other in families, neighbourhoods and elsewhere.

Social Support – The practical and emotional help available from social networks.

Standardized Mortality Ratio – Age-sex standardised ratio of mortality (deaths) under the age of 75 in comparison to another group which has a rate of 100. The other group is generally a national rate and in the case of this report is England and Wales.

Visual Analogue Scale / Health Thermometer– Commonly-used self-reported measure of health status today ranging from 0 (worst state you can imagine) to 100 (best state you can imagine).

X^2 test **– A statistical test used to compare the percentages between different groups.**

Introduction

On behalf of the Hull Social Capital Steering Group, I am pleased to present the preliminary findings of this important research project considering Social Capital in Hull and its links with health. This is part of a programme of work to support the development of Hull's Neighbourhood Renewal Strategy (NRS), whose goal is to improve quality of life in disadvantaged neighbourhoods

In March 2002 the Hull Local Strategic Partnership approved the NRS as a means of achieving real improvements in quality of life judged against a range of 'floor targets' including reductions in crime, improved education attainment, better housing, improved economic prospects and life expectancy, and fewer teenage pregnancies.

During the development of the strategy the notion of Social Capital as a productive resource was seen as one means of providing an assessment of 'community spirit'. It would then be theoretically possible to identify changes in the level of Social Capital over time, and thus provide some more qualitative assessment of performance improvement (with health as the outcome measure) than the output driven floor targets.

We have now conducted detailed questionnaires with over 4000 people in Hull as the first stage in producing a baseline assessment of the level and nature of Social Capital across the city. The data collection was undertaken from March to May 2004. Set out in the following report and appendices are the preliminary findings from the data that will allow us to subsequently answer a number of research questions.

I would like to pay tribute to the work of the steering group and to Andrew Gibson Consulting Ltd, the interviewers, and all those who took part in the survey, for all of the efforts to produce this report. I hope that all of you reading it will find it valuable, and will use the findings to have a more informed policy debate in Hull about the potential health benefits of Social Capital.

Simon C Hunter
Director – Hull and East Riding Health Action Zone

Section 1 : Rationale, Context and Methodology

1.   Hull in Context

Hull is a historic City with a population of approximately 253,000 people. Situated on the north bank of the Humber estuary, 38 miles from York and 55 miles from Leeds, it is one of Yorkshire's major centres and is the focal point for much of the eastern part of the Yorkshire and Humber region.

The City serves the needs and provides most of the employment, entertainment, learning, social and cultural facilities not just for those living in the city but also for the greater population within the City region.

The built-up area, including the adjoining suburbs of the East Riding of Yorkshire, has a population of approximately 315,000 and, when expanded to include the Hull-Travel-to-Work Area, becomes about 435,000 people.

Hull has a number of attractions, including a historic Old Town, and more recently through successful regeneration projects, Hull has seen the development of The Deep (a marine life centre) and the Kingston Communications Sports Stadium.

Hull has always prided itself on its fishing heritage, and up until the late 1960's the communities of Hull typically resided around its major industries. However, with the industrial decline, particularly the fishing industry, and the housing clearances in the early 1970's, these established communities were often fragmented, resettled in other areas and provided with Local Authority housing on purpose-built estates situated on the outskirts of the City.

The evidence of exclusion is particularly apparent in a number of the City's communities where economic disadvantage is exacerbated by a high crime rate, unacceptable levels of social disorder, poor and unpopular housing and facilities and marked differences in health and life expectancy.

The housing market has declined in some neighbourhoods, and population and pupil drift from the City has resulted in a significant number of vacant houses and surplus places in schools.

Genuine neighbourhood renewal is crucial to the future prospects of Hull. An understanding of Social Capital and its impact on health status will be an important component of that renewal.

2.   What is Social Capital?

There are numerous definitions of Social Capital but an early and influential one is 'Social Capital….refers to the features of social organisation, such as trust, norms and reciprocity, that can improve the efficiency of society by facilitating co-ordinated action' (Putnam, 1993).   This definition was the result of an assessment of Italian regions concluding that, even adjusting for confounding factors, those most successful economically had stronger traditions of civic engagement and higher levels of Social Capital than less successful regions.

Berkman and Kawachi et al (2000) draw together several definitions, concluding that common features focus on the 'social', or external, rather than individual 'ownership' of the resource. It is also defined as a 'public good' with benefits shared beyond those that create it.

This concept is important for public health because, if it can be shown that higher levels of Social Capital impact on health status, then its measurement should become a part of epidemiology; and public health action should develop at community or neighbourhood level rather than its more traditional focus on individual behavioural factors.

Whilst Social Capital as a concept has long antecedents back to Durkheim, it was only ten years ago that it became popularised by Robert Putnam, a Harvard Professor of Political Science in two major works: 'Making Democracy Work: Civic Traditions in Modern Italy' (1993) and 'Bowling Alone: The Collapse and Revival of American Community' (2000). Putnam's work and others has been adopted by the World Bank as a likely explanation of the failure of economic investment in the third world.   Such analysis has also included links with health status. In 'Bowling Alone', Putnam opens his chapter on health with the statement: 'Of all the domains in which I have traced the consequences of Social Capital, in none is the importance of social connectedness so well established as in the case of health and well-being' (Putnam, 2000). He then describes how high levels of Social Capital might actually stimulate the immune system to fight disease and lead to lower mortality.

The approach has been expanded upon greatly in the emerging field of social epidemiology by Ichiro Kawachi (also at Harvard) and his work with Lisa Berkman and Kimberly Lochnar. In Britain, Kawachi has worked with Richard Wilkinson whose 'Unhealthy Societies: The Affliction of Inequality' (1997) makes a powerful case for the important role differing levels of Social Capital play in health inequalities. Further work in the UK is being co-ordinated by the Health Development Agency (HDA) through quantitative and qualitative projects, including its Social Action Research Programme. This is noted in the Office for National Statistics' 'Social Capital: A Review of the Literature' (ONS 2001), who are undertaking HDA funded research looking at the Social Capital module in the General Household Survey

Health Action Zone area-based initiatives have also considered the concept when developing innovative approaches to tackling health inequalities. In particular, the work

commissioned in South Yorkshire Coalfields from the Centre for Regional Economic and Social Research based in Sheffield is an important forerunner whose experience was used to inform this current study. It is important to pay tribute to the work of Professor Geoff Green from Sheffield Hallam University who also provided advice during the development of the research proposal.

As part of this present study working definitions of Social Capital were agreed at 3 levels:-

1. to inform the research process and analysis
2. to be used to inform the researchers' training, and
3. to be used by the researchers on the ground to inform the general public

These definitions are set out below.

2.1   Level 1

Social Capital consists of those features of social organisation – such as networks of secondary associations, high levels of interpersonal trust and norms of mutual aid and reciprocity – which act as resources for individuals and facilitate collective action.

Social Capital has both direct and indirect consequences for a wide range of positive social and economic outcomes in areas such as employment, education, crime and well being, therefore health inequalities.

For example, a community rich in stocks of Social Capital is supposedly more likely to possess effective civic institutions and, hence, to prosper and be more likely to be effective in maintaining law and order.

The definition above relates to the mainly positive impact of Social Capital, but it is also important to recognise that in societies where segregation exists, individuals may well be integrated into their local community and yet isolated from the wider society, thus contributing to the social exclusion of stigmatised communities.

2.2   Level 2

Social Capital is a term used to describe community spirit and connectedness. The main aspects of Social Capital are citizenship, neighbourliness, trust and shared values, community involvement, volunteering, social networks and involvement in local democratic processes. These are seen to be important features of social life that encourage co-ordination and co-operation within and among groups for mutual benefit.

This research seeks to identify the quality of different types of Social Capital evident across all areas of Hull, and to relate these findings to how well the City is doing in terms of education, employment and well being.

The results from the research will be compared with other local statistics and surveys, and may help us to find out whether communities with different levels of Social Capital experience have differences in other aspects of life.

The current research is a starting point to identify some of the above and it is expected to provide ideas for further investigation in the future.

2.3   Level 3

This research is being undertaken to find out about levels of community spirit and support in different parts of Hull.

It is important to find out what influences people to feel confident or happy (or not) about where they live, and whether these influences bear any relationship to their feeling of well being, health and life opportunities.

2.4   Further Reading

For those who want to know more about Social Capital a list of references is provided at the end of this section.

3.   Developing the Research Project

Funding to support the production of a baseline assessment of Social Capital in Hull was secured from the Neighbourhood Renewal Fund for 2003/4. In agreeing funding it was noted that this work would provide an initial attempt to assess and understand the nature of this complex concept. Such an assessment would be valuable in generating a more structured debate about the role and value of Social Capital in Hull and its relationship to levels of health. From the outset it was agreed that priority be given to:-

- A quantitative baseline survey, recognising that further qualitative research would be necessary at a later stage
- Drawing upon the experience of the South Yorkshire Coalfields survey
- The investigation of opportunities to recruit and train local residents to undertake data collection

A small Steering Group was formed in July 2003, composed of interested and expert individuals from key organisations across Hull. It was important that this group reflected both academic, public health and community interests, and so a broad cross-section of people were invited to be involved.

Steering Group membership was subsequently confirmed as:-

Simon Hunter (Chair)	–	HAZ / Public Health Development Team
Sarah Frederick	–	HAZ / Public Health Development Team
Gwen Lunn	–	Hull City Council representing Area Directors
Derek Colquhoun	–	Institute for Learning, University of Hull
Andrew Taylor	–	HAZ / Public Health Development
Evelyn Krasner	–	Specialist Health Promotion Service
Jo Stott	–	Specialist Health Promotion Service
Dianne Frances / Ros Abbott	–	Hull Community Network

The Steering Group also had input from a number of other people including Eddie Madden, Andy Kingdom, Jill Copeland, Sheila Jones, Tim Greene, Mandy Lee, Amanda Killoran and Katherine Gronqvist. Members of Andrew Gibson Consulting Ltd were also part of the Group at various times.

The Steering Group took responsibility for the development of a series of key research questions which were then translated into the questionnaire to facilitate data collection.

Following a tendering exercise, Andrew Gibson Consulting Ltd (AGC), were appointed to develop and deliver a face to face questionnaire to 4000 people across the seven Area Partnerships in the city. Those invited to respond would follow a statistical profile of each area, based on age, gender, and social-economic status. It was also important to have a high response rate and to reduce possibilities for bias or the return of incomplete questionnaires. Face to face interviews (rather than postal surveys) were therefore proposed, even though this would be more costly and time consuming.

The work of AGC included recruitment, selection and training of community and professional interviewers, design and monitoring of the quota sample, management of all fieldwork, and initial statistical analysis and reporting of findings.

Main members of the AGC team were:

Graham Barnett
Wendy Bennett [*]
Roxane Gervais
Andrew Gibson [*]
Simon Gough
Ian Hargreaves
Cherine Lindsey
Geoff Lowe
Gill Lowe
Dawn Naylor

[*] *Project Leads*

4.   Research Objectives

The Steering Group developed a number of key questions that the data collection exercise was designed to answer:-

1. What is the nature and pattern of Social Capital in Hull?

2. How do levels of Social Capital vary according to age, gender and social group?

3. How do levels of Social Capital and health vary geographically across the seven area partnerships?

4. How do the levels in Hull compare with the national picture and the South Yorkshire Coalfields survey?

5. What are the levels and pattern of Social Capital as defined by specific dimensions of Social Capital?

6. What are the attitudes and views of residents of their local area and facilities?

7. What is the nature of the relationship between levels of Social Capital and health, including particular indicators of health and health-related behaviours?

8. Do areas with different levels of Social Capital tend to have better health outcomes?

9. What further research should be considered e.g. into particular dimensions of Social Capital, or in particular areas? What elements of qualitative research should be pursued?

The answers to some of these questions emerge from the preliminary findings reported here, but more analysis is needed to answer them properly and to produce a more robust analysis of Social Capital and health. Subsequent work is now being undertaken by the Steering Group to complete this analysis and present the findings to communities and key stakeholders across the city.

5.   Methodology

There are a number of important issues about how the research was undertaken that need to be kept in mind when considering this report. The key issues are set out below.

5.1   Quantitative Design

There are many ways to research Social Capital, and often qualitative survey methods are used because measuring such a complex community concept in a numerical way is seen as either difficult or inappropriate. This was considered during the development of the research proposal which was informed by findings from a variety of qualitative studies. However, it was felt that a baseline assessment would best be achieved through quantitative research methods, in order to capture citywide differences in Social Capital and to seek to relate these to health status. This would allow us to produce a snapshot that was reliable in measuring the concept consistently, repeatable on the basis that a subsequent snapshot could be undertaken if needed, and valid by enabling wider descriptions of the city to be made from the findings in the sample.

Indicators for the dimensions of Social Capital to be administered in questionnaires do exist. Lochnar et al (1999) have produced a 'guide' to the measurement of Social Capital which brings together several existing measures under the headings collective efficacy, psychological sense of community, neighbourhood cohesion and community competence. The Office for National Statistics (Harper, 2001) has produced a matrix of Social Capital survey questions following their assessment of eighteen large national surveys. As part of the Health Development Agency research programme, Pevalin and Rose (2002) investigated links between Social Capital and health using the British Household Panel Survey. Their detailed analysis of both the appropriateness of the questions used and outcome in terms of the relationship between Social Capital and health (using SF36 as a generic measure of health status –adopted for this survey tool) is helpful to this present study. A number of robust research questions have, therefore, been tested and piloted and can be used to conduct quantitative research (*Appendix 1*).

The final questionnaire was 10 pages long, with 35 questions (some with multiple components) - requiring 76 responses (or sections of information) in total (*Appendix 2*). Piloting by Steering Group members indicated a period of 15 minutes was required to complete questionnaires, although concern was raised by AGC that more time was needed in practice.

5.2   Achieving a Representative Sample

Achieving a sample representative of the whole local population was of prime importance in this study. Budgets available enabled 4000 interviews to take place, and using available statistics for the population of the city of Hull a "target" sample profile was drawn up for the 4000 interviews which would comprise a representative sample.

Four criteria were agreed for use in determining this target profile because they were believed to be important variables for Social Capital research:-

- Gender
- Age
- Geographical area, the City comprising seven areas based on Hull City Council's Area Partnerships
- Employment status

The agreed minimum age for respondents was 16 years. Statistics by age, gender and employment status for the City, sub divided by committee area were taken from the 2001 Census. The questionnaire employed a breakdown of occupational status and age used in the census, whereas locally provided statistics, which formed the basis of the quota calculations, were based on slightly different categories. A map of the seven geographical areas (area committees) is provided in *Appendix 3*. The linkage between these two classifications is set out in *Appendix 4*.

Using the information supplied, AGC designed a quota to which interviewers could work.

5.3   Rationale for Using Community Interviewers

The Steering Group considered there were significant merits in using local residents to undertake interviews, rather than professional market research interviewers. Three main reasons prompted this decision:

- Local residents might be more able to gain the confidence of respondents in their area, thereby generating higher quality information.
- Training (and paying) local residents invests in local awareness and expertise; i.e. it builds Social Capital in its own right.
- It was a requirement of the Neighbourhood Renewal Fund allocation.

It was also felt that the use of local residents would create a resource which could be drawn upon to support further research, should more detailed follow up be warranted following completion of this baseline study.

It was envisaged that the community interviewers might need to be supplemented by professional interviewers. In practice the fast moving timescales for this project (10 weeks from selection of community interviewers to completion of fieldwork), and the longer than expected settling in period for many of the community interviewers, meant that the professional team were required to undertake more interviews than was originally anticipated. Nonetheless, the ambition of creating a resource of local residents interested in helping with further research was achieved.

5.4   Recruiting the Community Interviewers

Rigorous efforts were made to recruit interviewers who would be representative of communities across the City. Personal contact was established with Neighbourhood Groups (Riverside and Wyke) in addition to attending promotional events such as a Women's Day held at the KC Stadium promoting women's involvement in a range of activities in their locality. Additionally, a Job Forum in North Carr offered the opportunity to disseminate flyers and recruitment sheets which described the Social Capital concept and the forthcoming survey. Various other contacts were made and presentations undertaken, both by AGC and by members of the Steering Group.

Particular attention was paid to raising awareness of the survey alongside recruiting community interviewers, and to this end, many voluntary groups, Family Centres, Libraries, Church Groups, Community Groups and Resource Centres were targeted. Hull Community Action Network helpfully provided a mailshot of the literature describing Social Capital, together with the Training Event application forms, to hundreds of groups and individuals who were actively interested in neighbourhood issues. This initiative produced contacts from a range of sources wishing to pursue the training. Similarly the North Hull Area Committee staff highlighted the literature and training event via their website - offering a repeat contact when a second training date was available.   Radio Humberside and the Hull Daily Mail newspaper also carried features on the project.

Consideration was given to including as many interested citizens of Hull as possible via these routes, whilst being mindful that there could be a limited follow-up in terms of commitment to sustained fieldwork.

One of the limitations to securing a more significant response was the timescale for completing the survey. It is more than likely that a higher response would have been achieved if the publicity and awareness-raising campaign had been held in advance of the recruitment stage. The imminence of the final training event, and a requirement for immediate commitment to fieldwork on behalf of the interviewers, precluded a number of community applicants from pursuing their involvement.

Careful consideration was given to the location of the training events, to offer ease of access, and avoid lengthy journeys for the participants. Two dates were offered for the events at a City Centre hotel located beside the bus and railway stations.

The agenda for the event included:

- An introduction to the concept of Social Capital and the purpose of the survey
- Non-verbal behaviour and subtle influence
- Health and safety issues for both interviewers and interviewees
- Introducing the questionnaire - with the afternoon session primarily allowing participation in role play as interviewers and interviewees
- Provision of maps of the Area Committee boundaries

Maps of Hull with specific Area Committee locations were included, designating interviewers to localities. Information was also included about local helplines. This was introduced as it was recognised that certain questions might trigger an emotional response if, for example, someone had been a recent victim of crime. Whilst this was probably unlikely to occur, it was nevertheless emphasised within the training that it was not the interviewer's role to adopt a counselling approach, and it would be more helpful to pass on a telephone number for accessing assistance, if the resident so wished.

5.5 Ensuring Consistency in Fieldwork

A number of mechanisms were used to guard against biasing the sample of respondents interviewed, or the consistency with which questions were asked and responses recorded. Each interviewer worked to a personal quota, and questionnaires were returned by community interviewers on a continuous basis (typically 10 at a time), such that the sample profile, and consistency in undertaking the fieldwork, could be monitored on a continuous basis.

Interviewers were required to undertake interviews through knocking on doors, but with the final phase of fieldwork being undertaken in public places as well as using a door to door approach in order to provide additional flexibility in achieving the pre-defined quotas.

Training of interviewers, and specific instructions to them, included the issue of bias. The training included how to interview in a consistent and neutral fashion, not leading respondents in any direction.

Bias in any survey must be kept to a minimum. It was felt that this work was best undertaken on a face to face basis rather than using telephone interviews or postal questionnaires. Face to face interviews usually produce the best response rates and the most representative of samples, and can handle long or complex questions plus issues of item non-response. The closed nature of the majority of questions (drawn from validated questions from existing surveys) also reduce question complexity and avoid the expense of extensive piloting.

Further advantages of face-to-face interviews include being able to explain the purpose of the survey in detail, answer questions and provide a supporting letter from the NHS – all of which tend to increase response rates. The views of hard to reach groups such as the less well educated or those who have difficulties reading or writing are also more effectively gathered through face to face interviews.

One main disadvantage relates to problems in eliminating socially desirable responses (those that the respondent believes the interviewer wants to hear) and distortion due to the influence of the interviewer. Training of interviewers specifically addressed the risk of such bias.

To ensure that the profile of the final sample matched the quota as originally set, a brief pause in fieldwork was scheduled. This allowed for a check to be undertaken, and the final quota design to be adjusted accordingly.

5.6   Quality Assurance and Back Checking

Following successful completion of training, each community interviewer was required to provide their first 10 completed questionnaires for detailed checking. Any concerns regarding misunderstanding particular questions or response sets could be addressed in individual cases. In practice errors were very few. Thereafter, a 10% check on respondents was undertaken from both the community and professional teams, primarily by telephone. Interviewers were required to supply (separately for the sake of confidentiality) lists of those they had interviewed, together with address or phone number. A member of the AGC office team simply checked that:

- The interview had taken place
- It had taken place on a face to face basis
- It had been undertaken courteously

All interviewers were informed from the outset that back checking would be undertaken throughout fieldwork.

The majority of respondents recalled undertaking the survey with an interviewer, and all felt it had been undertaken in a polite manner. However, there were a small number of individuals, most of whom were elderly, who said they did not recall the interview. In one case a family member was able to confirm the interview with their elderly relative had taken place.

A variety of checks was also undertaken for the consistency and accuracy of data entry.

5.7   Community Interviewers' Experience

Following an initial enthusiasm for the task, a number of interviewers dropped out of the survey. Each one received a telephone call from AGC and a letter to ask their reasons for withdrawing.

One particularly enthusiastic participant from the initial training day had experienced an increase in her workload at work. As a teacher, working 50+ miles outside of the City, her interest in continuing became untenable. This resulted in a further participant, planning to work alongside this lady, also deciding not to continue.

A young woman, working in two areas, was affected by an interviewee's unease when asked about mental health issues. Despite offering her support and advice to encourage her to continue, she felt unable to do so.

The comments of community interviewers who responded to a feedback sheet relating to their fieldwork activity are as follows:

What did you find helpful in maintaining your involvement with the project?

'Personal Interest - that if I ceased involvement, I would not be paid for work already completed'

'The participation of the people interviewed. Once it was explained what the survey was about, they were very willing to give their opinion, which is uplifting.'

'The leadership provided by Wendy and all the staff of Andrew Gibson Consulting was very helpful. They all were very polite and encouraging. It was a pleasure to work with you.'

'My interest in the nature of this type of work and also meeting people.'

'I enjoyed interacting with people and finding out for myself what people thought and had been through in the local area. I enjoy research and look forward to seeing the results of the project.

'Contact, (phone calls from project.)'

If you had to discontinue your work as an interviewer, what were the reasons for this?

'Lack of time, deadline quite tight to do as part-time.'

'Just wish I had time to do more than one hundred.'

There were few responses to this second question, as the people who responded to the interviewers' feedback questionnaire were those people who completed at least 100 questionnaires.

An incentive was introduced to encourage interviewers, requesting them to approach like-minded friends / contacts who would be interested in the second training event. Those people who nominated candidates who completed the training and questionnaire activity received a cash bonus.

The payment of interviewers for their training was dependent upon their delivering their questionnaire quota of 100 at least. All of the community interviewers received payment for their completed questionnaires on a regular basis. One interviewer and one respondent received £25 cheques from AGC from a prize draw once the survey was completed. As many interviewers discontinued fieldwork before completing 100 interviews, AGC decided to pay these individuals a proportionate payment toward their training day. Interviewers who continued beyond 100 received enhanced payments for their persistence.

The community interviewers completed 980 interviews, all undertaken on a doorstep basis. The remaining interviews were undertaken by professional interviewers, all of whom were registered with the Market Research Society (MRS). All lived in the Hull and East Riding of Yorkshire area.

5.8 Reducing Over-sampling

Managing the data collection process was complex and involved some over-sampling (around 700). This was corrected by removing individual questionnaires from the database used for the analysis contained in this report. Priority was given to removing respondents who generated a disproportionate 'excess' by gender, age group or occupational status within that particular Partnership Area, thereby reducing bias in the sample. Where a number of records were eligible for deletion, a randomised approach was adopted. The database was thereby reduced to 4002 respondents for the purpose of the subsequent analysis, although the complete set of records remains available for further research.

The profile of this final sample shows a good match to that set out in the quota originally designed, as described in *Appendix 5*.

5.9 Statistical Methods

Symbols used to denote a small value

The 'less than' symbol ($<$) has been used in the tables when there is a small percentage of responders providing a specific response, i.e. when the percentage is greater than zero but less than one percent. Similarly, the symbols $\leq$, $>$ and $\geq$ have been used on occasion to denote 'less than or equal to', 'greater than' and 'greater than or equal to' respectively.

Least square means

Least square (LS) means are "adjusted" means. The LS means have been calculated for the mean time a person has lived in a particular area adjusted for the age of the person. Since the least square means take into consideration differences in ages across the different area committees, the LS means can be compared more directly across different areas allowing for differences in the age structure.

Confidence intervals

Since we only have a sample and have not examined data from the entire population (e.g. all residents in Hull aged 16 years and over), we only have an estimate of the particular characteristic we wish to measure, for example, frequency of talking to family. The 95% confidence interval (CI) gives a range of values for which we are 95% confident that the interval will contain the true, underlying statistic (e.g. mean or difference between two means) of the entire population. Having a range of values for which the population

statistic lies is much more useful than having a single value. The interval also takes into consideration the number of people for which the estimate is based, so that if there are many people surveyed the interval tends to be narrower (and therefore more useful).

Bar charts

Bar charts have been provided in this report, which give the percentage of responders with a particular characteristic and these are generally produced for different groups or sub-groups. For instance, the percentage of responders within a particular age group or the percentage of males who are unemployed. The characteristic is given on the horizontal x-axis and in some cases the legend if subgroups are used. The percentage of responders with this characteristic is given on the vertical y-axis.

Median and quartiles

The mean is often used as a measure of the "location of a distribution" or to represent a "typical" value of a variable. For instance, the mean age of responders in a study. However, if the values for a particular variable are skewed, that is most people have a very similar value but a small number of people have very high (or low) values compared to the rest of the people, the mean is not the most appropriate measure of a 'typical' value, as it is influenced by the small number of atypical people who have very high values (the mean is dragged upwards by these people). The median is another measure of location or to represent a typical value, and it is not influenced by these small number of individuals. The median is the value which divides the group of people into two approximately equal groups. Half of all the people have a value of the median or more, and half the people have a value of the median or below. The quartiles are similar in that they divide the two groups above and below the median into a further two groups. The upper quartile divides the group into the top 25% and the bottom 75%, and the lower quartile divides the group into the bottom 25% and the top 75%. So that 25% of the people have a value which equivalent to or below the lower quartile.

Boxplots

Boxplots have been produced for the health measures that comprise of a scale. These illustrate the range of values observed for the health measure for particular groups of individuals. They are most useful when illustrating the distribution of skewed variables (see median and quartiles above). A boxplot divides the responders into four groups with approximately equal numbers of people in each group based on the value they take. In a boxplot, the top of the box is the upper quartile, the line across the box is the median and the bottom of the box is the lower quartile. The "whiskers" on a boxplot show the general spread of the points. [Any observations between 1.5 and 3 box lengths away from the end of the box are classified as outliers (circles) and any observations more than 3 box lengths away as extreme values (asterisks).]

6.   Conclusion

Preliminary findings are described in the subsequent sections of the report and, together with the Appendices, provide a wealth of data with which the Steering Group can answer some of the more detailed questions posed by this project.

7.   References

Berkman L and Kawachi I (Ed) (2000) ,'Social Epidemiology',Oxford University Press

Campbell C, Wood R and Kelly M (1999), 'Social Capital and Health', Health Education Authority

Green G, Grimsley M and Suokas A (2000), 'Social Capital, Health and Economy in South Yorkshire Coalfield Communities', Sheffield Hallam University

Harper R (2001), 'Social Capital: A Review of Literature', ONS

Lochner K, Kawachi I and Kennedy B (1999), 'Social Capital: A Guide to its Measurement', Health and Place Vol. 5, Issue 4, pp 259-323 (December 1999)

Pevalin D & Rose D (Eds) (2002), 'A researcher's guide to the national statistics socio-economic classification', Sage

Putnam R (1993), 'Making Democracy Work: Civic Traditions in Modern Italy', Princeton University Press

Putnam R (2000), 'Bowling Alone: The Collapse and Revival of American Community', Simon and Schuster

Subramanian S, Lochner K and Kawachi I (2003), 'Neighbourhood Differences in Social Capital: A Compositional Artefact or a Contextual Construct?', Health and Place Vol. 9 Issue 1, pp 33-44, March 2003

Swann C and Morgan A (Ed) (2002), 'Social Capital for Health: Insights from Qualitative Research', Health Development Agency

Wilkinson R (1996), 'Unhealthy Societies: The Affliction of Inequality', Routledge

Section 2 : Main Findings

1. Introduction

Summary

- Approximately 2% of the total adult population in Hull participated in the Social Capital survey.

- Through the use of quota sampling the sample responders matched the population profile of the city in terms of age, gender, employment status and residential areas (area committees).

- The seven area committees differed in relation to the following characteristics:

  - Age structure.
  - Employment status.
  - Home ownership.
  - Deprivation.

1.1 Key Facts and Figures

This Social Capital Baseline Report is drawn from a survey of the people of Hull conducted in 2004. Just under 250,000 people live in the city (around 193,000 aged 16 or over) and given the survey sample was 4002 people then this represents 2% of the total adult population.

There is much more to this city than facts and figures and this report demonstrates some of the more qualitative features of life in Hull. It is important, however, to set this report in context particularly because the quota upon which the sample was based was drawn from key population and economic data sources.

An initial analysis of the data was produced by AGC (*Annex I and Annex II of Appendix 6*).

1.1.1 Age and Gender of Sample

The age and gender structure of the sample (and the Area Committee breakdown) was taken from the 2001 Census. One in five residents is under 16, compared to one in seven aged 65 or more. Within Hull, North Carr has the greatest proportion of under 16's and the lowest for over 65's. The West and East areas have the highest proportion of older people. Over the last decade (from 1991), Hull has seen a fall in the number of the very young, teenagers and young people and a growth in the numbers of the most elderly. The overall population has reduced by 8% during that time.

The way in which the sample was obtained through quota sampling means that the sample responders match the population profile of the city in terms of age, sex, employment status and residential area (see Section 1 for further information).

- There are approximately equal percentages of men and women in each age group.
- But slightly more women aged 75 years old or more (***Figure 1***).

Figure 1: Distribution of age for each sex separately
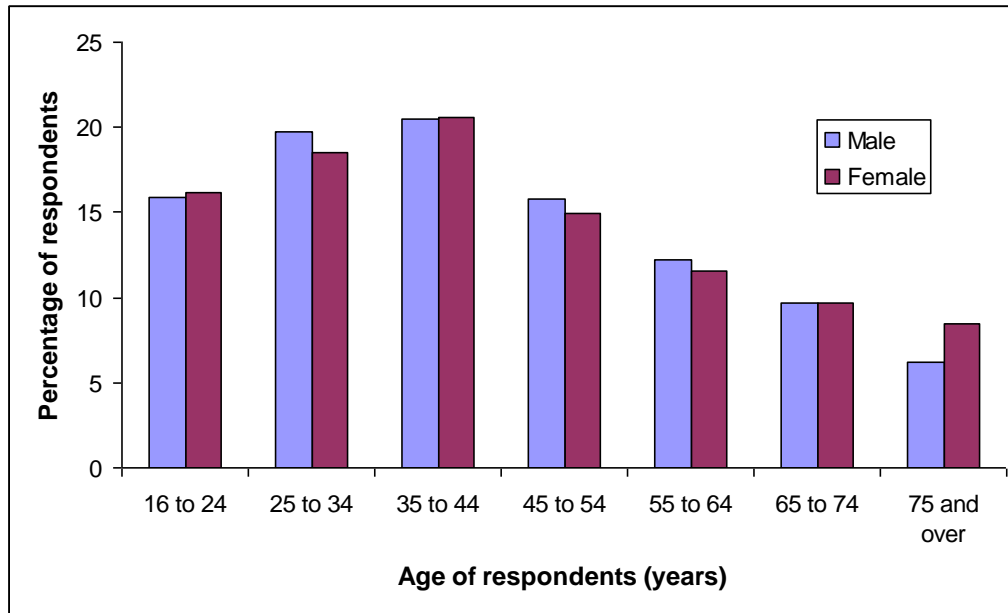
- There are also approximately equal percentages of males and females within each area committee.
- Riverside has the highest percentage of study responders and North Carr the lowest (*Figure 2*).

Figure 2: Distribution of sexes for each area committee
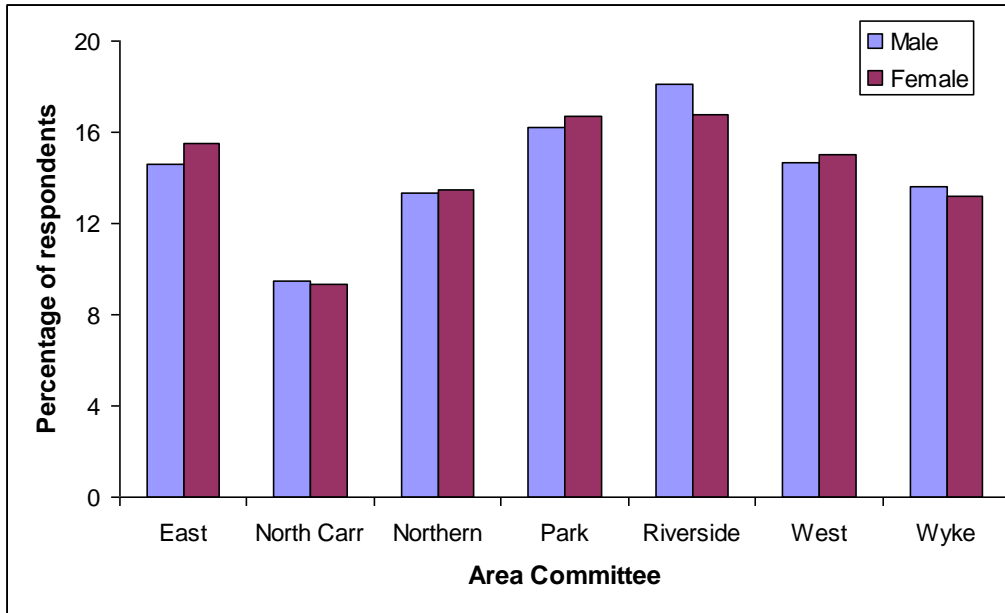
Figure 3 illustrates the distribution of ages over all study responders.
- It can be seen that approximately 6% of the sample are 16-19 years of age.
- Approximately 9% of the sample are in each of the five year age bands from 20-24 years to 45-49 years.
- Approximately 6% of the sample are in each of the five year age bands from 50-54 years to 65-69.
- Approximately 3% of the sample aged 70-74 years.
- The remaining 7% of the sample are aged 75 years or more.

Figures A1 to A8 in Annex III of Appendix 6 give the distribution of ages (10 year age bands) overall and for the each of the seven area committees.

Figure 3: Distribution of age over all study responders
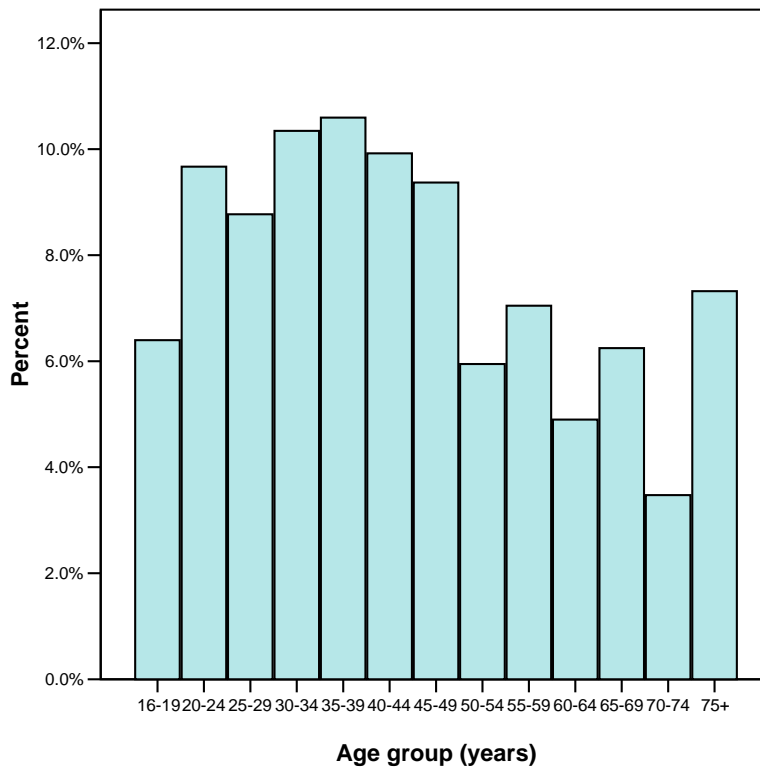
1.1.2 Employment Status and Qualifications

Employment status was also used to develop the sample quota as this would offer some measure, albeit imperfect, of the socio-economic status. Again this was taken from the 2001 Census.

Figure 4 gives the distribution of employment status for males and females separately. Working full-time is classified as working 30 or more hours per week, carers are included in those who look after the home or family, and the other category includes four people who stated "other" work, one person who was waiting for a work permit and one person who was undertaking community service (and the other two did not specify what the "other" work was), with the remaining people in this category undertaking voluntary work.

Figure 4: Distribution of employment status for each sex separately
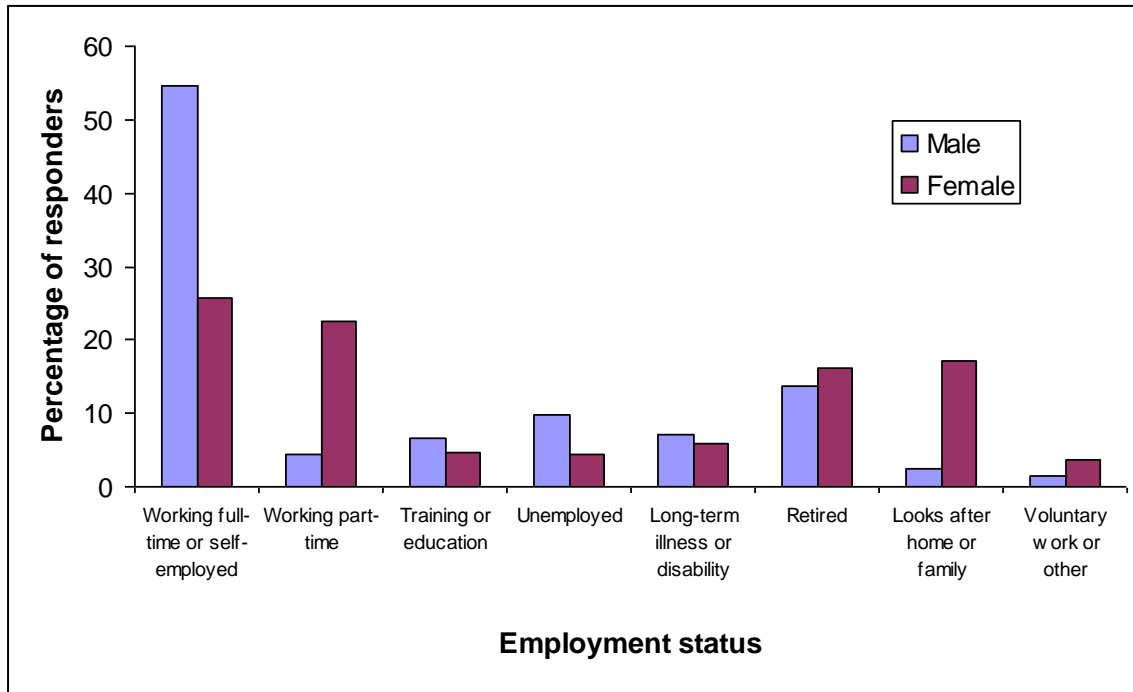
The employment status differed among residents from different area as illustrated in *Figures 5 and 6*.

- Male unemployment was highest in Northern, North Carr and Park areas.
- Male unemployment was lowest in the West area.
- Riverside and North Carr had the highest percentage of retired men.
- Wyke had the highest percentages of women who were working full-time or were self-employed.
- East area had the highest percentage of women who had long-term illness or disability of any area.

Figure 5: Distribution of employment status for each area committee for men
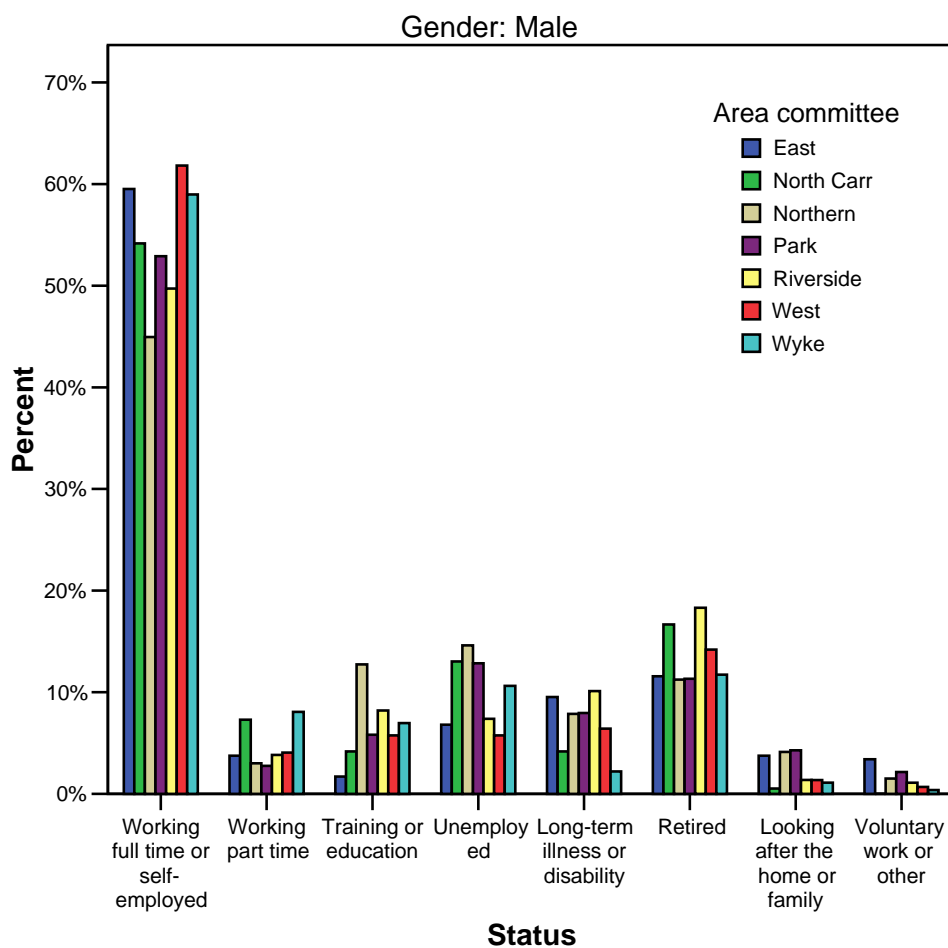
Figure 6: Distribution of employment status for each area committee for women
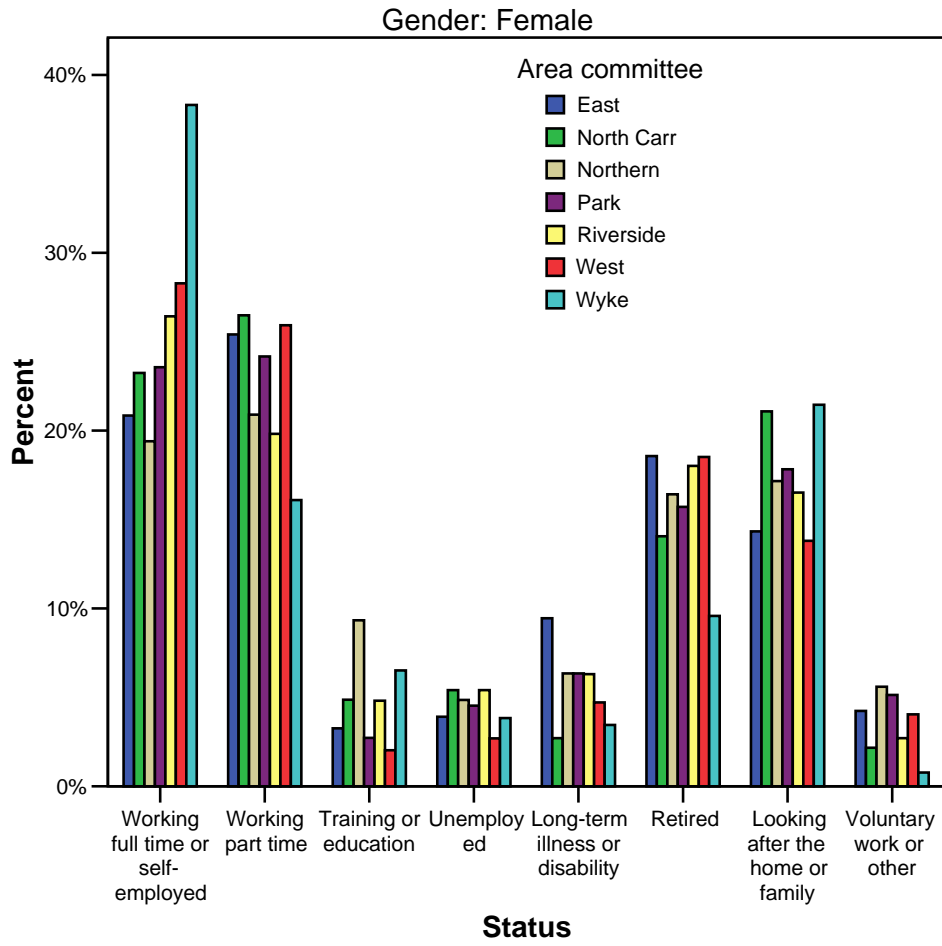
The responders were asked to record their highest qualification or skill. *Figure 7* illustrates the distribution in the entire sample.

- Similar proportions of men and women have no qualifications, NVQ1 and NVQ4+ qualifications.
- But men are more likely to have NVQ2 or NVQ3 qualifications than women.
- Whereas women are more likely to report having other skills with no formal qualifications.

Figure 7: Distribution of qualifications for males and females separately
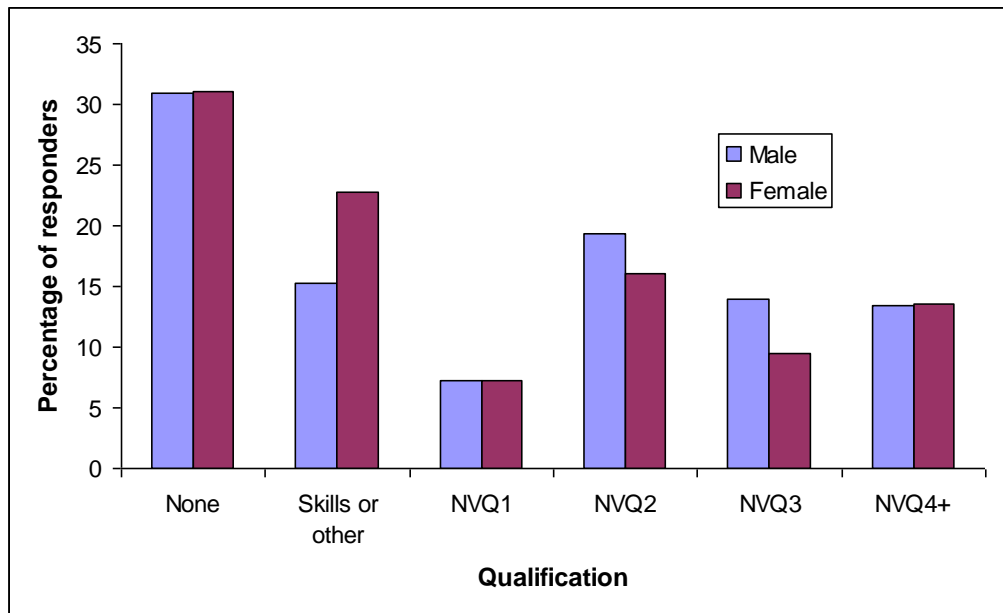
1.1.3   Home Ownership

Whilst not included in the quota against which the sample was generated, the survey did collect data on housing tenure/ownership. The small percentage of responders with missing data or who responded "don't know" (0% to 1.3%) have not been included in *Figure 8*, which shows the distribution of home ownership.

- In all areas, except for North Carr, ownership was the most common form of home occupancy.
- Overall 57% of respondents were home owners.
- Whilst 28% were Council tenants.
- Home ownership was most frequent in the West and Park areas.

Home ownership in the sample is higher than the average for the City which is 52% (in England as a whole the figure is 69%). The percentage of council tenants in the sample is similar to the City average (28%), but the percentage rented from other sectors is lower in the sample (13%) compared to the City average (20%). Nationally council and renting from other landlords is 13% and 18% respectively. (Source Key Facts for Hull – City Regeneration Services, 2003)

Figure 8: Distribution of home ownership for each area committee
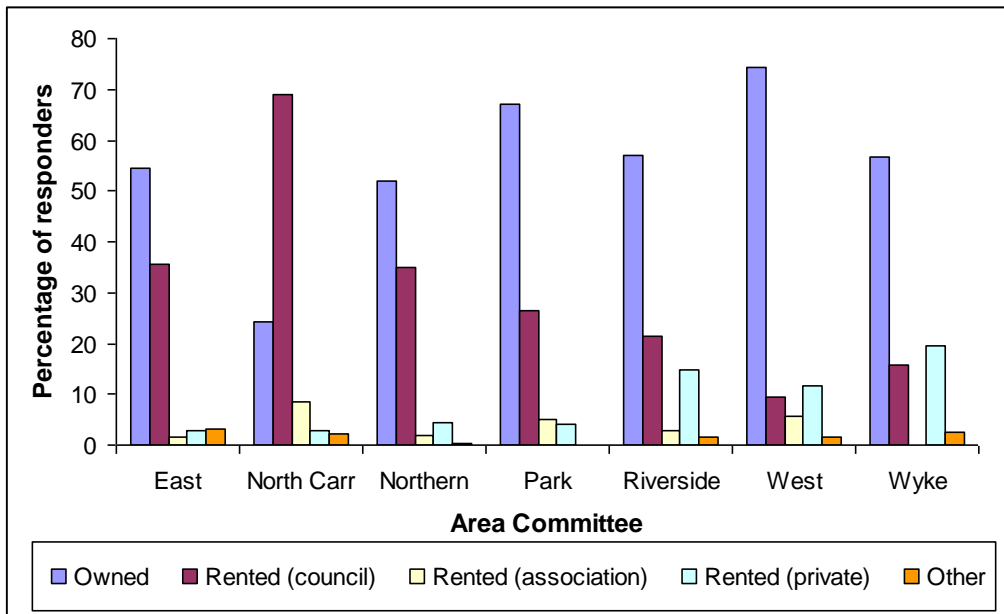
1.1.4   Deprivation

Hull is one of the more socially and economically disadvantaged cities in England. The Office of the Deputy Prime Minister produced an updated Index of Multiple Deprivation (IMD) in 2004 (based on the 2001 Census), and most areas of Hull were classified as having a high level of deprivation. The index combines a wide range of indicators for small geographical areas in a set of themed 'domains'.

There are seven domains which are:
- (i)   income deprivation;
- (ii)   education deprivation;
- (iii)   health deprivation and disability;
- (iv)   education, skills and training deprivation;
- (v)   barriers to housing and services;
- (vi)   living environment deprivation;
- (vii) crime.

Each domain is given a domain score for each geographical area. These seven domains have then been combined to give a single multiple-deprivation score. Scores for Local Authority areas have then been calculated as the population-weighted average of the scores of their constituent small areas.

Since this was last done in 2000, Hull has moved from the 13th most deprived to the 9th most deprived local authority area in England. Although there is no official ward-level version of the index, Hull City Council have calculated a population-weighted averages for wards, using 2001 Census population figures, in the same way the official local authority figures were calculated. *Table 1* gives this index score for each of the wards in Hull. The local rank for each of the 23 wards is also given, with a rank of one denoting the most deprived ward in Hull and a rank of 23 denoting the most affluent ward in Hull. The national rank is also given which is a rank out of the 7,932 wards in England for which it was possible to derive the deprivation index for the ward; again the lower the score the more deprivation. The National Percentile gives the position of the ward relative to the 7,932 English wards. A value of one denotes that the ward is in the most deprived 1% of all wards nationally.

- St Andrew's is the most deprived ward in the City, and the 15th most deprived in England.
- An additional four other wards in Hull are also in the most deprived 1% in England (Orchard Park and Greenwood, Myton, Southcoates East and Marfleet). Across all of England there are 79 wards which are in the most deprived 1%. These are in Liverpool (14), Manchester (9), Knowsley (6), Middlesbrough (6), Newcastle upon Tyne (5) and Hull (5), so over half (45) of the 79 are in just five authorities, one of them being Hull.
- In addition, it can be seen that none of the wards in Hull are in the most affluent 64% wards nationally (i.e. highest national percentile value is 36 for both Holderness and Beverley).

Table 1: Index of Multiple Deprivation 2004 for each ward in Hull

Area and Ward	Index Score	Local Rank	National Rank	National Percentile
EAST AREA				
Ings	32.9	15	1,019	13
Longhill	48.5	9	247	4
Sutton	29.6	17	1,315	17
NORTH CARR AREA				
Bransholme East	57.1	6	84	2
Bransholme West	53.7	7	131	2
Kings Park	21.6	21	2,349	30
NORTHERN AREA				
Beverley	18.7	23	2,842	36
Orchard Park and Greenwood	66.8	2	28	1
University	37.5	11	699	9
PARK AREA				
Holderness	18.8	22	2,830	36
Marfleet	57.7	5	78	1
Southcoates East	57.8	4	77	1
Southcoates West	32.4	16	1,064	14
RIVERSIDE AREA				
Drypool	35.0	14	866	11
Myton	65.5	3	34	1
Newington	53.0	8	136	2
St Andrew's	70.1	1	15	1
WEST AREA				
Boothferry	24.5	19	1,880	24
Derringham	27.0	18	1,598	21
Pickering	36.8	12	749	10
WYKE AREA				
Avenue	36.3	13	784	10
Bricknell	22.1	20	2,258	29
Newland	39.1	10	598	8

Figure 9 below illustrates this graphically relative to the national quintiles. The national IMD 2004 index is divided into five approximately equal groups which is equivalent to examining the national percentiles[1] into groups 0-19, 20-39, 40-59, etc.

Figure 9: National quintiles of Index of Multiple Deprivation 2004 for each ward in Hull

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[1] Percentiles divide a group into two based on the value they take of a particular measure (in this cases the IMD 2004 deprivation score). If the 10th percentile is 100, this means that 10% of the responders have a value of 100 or more and 90% of the responders have a value of 100 or less. The median and quartiles explained in the Statistical Methods section (5.9) are special cases (25th, 50th and 75th) of percentiles.

1.2   Perceptions About Life in Hull

Summary

- The number of years a person had lived in an area differed among the seven area committees.

- Most residents enjoyed living in their area (range 84% in Northern to 94% in North Carr and West).

- Overall, over 60% rated rubbish collection, health services and public transport as very good or good in their area. Overall, between 40% and 50% rated social and leisure facilities and education very good or good in their area. Overall, less than one-third of residents rated facilities for young people and teenagers, and police services as good or very good.

- Wyke and West areas tended to have the lowest percentage of residents rating local services as good or very good, and the highest percentages tended to occur for North Carr residents.

- The main concerns within the areas were for car crime, and alcohol or drugs use (8% and 7% reporting they were a very big problem in their area). Road traffic, parking, litter, dog mess, graffiti and vandalism, and noise having <7% reporting they were a very big problem in their area.

- A higher percentage of Riverside residents were thought these problems were 'a very big problem' in their area compared to all other areas.

- Between 88% and 95% of residents felt very or fairly safe when walking alone during the daytime in their area in all areas except the East (81%).

- The East area was also reported as the most unsafe after dark together with Riverside. In addition, a sizeable percentage of East residents in these areas never went out after dark (10% for males and 20% for females).

- West was the safest in terms of reported crime within the last year followed by Park (10% and 13% had been a victim of crime respectively).

- East, Riverside and Wyke had the highest percentage of reported crime with between 17% and 19% of residents reporting they had been a victim of a crime within the last year.

- The percentage of people feeling safe when walking alone in their area and the percentage who had been a victim of crime did not correspond directly.

As part of the context setting, but more importantly because it provides important background material to understand the workings of Social Capital, a series of questions were asked about the length of time living in the area and how much respondents enjoy living there, local facilities and services, followed by local area safety issues and problems. This will provide information which should be useful generally across the city but from a Social Capital perspective how people view their local area can have an impact on civic engagement and how much trust they have. If people have lived in the area for a long time then they are likely to have built up more immediate support and information networks.

1.2.1 Longevity and Enjoyment of Local Area

- Most people reported living in their area for 20 years or less, although almost one in five said they had lived in the same area for more than 20 years (*Table 2*).
- The longest attachment to particular areas are seen in East, Park and West.
- Whereas, Riverside, North Carr and Wyke had the 'newest' residents with over one third of residents in each of the areas having lived there for less than 5 years.

Clearly, how many years a person has lived within an area will be dependent on their age. The least square (LS) mean and 95% confidence interval (CI) gives the number of years living in a particular area taking into account the differences in the age structures between the areas[2].

Table 2: Number of years living in same area for each area committee

Living in area (years)	Percentages within each area committee							
	East	**North Carr**	**Northern**	**Park**	**Riverside**	**West**	**Wyke**	**Hull**
0 – 5	22	41	26	21	38	24	34	**29**
6 – 10	24	25	26	26	23	28	28	**26**
11 – 20	31	24	30	32	22	31	23	**28**
21 – 30	12	7	10	9	6	7	8	**8**
>30	11	3	8	12	10	11	7	**9**
LS Mean	**15.6**	**12.2**	**15.2**	**16.4**	**13.5**	**15.6**	**15.0**	
95% CI	**14.7-16.4**	**11.1-13.3**	**14.2-16.1**	**15.6-17.3**	**12.7-14.3**	**14.8-16.5**	**14.1-16.0**	

[2] See statistical methods section for more information about least square means and confidence intervals. The LS mean gives the number of years living in the areas for each area committee adjusting for the difference in age groups among the different area committees. The 95% CI gives a range of values for the LS mean for which we are 95% confident that the range contains the true underlying mean for the population as a whole.

In addition, estimating age from the mid-point of the age group, the percentage of each person's lifetime they have lived in the area has been calculated (*Table 3*).

- Almost one third of North Carr and Riverside residents had lived in that area for less than 10% of their lifetime. So it is possible that the Social Capital for these areas is lower, because networks have had less time to develop compared to other areas.
- Whereas 15% or less of East and Park residents had lived in the area for less than 10% of their lifetime.

Table 3: Percentage of lifetime person has lived within area separately for each area committee

Percentage of lifetime living in area	Percentages within each area committee							
	East	**North Carr**	**Northern**	**Park**	**Riverside**	**West**	**Wyke**	**Hull**
0 – 9	15	30	18	13	30	18	22	**20**
10 – 19	21	26	19	21	24	20	22	**22**
20 – 39	32	27	34	34	25	36	33	**32**
40 – 59	18	9	17	16	11	13	12	**14**
60 – 79	6	3	4	7	4	5	4	**5**
80 – 100	9	6	8	8	6	8	8	**8**

- Most respondents (90%) enjoyed living in their local area ranging from 84% in Northern to 94% in North Carr and West (*Table 4*).

Table 4: Enjoy living in area separately for each area committee

Enjoy living in area	Percentages within each area committee							
	East	**North Carr**	**Northern**	**Park**	**Riverside**	**West**	**Wyke**	**Hull**
Yes	90	94	84	91	89	94	86	**90**
No	9	5	13	7	8	5	10	**8**
Don't know	1	2	4	2	2	2	4	**2**
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

1.2.2   Quality of Local Facilities and Services

The survey asked people what they thought of local services (*Table 5*).
- Highest rankings (>60% very good or good):
  - o   Rubbish collection.
  - o   Public transport.
  - o   Local health services.
- Middle rankings (45% to 50% very good or good):
  - o   Social/leisure facilities for people.
  - o   Education.
- Poorest rankings:
  - o   Facilities for young people (although one in five of those surveyed did not have an opinion).
  - o   Facilities for teenagers (although one in five of those surveyed did not have an opinion).
  - o   Police services.

Table 5: Assessment of quality of local services

Local Services	Percentages of responders rating service				
	Very Good or Good	Average	Poor or Very Poor	Don't know	Total
Social/leisure facilities for people	47	29	21	3	**100**
Facilities for young people	32	28	20	20	**100**
Facilities for teenagers	22	25	33	20	**100**
Rubbish collection	64	31	3	2	**100**
Health services	63	29	5	3	**100**
Public transport	64	28	4	4	**100**
Schools, colleges, adult education	49	32	6	13	**100**
Police services	31	42	20	7	**100**

Examining these services across the seven areas for social and leisure facilities (***Table 6***):
- The highest rating in the West area.
- Lowest rating in the East and Northern areas with almost one third of respondents indicating they thought such facilities were poor or very poor in that area.

Table 6: Rating of social and leisure facilities for people for each area committee

Rating for social and leisure facilities	Percentages of responders for each area committee							
	East	**North Carr**	**Northern**	**Park**	**Riverside**	**West**	**Wyke**	**Hull**
Very good/Good	37	46	35	51	50	59	50	**47**
Average	29	26	31	29	30	28	29	**29**
Poor/Very poor	31	25	31	16	17	12	19	**21**
Don't know	3	3	2	4	4	1	2	**3**
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

- Health services were generally well regarded (***Table 7***).
- Highest (79% very good or good) in North Carr.
- Lowest (52%) in Wyke.

Table 7: Rating of local health services for each area committee

Rating of local health services	Percentages of responders for each area committee							
	East	**North Carr**	**Northern**	**Park**	**Riverside**	**West**	**Wyke**	**Hull**
Very good/Good	68	79	58	65	64	58	52	**63**
Average	21	18	32	27	28	37	38	**29**
Poor/Very poor	7	1	7	5	6	4	7	**5**
Don't know	4	2	3	3	1	1	4	**3**
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

A wide range of opinion is also shown when looking at educational services and facilities (*Table 8*).

- As with health services North Carr has the highest rating with 64% of responders recording a very good or good rating.
- Less than half of responders rate education as very good or good in West, Northern and Wyke.

Table 8: Rating of local schools, colleges and adult education for each area committee

Rating of local educational establishments	Percentages of responders for each area committee							
	East	North Carr	Northern	Park	Riverside	West	Wyke	Hull
Very good/Good	50	64	43	52	54	44	40	**49**
Average	32	20	29	32	29	43	36	**36**
Poor/Very poor	4	5	13	7	4	2	8	**8**
Don't know	14	12	16	10	13	11	15	**15**
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Survey responders were also asked to rate their local police services. At the time of the data collection for the study, there had been some recent adverse publicity for Humberside Police Services and it is possible that this could have influenced the ratings given. Therefore, it is possible that the ratings of police services could now be slightly different.

The rating of police services as very good or good was more uniform across the city, as shown in *Table 9*.

- With similar percentages of responders for East, North Carr, Northern and Park (32-36%).
- Slightly lower percentages for Riverside (29%), West (27%) and Wyke (23%).
- There are also slight differences in the percentage of responders rating the police as poor or very poor (18-25%) and only 12% for the West area.

Table 9: Rating of local police services for each area committee

Rating of local police services	Percentages of responders for each area committee							
	East	North Carr	Northern	Park	Riverside	West	Wyke	Hull
Very good/Good	34	35	32	36	29	27	23	**31**
Average	37	43	39	39	39	53	48	**42**
Poor/Very poor	23	18	23	20	25	12	20	**20**
Don't know	6	5	7	6	7	9	9	**7**
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

The rating of facilities for young children (*Table A1*) and teenagers (*Table A2*) and the rating of rubbish collection (*Table A3*) and local public transport (*Table A4*) for each area committee are given in *Annex III of Appendix 6*.

- Northern and Wyke residents rated the facilities for young children the lowest compared to other areas.
- East and Northern had the worst ratings for teenagers.
- West and Wyke had the poorest ratings for rubbish collection and local public transport.

1.2.3   Problems Within Area

We also asked people if they had problems with the following in their areas:
- (i)   speed or volume of road traffic;
- (ii)   parking on residential streets;
- (iii)   car crime;
- (iv)   rubbish and litter lying around;
- (v)   dog mess;
- (vi)   graffiti or vandalism;
- (vii)   level of noise;
- (viii)   alcohol or drug use.

A breakdown of answers can be found in *Annex III of Appendix 6 (Tables A5 to A12)*.
- Main concerns:
  - o   Car crime.
  - o   Alcohol or drug use.
- Between one quarter and one third of responders thought that car crime was a very big or fairly big problem (with the exception of the West where it was only 9%).
- The percentage of people reporting that alcohol or drug use was a problem varied among the seven areas.
  - o   It was less of a problem in the West (8% reporting it was a very big or fairly big problem).
  - o   Intermediate areas were Wyke, Park, East and North Carr (19% to 23%).
  - o   More of a problem in the Northern area (26%) and Riverside (34%).
- Levels of noise and litter scored lowest as problems.
- In most cases, however, well over half of the respondents did not identify any of the issues listed as a problem except for East (parking on residential streets and graffiti or vandalism) and Riverside.
- More than a quarter of Riverside residents reported that the speed or volume of road traffic, parking on residential streets, rubbish and litter lying around, dog mess, and graffiti or vandalism were a very big or fairly big problem.

1.2.4   Safety Issues

1.2.4.1   Feelings of Safety When Walking in Area Alone

We asked people how safe they felt when walking alone either during the day or after dark.

- For responses in relation to safety during the daytime, there was a difference[3] between males and females.
- However, this was due to differences in the percentages feeling very safe (47% and 41% respectively) and fairly safe (42% and 47% respectively).
- If these two categories were combined, the percentages feeling very or fairly safe, a bit unsafe, very unsafe or never going out were similar between the sexes.

- *Table 10* shows that between 88% and 95% of people felt very or fairly safe when walking alone during the daytime in all areas except the East (81%).
- Three percent of respondents in the East felt very unsafe and a further 2% never went out during the daytime.
- These figures were both between 0% and 2% for all other areas.

Table 10: How safe residents feel when walking alone in the area during daytime for each area committee

Safety within area during daytime	Percentages of responders for each area committee							
	East	North Carr	Northern	Park	Riverside	West	Wyke	Hull
Very safe	33	37	50	43	32	55	62	**44**
Fairly safe	48	54	38	45	56	40	31	**45**
A bit unsafe	14	8	9	9	9	4	6	**8**
Very unsafe	3	1	2	1	2	<1	<1	**1**
Never goes out	2	1	<1	2	2	2	<1	**2**
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

There was a difference[4] in responses between men and women with respect to safety after dark. Therefore, the *Tables 11 and 12* show responses for males and females separately.

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[3] The difference was statistically significant (χ^2 test, df=4, p=0.003).
[4] The difference was statistically significant (χ^2 test, df=4, p<0.001).

- After dark, the East area was also reported as the most unsafe; 33% of men and 44% of women felt a bit or very unsafe in this area.
- In addition, a further 10% of men and 20% of women living in the East area reported that they never went out alone after dark.
- The West and Wyke areas were reported as the safest areas for both men and women after dark, with 71-80% of men and 70-75% of women feeling very or fairly safe.
- For men, there was also a similar level of safety reported for North Carr as there was for Wyke.

Table 11: How safe male residents feel when walking alone in the area after dark for each area committee

Safety within area after dark	Percentages of male responders for each area committee							
	East	North Carr	Northern	Park	Riverside	West	Wyke	Hull
Very safe	19	5	34	20	16	31	36	**24**
Fairly safe	37	60	37	46	46	49	35	**44**
A bit unsafe	24	27	14	18	18	9	17	**18**
Very unsafe	9	6	11	6	10	3	9	**8**
Never goes out	10	3	3	10	11	7	3	**7**
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Table 12: How safe female residents feel when walking alone in the area after dark for each area committee

Safety within area after dark	Percentages of female responders for each area committee							
	East	North Carr	Northern	Park	Riverside	West	Wyke	Hull
Very safe	8	3	30	19	11	28	40	**20**
Fairly safe	28	50	26	37	28	42	35	**34**
A bit unsafe	33	30	25	22	34	20	13	**25**
Very unsafe	11	11	13	9	14	3	7	**10**
Never goes out	20	6	5	14	12	7	5	**11**
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

1.2.4.2 Victim of Crime Within Last Year

There was a difference[5] in the percentage of responders stating that they had been a victim of a crime within the last year among the seven areas of Hull (*Table 13*).

- The West had the lowest rate (10%).
- Followed by Park (13%), Northern (15%), Wyke (17%), Riverside (18%) and East (19%).
- With North Carr reporting the highest rate of crime (23%).

Table 13: Victim of crime in last year

Type of crime	Percentages of responders for each area committee							
	East	North Carr	Northern	Park	Riverside	West	Wyke	Hull
None	81	77	85	87	82	90	83	**84**
House	6	10	4	5	6	3	3	**5**
Car	7	6	6	4	5	4	4	**5**
Theft	2	1	2	1	1	1	1	**1**
Physical	2	1	1	<1	1	1	2	**1**
Racial	<1	<1	<1	<1	1	0	2	**1**
Other	1	1	1	1	1	1	2	**1**
Multiple*	<1	2	1	<1	2	<1	2	**1**
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

*It is unknown whether these different types of crime occurred on the same occasion or on multiple occasions over the 12 month period.

The West and Wyke areas were consistently reported as the safest in terms when walking alone, and the East area as the most unsafe. However, in terms of reported crime, the East area is not the worst area and Wyke is not the best area, although the West does have the lowest reported crime. In fact, excluding car crime which might be thought of as less 'personal', 12.2% report house crime, theft, physical, racial and/or other types of crimes in Wyke (which is relatively high in relation to other areas with only Riverside (12.7%) and North Carr (16.4%) have higher percentages). The East area reported a corresponding figure of 11.3% with Northern (9.4%) and Park (9.1%) having similar levels of reported crime and West having the lowest levels of such crimes (5.9%).

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[5] The difference was statistically significant (χ^2 test, df=4, p<0.001).

1.3 Conclusions

The majority of people within each area enjoyed living there, and the number of years they had lived there differed across the seven area committees which could influence the build up of Social Capital. The majority of people within all areas rated local health services as good or very good, but this was not true for every area committee for other services, for example, education, social facilities or the police services. Feelings of personal safety when walking alone within the areas and reported crime differed among the areas, but it was not always the areas that felt the least safe that had the highest levels of reported crime.

2 Health in Hull

2.1 Health Status in Hull in Relation to National Health

Summary

- The life-expectancy of men and women living in Hull is lower than the national average.

- The gap between life-expectancy of Hull residents and the national average has increased over time (1991-2001) for men.

- The age-sex standardized mortality ratio for persons less then 75 years of age (SMR) in Hull between the period 1988 and 2000 is higher than the national average for all seven area committees (and 17 of the 23 wards within these areas).

- Riverside had the highest SMR (over 150, i.e. 50% higher than the national average), followed by North Carr, Wyke, Park and Northern (ranging from approximately 130 to 120), followed by East (approximately 115), and West (approximately 108).

We know that health in Hull could be better. Each year the Director of Public Health for the city produces a report that describes the health status of the population (usually measured by the extent of disease or death as compared to regional or national averages).

In her last report for 2003, it was shown that for both men (*Figure 10*) and women (*Figure 11*) average life expectancy was less than the national average (although women fair better than men).

Figure 10: Male life expectancy in Hull compared to England and Wales (1991-2001)

Male life expectancy in Kingston upon Hull compared with England and Wales (1991-2001)
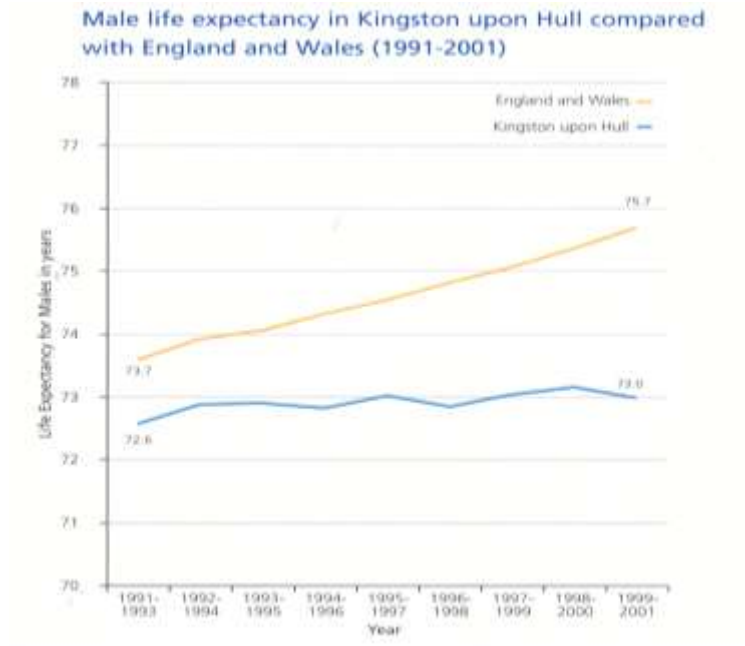
Figure 11: Female life expectancy in Hull compared to England and Wales (1991-2001)

Female life expectancy in Kingston upon Hull compared with England and Wales (1991-2001)
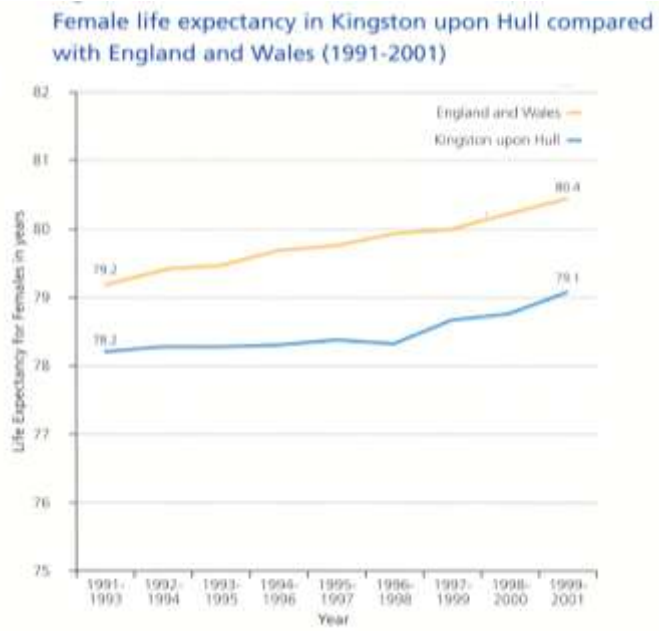
There are also real differences in health status across Hull. *Figure 12* shows differences in the standardised mortality ratio (SMR) for those aged less than 75 years for the period 1998 to 2000 among Area Partnerships (with the blue dots representing the individual committees and the red dots represent individual wards).

- As can be seen there is considerable difference among the wards within each area committee with the exception of Wyke.
- In particular, Riverside, North Carr and Northern have one ward that has a considerably lower mortality rate compared to the other wards within their area.
- Overall, Riverside area committee has the highest standardised morality ratio and the West the lowest.
- However, it can also be seen that all the ward averages are above 100 and therefore are higher than that expected from national death rates given the age and sex distribution within each ward.

Figure 12: Standardised mortality ratio for persons less than 75 years of age in Hull over the period 1998 to 2000

51
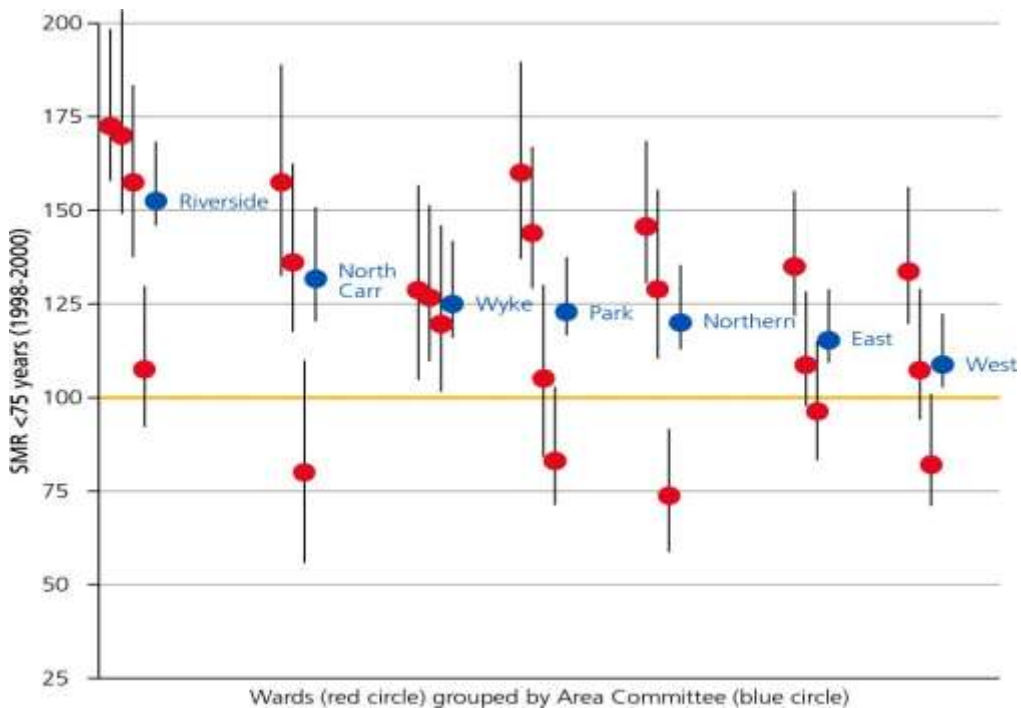
2.2 Health Status in the Survey

The survey asked a number of questions about people's perceptions of their health, whether they had long term illness or disability, and how they would describe their health and mental well-being. The answers to some of these questions were combined to produce either an overall score for general health or mental well-being.

2.2.1 Age and Gender

Summary

- The percentage of survey responders reporting they suffered from a long standing illness or disability which limited daily activities increased from 3% of those aged 16 to 24 years to 58% for those aged 75 years or more.

- The Visual Analogue Scale (Health Thermometer) also differed significantly with a lower score (worse health) reported by the eldest responders.

- Eighty percent reported the highest possible health-related quality of life for those aged 16 to 54 years, but this fell to 62% for those aged 55-64 years and to 51% for those aged 65 years or over.

- The Mental Health Inventory score did not differ substantially among the age groups.

- The highest percentage of people reporting a moderate or large amount of stress or pressure occurred for those aged 35-54 years (40%) followed by those aged 16-34 years (35%). The percentage reporting stress decreased as age increased in the older age groups (55+ years) but increased again in the oldest age group.

There were no real differences between men and women in terms of health status from the survey, although men reported slightly better mental health than women.

Most of the differences in health status are associated with age and ageing which is not unexpected (*Figure 13*). In response to the question 'Do you suffer from any long standing illness, health problem or disability which limits your daily activities?' there was a significant difference among the age groups.

- There was a gradual increase from 3% for those aged 16 to 24 years to 15% for those aged 45-54 years. Thereafter, a more dramatic increase occurred.
- Similar percentages in the 55-64 and 65-74 year age groups were reported (36% and 40% respectively), but this increased to 58% in those aged 75 years or more.
- Over all age groups combined, this figure was 19% which is comparable to the 2001 census when the same question was asked (21%).

Figure 13: Percentage of responders suffering from a long standing illness or disability which limits daily activities for each age group
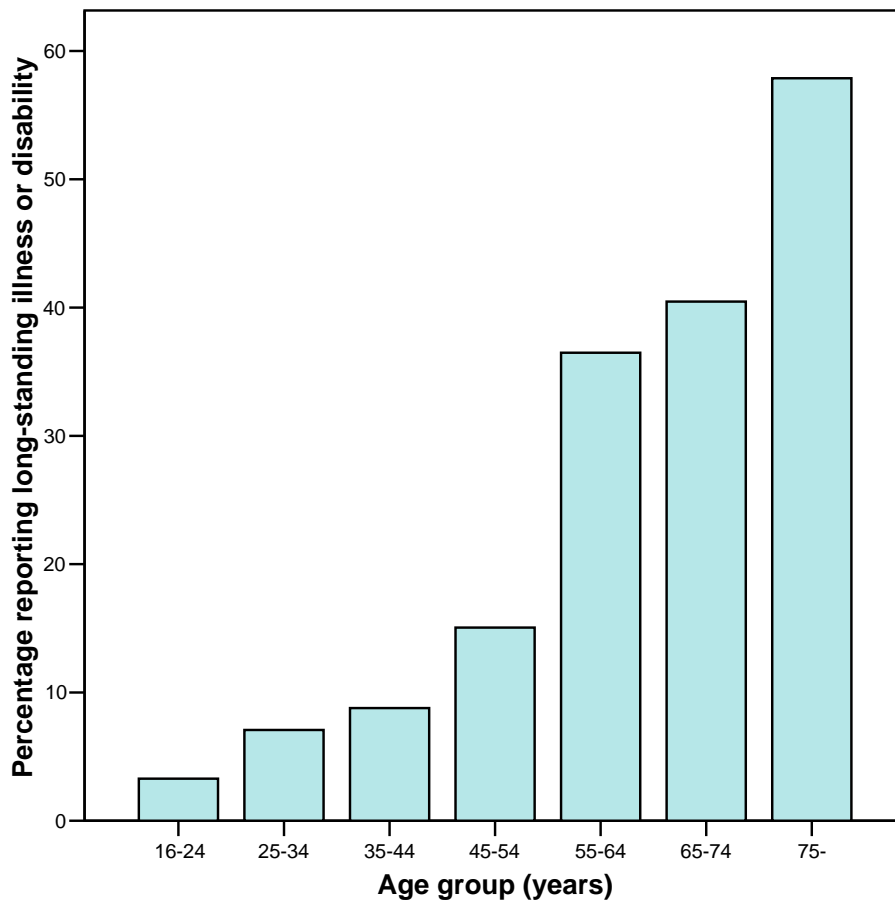
The Visual Analogue Scale (VAS) or Health Thermometer was used as a measure of self-reported health. Study responders were asked to rate their health on a scale from zero to 100, with 0 representing the worst state and 100 representing the best state. *Figure 14* uses a boxplot to illustrate the distribution of the VAS Health Thermometer. The boxplot illustrates the quartiles which divides responders into four groups in terms of the VAS Health Thermometer value they report[6], with half of the survey responders having a value within the range of the box. As expected, the score decreases as age increases.

- One quarter of responders aged 16 to 24 years rate their health as 85 or less.
- Whereas one quarter of people aged 75 years or more rating their health as 50 or less (half way between the worst and best state).

Figure 14: Boxplot illustrating distribution of the VAS Health Thermometer score for each age group

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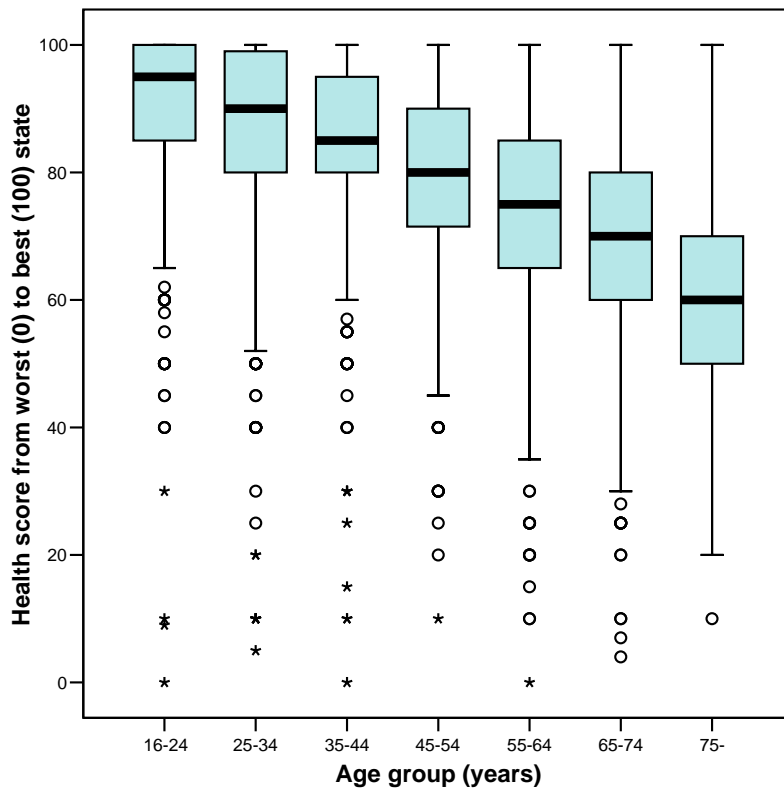
[6] Since the VAS (Health Thermometer) has a skewed distribution in that the majority of people in the survey have values within a narrow range and a small number of values are very low in relation to the majority, the mean is not the most appropriate measure to summarise the measure. See statistical methods for more explanation of a boxplot. As mentioned above, the boxplot divides the survey responders into four groups based on the value of the measure (VAS/Health Thermometer in this case). One quarter have a value equal to or higher than the top line of the box, one quarter the value between the line in the box and the top of the box, one quarter the value between the line in the box and the bottom of the box, and the final quarter a value equal to or lower than the bottom edge of the box. The "whiskers" show the general spread of the points. [Any observations between 1.5 and 3 box lengths away from the end of the box are classified as outliers (circles) and any observations more than 3 box lengths away as extreme values (asterisks).]

The EuroQoL is another measure of health which focuses more on quality of life. It produces a score derived from five questions rating mobility, self-care, ability to perform usual activities, pain/discomfort and anxiety/depression. The resulting score ranges from negative values (extremely poor quality of life) to the value of +1 (perfect quality of life). *Table 14* gives the percentage of persons in each age group who have different ranges of values for the EuroQoL.

- It can be seen that approximately 80% of those aged 16 to 54 years have the highest quality of life and between 2% and 4% of people in these age groups have a poor or very poor quality of life.
- However, these figures change to 62% and 8% for those aged 55-64 years increasing to 51% and 16% in the oldest age group.

Table 14: Distribution of EuroQoL measure of quality of life for each age group

EuroQoL (measure of quality of life)	Percentages of responders for each age group						
	16–24	25–34	35–44	45–54	55–64	65–74	75+
Zero or less (very poor)	1	<1	1	1	3	4	6
0.001 to 0.499 (poor)	1	2	3	3	5	4	10
0.500 to 0.999 (not perfect)	16	18	17	13	30	41	34
1 (perfect)	81	80	79	82	62	51	51
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

The Mental Health Inventory is derived from five questions from the SF-36 questionnaire. The questions form a score which ranges from 5 to 30 with a higher score denoting better mental health. A transformed score can also be calculated and the shape of the distribution is identical as the only difference is a change to the scale (0-100).

The distribution of the untransformed index is illustrated in *Figure 15*. It can be seen that the majority of responders have a score of between 24 and 30, but 10% have a score of 21 or lower and 5% have a score of 18 or lower.

Figure 15: Mental Health Inventory (on original scale from 5 to 30) for all responders with a highest score denoting better mental health
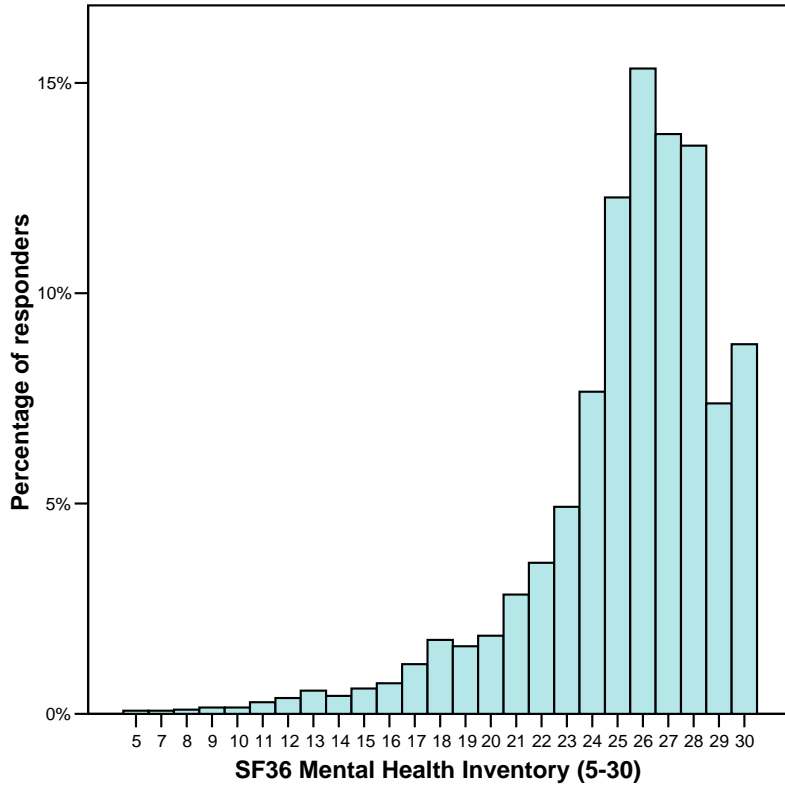
There is not a great deal of difference in distribution of the Mental Health Inventory score for the different age group (***Figure 16***).

- The oldest age groups tend to have a slightly lower score denoting worst mental health.
- The medians[7] are all the same except for the oldest age group, so that half the population aged 16-74 years have a score of 26 or less, and half of those aged 75 years or more have a score of 25 or less.

Figure 16: Boxplot of Mental Health Inventory (on original scale from 5 to 30) for all responders with a highest score denoting better mental health by age group
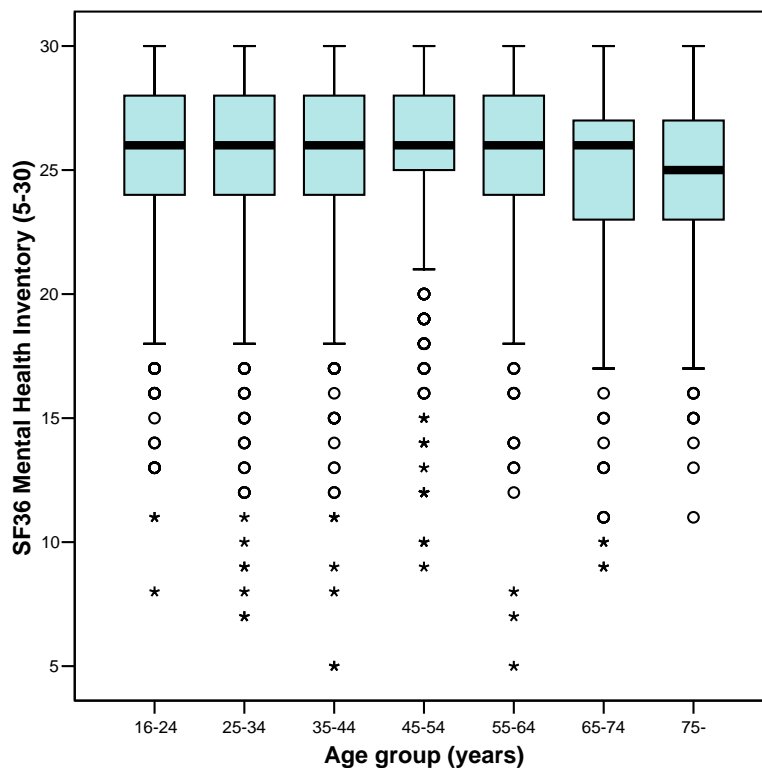
[7] See statistical methods for more details. The median divides the responders into two groups based on the value of their Mental Health Inventory. The black line across the box denotes the median. The top and bottom of the box denote the upper and lower quartiles respectively. One quarter of people have a value equivalent or higher than the top line of the box, half of responders have a value within the box, and the remaining quarter of responders have a value equivalent to or lower than the bottom line of the box. The general spread of the responses are denoted by the "whiskers" and the circles and asterisks denote "outliers" and "extreme values" respectively.

Survey responders were also asked to describe the amount of stress or pressure they had experienced in the past 12 months. *Figure 17* illustrates the percentage reporting a moderate or large amount of stress or pressure.

- A higher percentage of people report stress as age increases.
- From 33% in the 16-24 year age group to 41% in the 35-44 and 45-54 year age groups.
- This then decreases to 26% in the 65-74 years age group.
- But increases again in the oldest responders to 32%.

This pattern is as would be expected with stress or pressure increasing as domestic and working responsibilities increase and then decrease into later life, and the increase in the oldest group may be associated with increase stress or pressure due to health-related issues.

Figure 17: Percentage of persons reporting moderate or large amounts of stress or pressure by age group
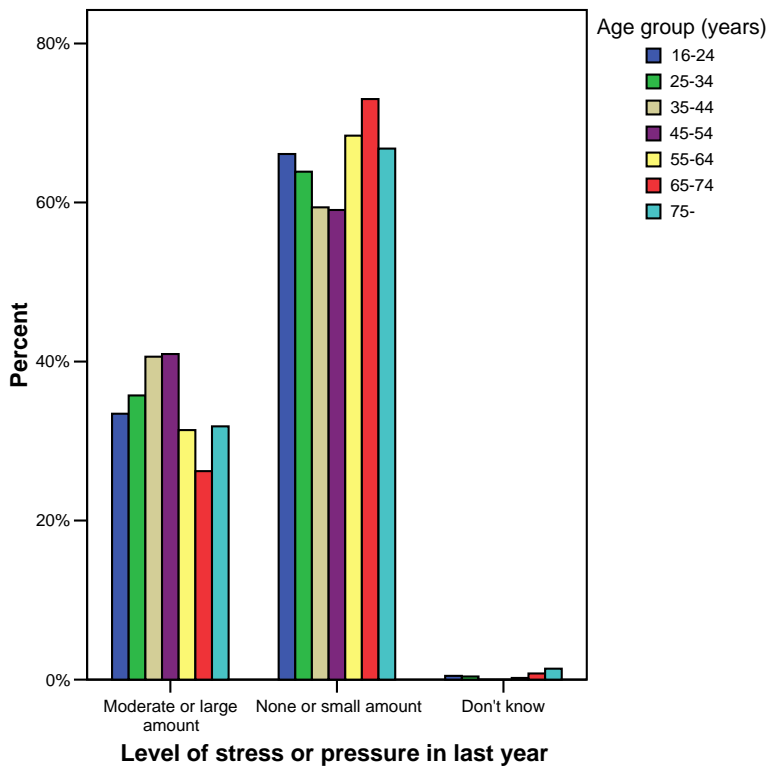
2.2.2   Area

Summary

- Comparison of health status among the seven area committees is complicated by the fact that they have different age structures and the elderly are more likely to report ill-health.

- Nevertheless, Riverside residents tend to report much higher levels of physical ill-health, with approximately 60% of Riverside residents aged 55 years and over reporting they suffer from a long standing illness, health problem or disability. This figure is higher than even those aged 75 years and over in all other areas with the exception of the oldest residents in Wyke.

- There was less of a difference in the Mental Health Inventory score among the seven area committees, although Northern and Wyke residents tended to have the lowest (worst) scores.

- The percentage reporting a moderate or large amount of stress or pressure differed substantially among the areas. North Carr and East reported the lowest percentage with stress (<30%), and Riverside, West and Wyke tended have the highest percentages (30% to 45% depending on age group).

- The highest percentage (55%) reporting high levels of stress or pressure occurred for the Wyke residents aged 16-24 years. Wyke has a high student population and since the survey was conducted at a time traditionally associated with examinations, this finding is not unexpected.

An analysis of health status by area is complicated by their age profile in that older people have been identified as having poorer health and if there are more older people living in one area than another this could bias the results.

The majority of the analyses presented below do not take into account this factor because it is important to describe the areas as reported in the survey, and it become much more complicated examining age simultaneously. In *Figures A2 to A8* within *Annex III of Appendix 6* it can be seen that North Carr and Wyke have the youngest profile in the city with the West and East areas having the highest profile of older people.

Figure 18 illustrates the percentage of respondents who suffer from any long standing illness, health problem or disability which limits their daily activities.

- There is considerable difference between the area committees.
- Riverside residents more inclined to suffer from such illnesses or disabilities.
- Wyke residents the most unlikely to report that they suffer from long-standing illnesses, health problems or disabilities which limit their daily activities.

Figure 18: Percentage suffering from any long standing illness, health problem or disability which limits their daily activities for each area committee separately
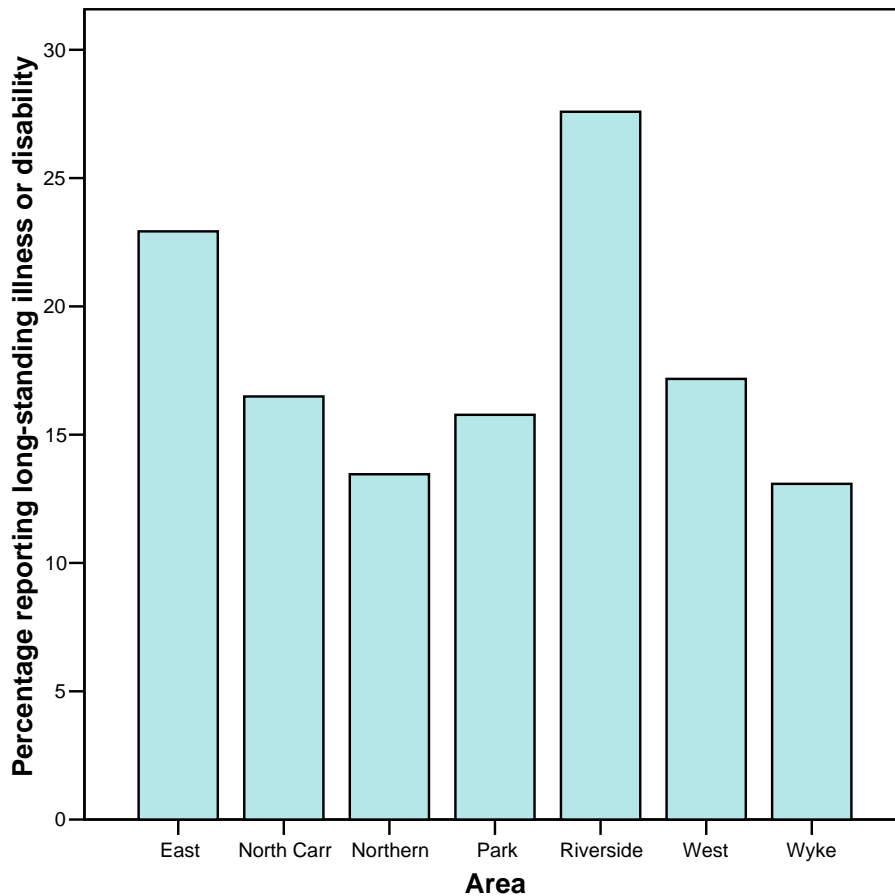
It is possible to examine the percentage reporting long-term illness and disability for each age group within each area. *Figure 19* illustrates these percentages.

- Within each area, the highest percentage reporting long-standing illness or disability occurs in those aged 75 years and older.
- Over all age groups, Northern residents report the lowest levels of illness.
- Residents in Riverside report the highest levels.

In fact, in Riverside, approximately 60% of those aged 55 years and older report that they suffer from long-standing illness or disability, which is a higher percentage than even those aged 75 years or older from other areas, with the exception of the eldest Wyke residents (73%, of whom there are only a small number who are within this age group in this area).

Figure 19: Percentage suffering from any long standing illness, health problem or disability which limits their daily activities by age group for each area committee separately
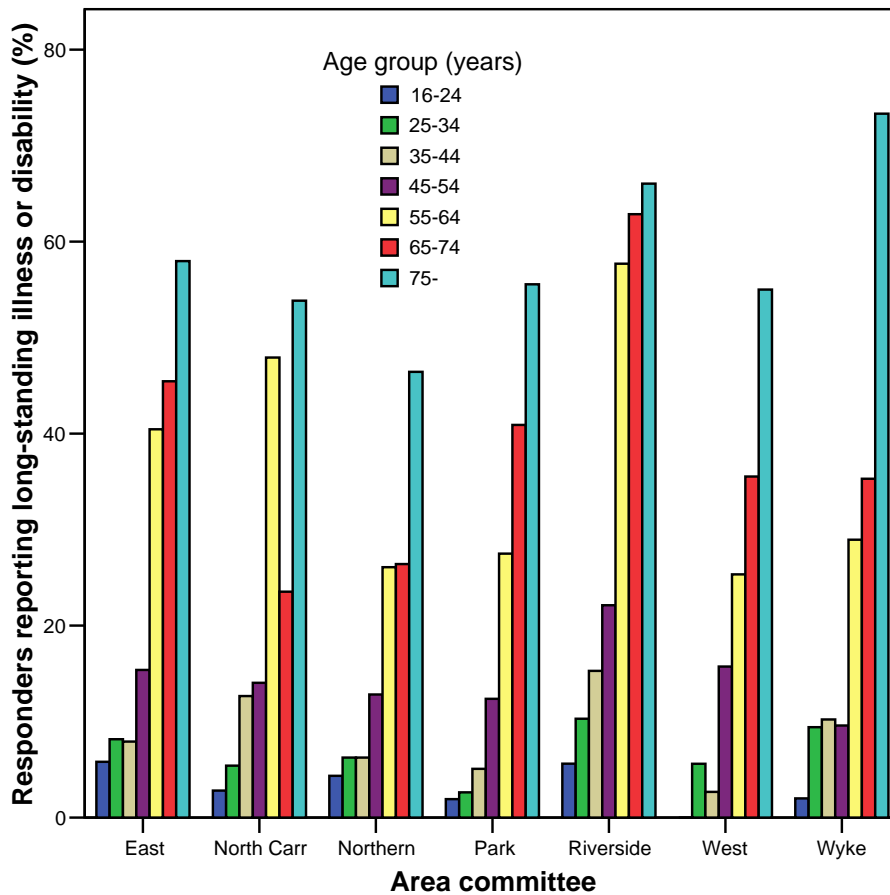
A boxplot is used to illustrate the self-reported VAS Health Thermometer which ranges from 0 (worst possible health) to 100 (best possible health) for the different area committees for each of three age groups (*Figure 20*). Again, the bottom and the top of the box and the line across the box denote the lower quartile, upper quartile and median respectively. The median divides responders into two groups based on their value of the VAS Health Thermometer with half of responders have a value of the median or more (and half having a value or the median or less)[8].

- The figure confirms that Riverside residents report the highest levels of ill health, this appears to be particularly so for those aged 16-54 years.
- Half of Riverside residents in this age group (16-54 years) report a score of 80 or lower, whereas half those in the same age group from other areas report a score of 90 or lower.

Figure 20: Boxplot illustrating distribution of the VAS Health Thermometer score for three age groups for each area committee separately

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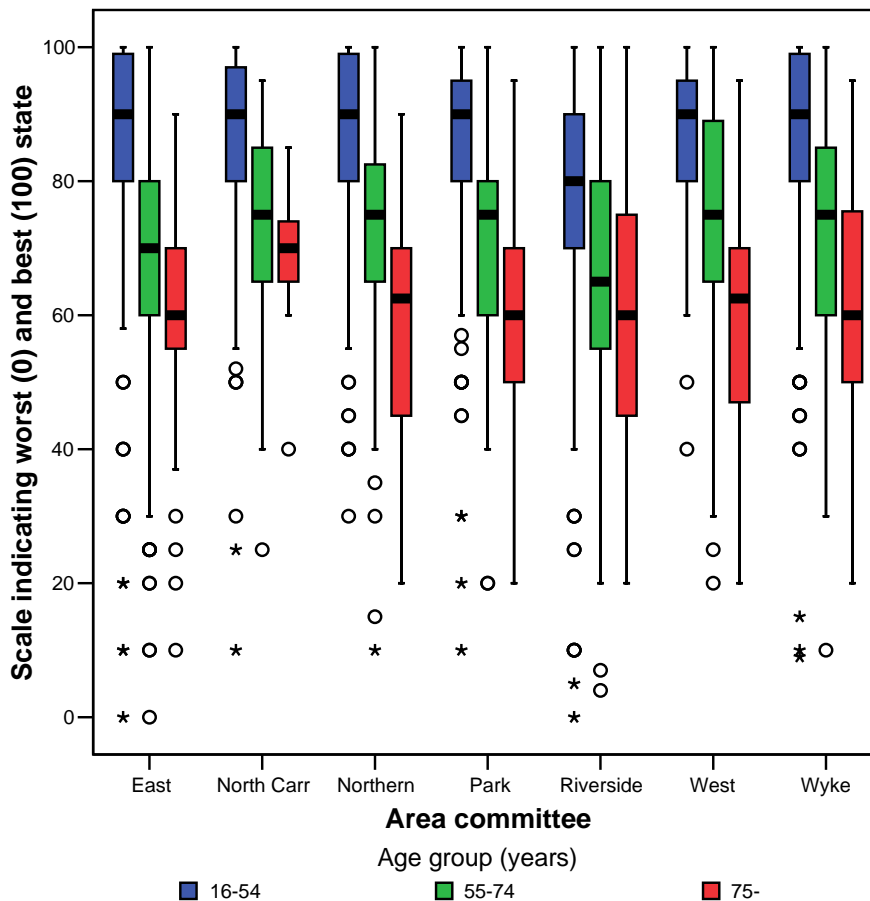
8 See statistical methods section for more details.

Table A13 in *Annex III of Appendix 6* illustrates the percentage of residents in each area (by age) who have poor or very poor quality of life and perfect quality of life.

- For those aged 16-54 years, between 82% and 85% have perfect quality of life except for residents in the East (75%) and Riverside (72%) areas. The same pattern occurs for those aged 55-74 years where over 60% report perfect quality of life, but less for East and Riverside residents (54% and 41% respectively).
- Also, 15% of Riverside residents of this age report poor or very poor quality of life.
- In those aged 75 years or more, over 50% report perfect quality of life except for East (46%) and Riverside (42%). The percentages are also low for North Carr (39%) and Wyke (29%) in this age group, however, the estimates are only based on a small number of individuals (13 and 14 respectively).
- Almost 20% of residents aged 75 year or more in Park and Riverside report poor or very poor quality of life.

Figure 21 illustrates the Mental Health Index for the seven areas for each of the three age groups. In all areas, the median score is lowest in the oldest age group or the same as the middle age group, except for North Carr (but the number aged 75+ years is small).

Figure 21: Boxplot illustrating distribution of the Mental Health Inventory score for three age groups for each area committee separately
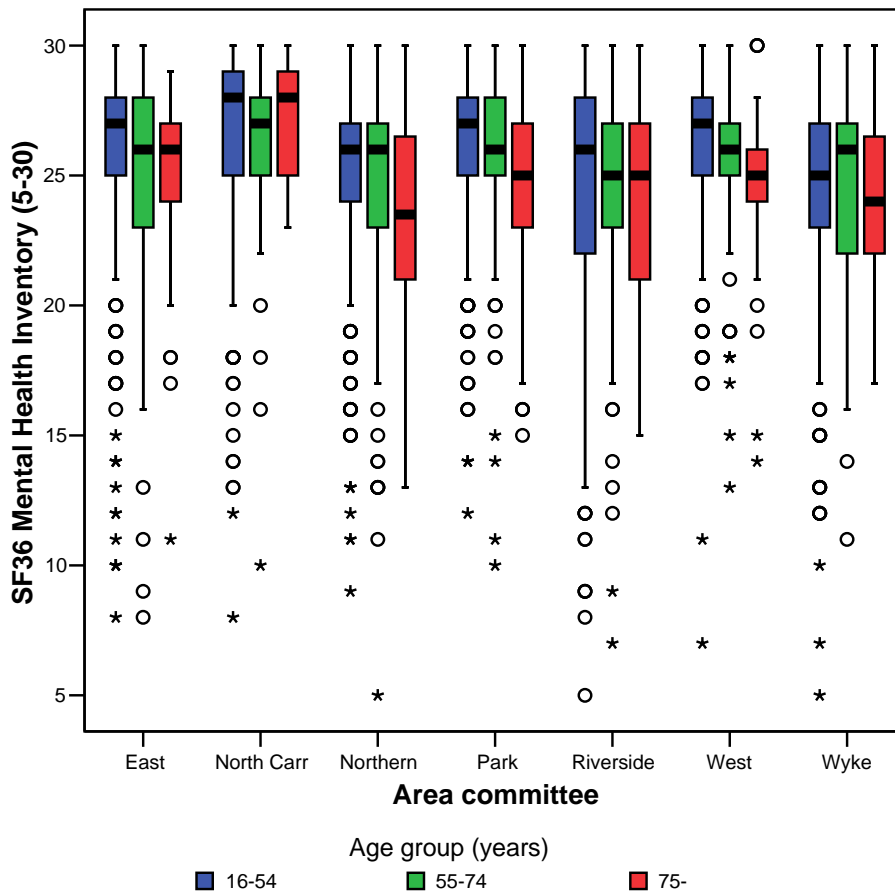
From information provided earlier in this report, it was noted that the stress levels were similar for age groups 35-44 and 45-54 years, and for age groups 55-64 and 65-74 years so these groups have been combined in the *Figure 22*. The figure reveals a large difference in the percentage of responders who report having experienced a large amount or moderate amount of stress or pressure within the last 12 months.

- In general, East and North Carr report lower levels of stress.
- Residents in Riverside, the West and Wyke report the most stress. In particular, those aged 16-24 years living in Wyke (where 58% report a large or moderate amount of stress or pressure).

Wyke is an area where a relatively large number of students live, and since the survey interviews were completed around the time of their examinations (June), this finding is not unexpected.

Figure 22: Percentage of residents in different age groups reporting large or moderate amounts of stress or pressure for each area committee
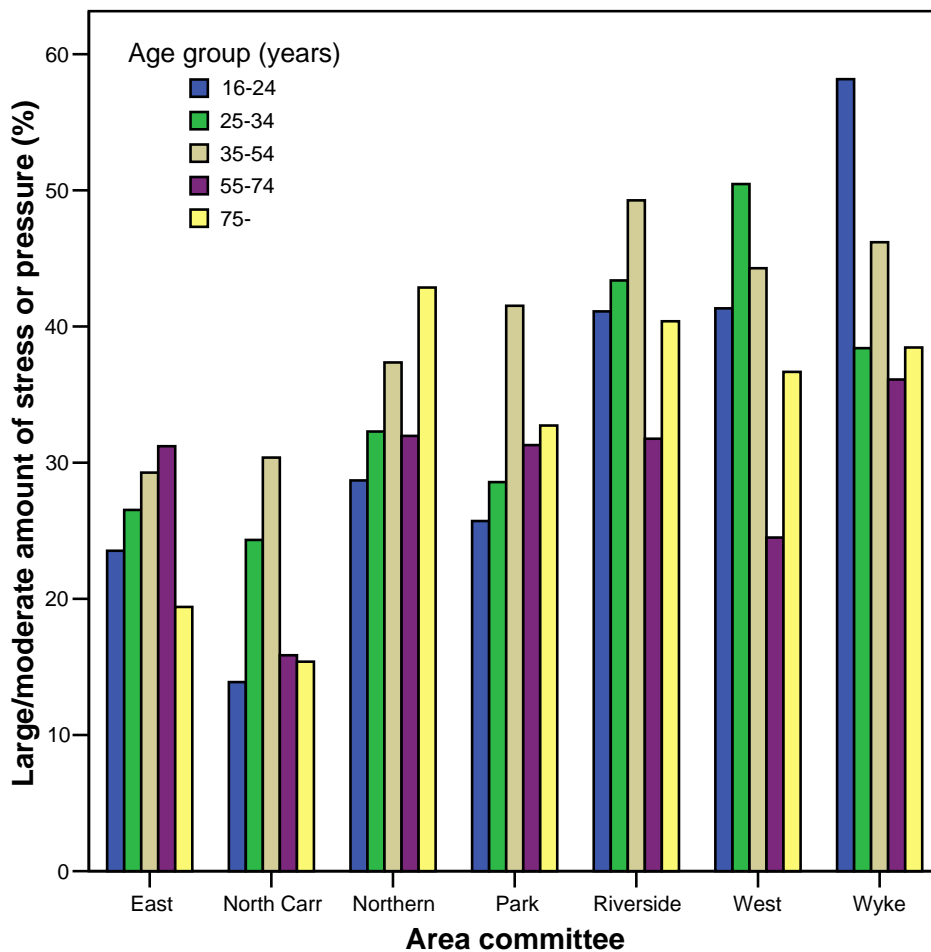
2.2.3   Employment Status

Summary

- Comparison of health status among different employment statuses is complicated by the fact that employment status is associated with age, and age is associated with ill-health.

- As expected, those who report they cannot work due to long-standing illness or disability tend to report that they suffer from such a condition that limits their daily activities, but interestingly not all of them.

- Unemployed residents are more likely to report they suffer from a long-standing illness or disability compared to those who are working or on training schemes or in education.

- Those who were unemployed or not working due to long-term illness or disability have, on average, the lowest Mental Health Inventory scores denoting more mental health.

- Between 20% and 30% of those who are working report they suffer from a moderate or large amount of stress or pressure (depending on age). Those in the youngest age group (16-34 years) who are unemployed report similar levels of stress (more than 25%). Those who look after the home, who are not working due to long-term illness or disability and who are undertaking voluntary work report the lowest levels of stress (less than 15% except for those aged 55 years or more who have long-term illness (20%) or undertake voluntary work (40%)).

Figure 23 illustrates the percentage of responders who report they suffer from a long-standing illness, health problem or disability which limits their daily activities for three age groups by employment status. As expected, those who report they cannot work due to long-standing illness or disability tend to report that they suffer from such a condition that limits their daily activities, but interestingly not all of them.

- In the 16-54 year age group, 4% of those working full-time or are self-employed report that they suffer from such a medical condition that limits daily activities, and 14% of those who are unemployed within this age group.

- For those aged 55-74 years, the percentages who report a long-standing illness or disability which limits daily activities are higher for those who are retired compared to those working, and it is likely that some of these people could have retired due to ill health.

Figure 23: Percentage of responders reporting long-standing illness, health problem or disability which limits their daily activities for three age groups by employment status
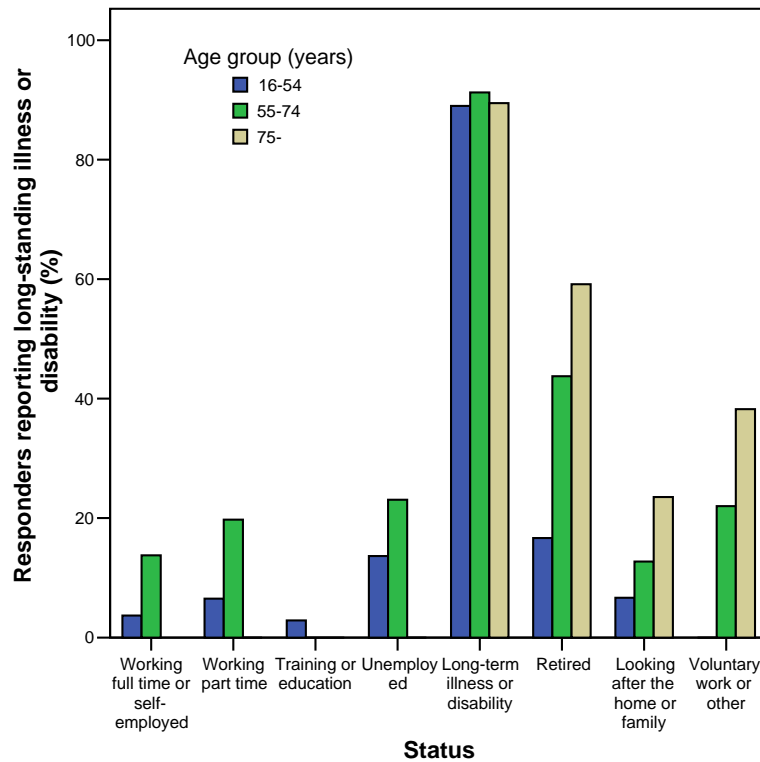
In general, those who report they cannot work due to long-term illness or disability have the lowest score on the VAS Health Thermometer scale (***Figure 24***).

- There is not a huge difference in the Health Thermometer scale for those aged 16-54 years except for those who retired (who are likely to have taken early retirement due to ill health).
- In the 55-74 year age group, those reporting long-term illness and who are retired report the lowest VAS Health Thermometer scores, in addition to those who are unemployed.

Figure 24: Boxplot of VAS Health Thermometer for three age groups by employment status
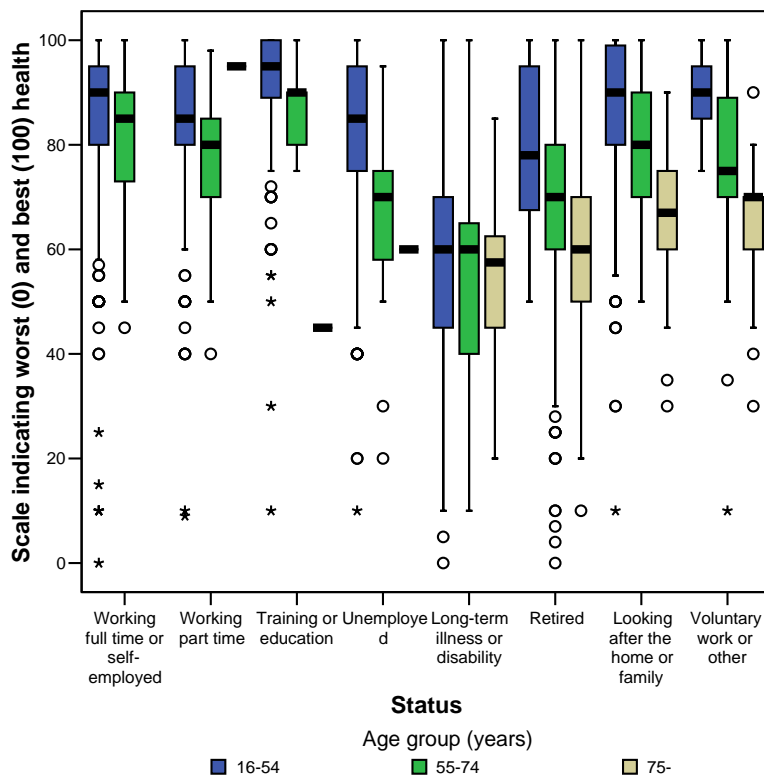
The Mental Health Inventory score does not appear to differ substantially among the different groups relating to employment status with the exception that those who are unemployed or cannot work due to long-term illness or disability report lower scores and worse mental health, and this is particularly the case for those unemployed aged 16-54 years (*Figure 25*).

Figure 25: Boxplot of Mental Health Inventory score for three age groups by employment status
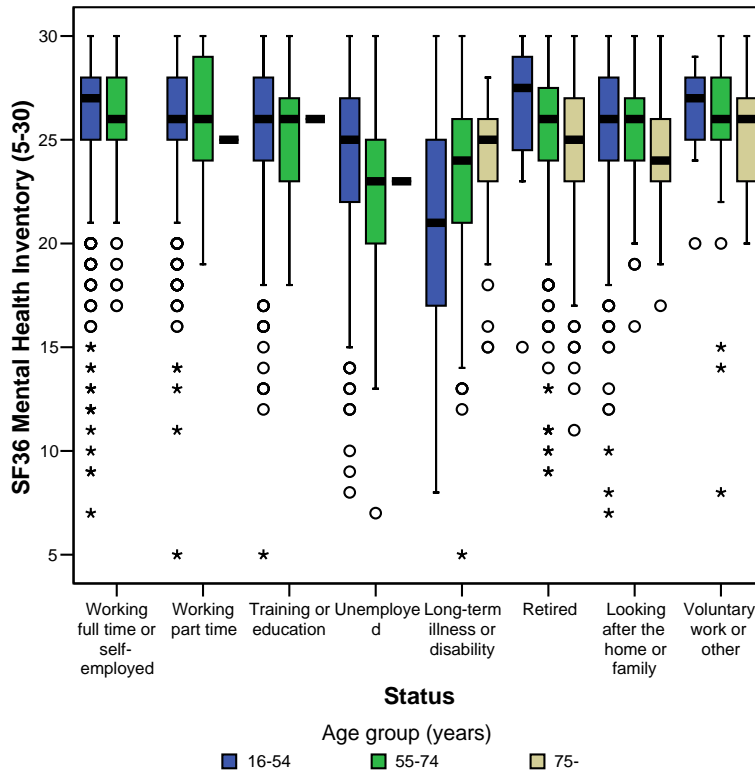
Figure 26 illustrates the percentage of responders reporting a large or moderate amount of stress or pressure by employment status.

- More than 25% report stress for those who are working full-time or are self-employed (regardless of age), and in those who are over 55 years of age who are working part-time, are retired or undertaking voluntary work.

Over 60% of those who are aged 35-54 years who are retired report a large or moderate amount of stress or pressure, but this is only based on a small number of people (n=8) in this category so the estimate may not be very reliable.

Figure 26: Percentage of responders reporting a moderate or large amount of stress or pressure for three age groups by employment status
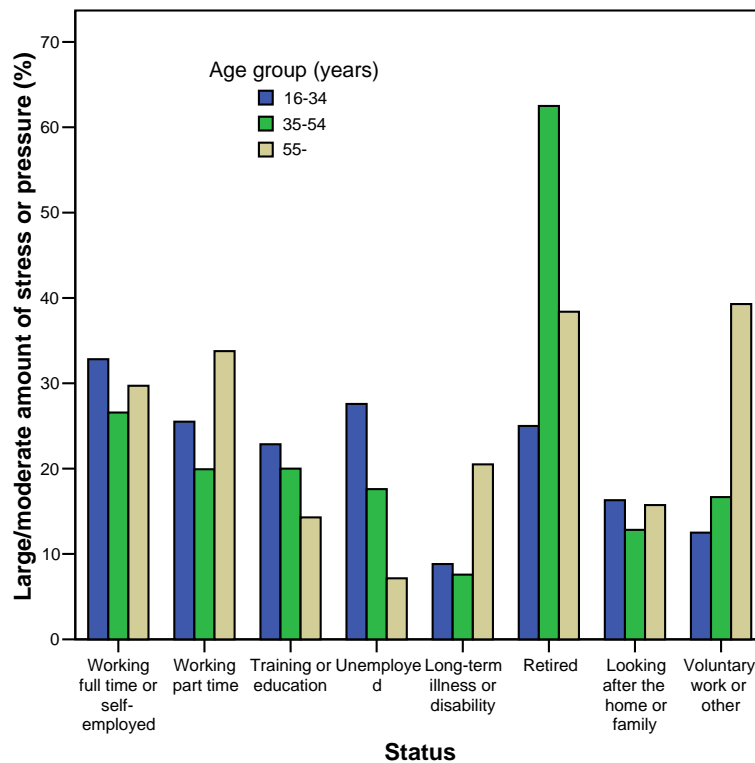
2.2.4   Conclusions

As expected, there was a strong association between reported health status and age with deteriorating health as age increased. Health status also varied over the different area committees and by employment status. Residents in Riverside, after allowing for differences in age, reported the worst physical health. Residents of North Carr reported the lowest levels of stress or pressure, with those in Riverside, West and Wyke reporting the most, in particular young persons in Wyke. There was also an association between health and employment status, with those who were not working due to long-standing illness or disability, who were unemployed or had retired early reported the worst health. Those who were not working due to health problems reported the worst mental health, particularly those in the youngest age groups. Those who were working full-time or were self-employed tended to report the highest levels of stress or pressure.

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2.3   Lifestyle and Health Attitudes From the Survey

The importance of lifestyle factors such as smoking, diet and attitudes towards them are crucial to health. The responses to the questions below will help to understand in more detail about these factors in Hull and allow comparison with other local studies. They may also be important to an understanding of how Social Capital relates to health, and while it is beyond the scope of this report to consider these issues in detail, it will be included in subsequent research using the data from the survey.

2.3.1   Age and Gender

Summary

- Overall, 34% smoked daily and a further 9% smoked occasionally.

- The highest percentage who smoked daily or occasionally occurred in the youngest age groups (16-24 years) and was 59% for men and 54% for women.

- Of those who smoked daily or occasionally, approximately one quarter of men aged 25-44 years thought that the impact on health of quitting smoking would be very small rising to one third for those who were older. However, the highest percentage occurred (40%) in those aged 16-24 years.

- The pattern was similar for women smokers, 17% of those aged 25-34 thought the impact on health of quitting smoking would be very small and this percentage gradually increased to 27% for those aged 75 years or more. A similarly high percentage was reported by the youngest age group (26%).

- Females were more likely to agree than males that exercise and that a healthier diet had a beneficial effect on health.

- Those in the youngest age groups tended to eat fruit and/or vegetables the least frequently, in particular males.

- For males, 40% in the youngest age group reported that they ate healthily compared to 58% in the oldest age group. For females, these figures were 50% and 70% respectively.

- Almost a half (48%) of men aged 16-24 years reported they did not eat healthily and 11% reported a lack of knowledge about what constituted a healthy diet. Older men were much less knowledgeable (57% and 30% reporting not eating healthily and lack of knowledge respectively).

Tables 15 and 16 give the smoking status for males and females, and by age groups respectively.

- Overall 34% of the full sample were regular smokers and a further 9% occasionally smoke.
- More men than women smoke.
- More young people compared to older people smoke.

Table 15: Smoking status for all males and females responders

Smoking behaviour	Responses (in %)		
	Male	Female	Overall
I have never smoked	24	35	**29**
I used to smoke	28	25	**27**
I now smoke occasionally	9	10	**9**
I now smoke daily	38	31	**34**
Total	**100**	**100**	**100**

Table 16: Smoking status by age group

Smoking behaviour	Responses (in %)						
	16–24	25–34	35–44	45–54	55–64	65–74	75+
I have never smoked	28	31	29	26	27	32	37
I used to smoke	15	24	28	26	31	35	38
I now smoke occasionally	13	9	8	10	9	7	10
I now smoke daily	44	36	35	38	33	25	15
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

However, the smoking status appears to differ between men and women with fewer women stating that they smoke daily and a higher percentage reporting that they have never smoked. *Tables 17 and 18* show smoking status by age group for men and women respectively.

Table 17: Smoking status by age group for men

Smoking behaviour	Responses for men (in %)						
	16–24	25–34	35–44	45–54	55–64	65–74	75+
I have never smoked	26	29	26	23	19	20	19
I used to smoke	15	24	27	27	34	41	54
I now smoke occasionally	11	9	8	9	8	9	10
I now smoke daily	48	38	38	42	39	30	16
Total	100	100	100	100	100	100	100

Table 18: Smoking status by age group for women

Smoking behaviour	Responses for women (in %)						
	16–24	25–34	35–44	45–54	55–64	65–74	75+
I have never smoked	29	34	32	30	36	45	50
I used to smoke	16	24	28	25	29	30	25
I now smoke occasionally	14	8	8	11	9	6	10
I now smoke daily	40	34	32	35	26	20	15
Total	100	100	100	100	100	100	100

Interestingly when asked what impact people thought giving up smoking would have on their health (*Table 19*):
- Over 20% of the youngest age group thought is would have a fairly small to no effect.
- More women than men thought it would have a big effect.

Table 19: Perceived effect on health after giving up smoking by age group

Impact on health of quitting smoking	Responses (in %)						
	16–24	25–34	35–44	45–54	55–64	65–74	75+
Very or fairly big effect	79	89	90	84	84	83	86
Fairly small effect	17	7	7	12	12	12	9
Very small or no effect	4	4	4	3	5	5	5
Total	100	100	100	100	100	100	100

For those who smoked daily or occasionally, the perceived impact of giving up smoking was even lower for men (***Table 20***) and women (***Table 21***), particularly so for men.

Table 20: Perceived effect on health after giving up smoking by age group for men who smoke daily or occasionally

Impact on health of quitting smoking	Responses for male smokers (in %)						
	16–24	25–34	35–44	45–54	55–64	65–74	75+
Very or fairly big effect	60	71	77	66	66	57	56
Fairly small effect	31	15	15	26	21	28	25
Very small or no effect	9	13	8	8	12	15	19
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Table 21: Perceived effect on health after giving up smoking by age group for women who smoke daily or occasionally

Impact on health of quitting smoking	Responses for female smokers (in %)						
	16–24	25–34	35–44	45–54	55–64	65–74	75+
Very or fairly big effect	74	83	80	79	74	72	68
Fairly small effect	20	12	12	16	22	23	23
Very small or no effect	6	5	8	5	4	4	10
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

When asked whether they agreed that "a healthier diet" and "more exercise" would generally improve people's health:
- 54% of all respondents thought that both would improve people's health.
- 23% thought more exercise would.
- 16% thought a healthier diet would.
- The remaining 7% thought that neither factor would improve people's health.

Females were more likely to agree than males[9] that exercise (78% v 76% respectively) and that a healthier diet (74% v 66% respectively) had a beneficial effect on health.

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[9] The difference between males and females was statistically significant for both exercise (χ^2 test, df=1, p=0.047) and diet (χ^2 test, df=1, p<0.001).

Tables 22 and 23 illustrate the percentages of responders who eat fruit and/or vegetables every day, most days, some days, rarely or never for each sex and different age groups respectively.

- More women than men consumed fruit and/or vegetables.
- Younger people who were more likely to report that they rarely ate fruit or vegetables.

Table 22: Consumption of fruit and vegetables for males and females

Fruit and/or vegetables	Responses (in %)	
	Male	**Female**
Every day	19	26
Most days	36	43
Some days	36	26
Rarely	9	5
Never	<1	<1
Total	**100**	**100**

Table 23: Consumption of fruit and vegetables by age group

Fruit/veg	Responses (in %)							
	16-24	**25-34**	**35-44**	**45-54**	**55-64**	**65-74**	**75+**	**Total**
Every day	13	22	25	21	24	30	25	**22**
Most days	29	44	44	38	37	39	47	**39**
Some days	39	26	28	35	34	25	23	**31**
Rarely	19	7	4	5	5	5	4	**7**
Never	<1	<1	<1	0	<1	<1	0	**<1**
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Tables 24 and 25 show the frequency of eating fruit and/or vegetables across the age groups for each sex separately.

- Females were more likely to eat fruit and/or vegetables every day or most days across all ages.
- Approximately 20% of males ate fruit and/or vegetables every day in the 25-44 and 55-64 age groups.
- 26% of older males (65+ years) ate fruit and/or vegetables every day
- The percentages for men were only 10% and 16% in the 16-24 and 45-54 year age groups respectively.

Table 24: Consumption of fruit and vegetables by age group for men

Fruit/veg	Responses for males (in %)							
	16-24	25-34	35-44	45-54	55-64	65-74	75+	Total
Every day	10	20	20	16	21	26	26	**19**
Most days	26	39	42	35	34	33	42	**36**
Some days	42	32	32	41	39	34	26	**36**
Rarely	21	9	5	8	6	8	6	**9**
Never	0	1	<1	0	0	0	0	**<1**
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Table 25: Consumption of fruit and vegetables by age group for women

Fruit/veg	Responses for females (in %)							
	16-24	25-34	35-44	45-54	55-64	65-74	75+	Total
Every day	16	25	29	26	28	35	24	**26**
Most days	31	50	45	42	40	45	51	**43**
Some days	36	20	24	29	29	17	22	**26**
Rarely	17	4	2	3	3	3	3	**5**
Never	<1	0	0	0	<1	1	0	**<1**
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

When people were asked if they felt they had a healthy diet the age (*Table 26*) and gender (*Table 27*) bias was again seen although interestingly almost one in five men did not know what a healthy diet was or did not know if they had one.

Table 26: Healthy diet for each age group

Concept of healthy diet	Responses (in%)						
	16-24	25-34	35-44	45-54	55-64	65-74	75+
Yes	45	65	68	62	61	67	65
No	44	26	20	24	21	14	8
Don't know what a healthy diet is	4	3	3	5	6	7	12
Don't know if I have a healthy diet	7	6	9	8	12	12	15
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Table 27: Healthy diet for males and females separately

Concept of healthy diet	Responses (in %)	
	Male	**Female**
Yes	55	69
No	28	20
Don't know what a healthy diet is	6	4
Don't know if I have a healthy diet	11	7
Total	**100**	**100**

As can be seen from the **Tables 28 and 29**, the difference in the percentages eating healthily for males and females differed depending on the age group.

- For those aged 16-44 years, there was a difference of approximately 10% between males and females in the percentages reporting that they ate healthily, but this increased to almost 20% for those aged 45-74 years.
- This was also true for those who reported that they did not know what a health diet was or did not know if they had a healthy diet. The same percentages (11%) were reported for males and females for the youngest (16-24 years) age group, but there were more males reporting lack of knowledge compared to females for all other age groups, particularly so for those aged 45-74 years.
- Between 70% and 80% of females aged 25 years and older reported that they had a healthy diet, compared to between 52% and 65% of males.
- In the youngest age group (16-24 years), there was less of a difference between males and females with 50% of women reporting that they ate healthily compared to 40% of men.

For women, aged 74 years or less, whilst there was a difference[10] in the percentage who reported that they did not know what a healthy diet is or whether they had a healthy diet, the differences in the percentage were not huge (range 6% to 13% depending on the age group). However, there was a bigger difference in the oldest women (75 years or more) as one quarter of them reported they did not know what a healthy diet was or whether they had one. For men, this percentage increased as age increased[11], ranging from 13% in the youngest men to 31% in the oldest men.

Table 28: Healthy diet for each age group for men

Concept of healthy diet	Responses for males (in%) by age (years)						
	16-24	25-34	35-44	45-54	55-64	65-74	75+
Yes	40	59	65	52	53	55	58
No	48	29	21	30	25	17	11
Don't know what a healthy diet is	3	4	3	8	9	12	12
Don't know if I have a healthy diet	9	9	11	10	13	16	19
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Table 29: Healthy diet for each age group for women

Concept of healthy diet	Responses for females (in%) by age (years)						
	16-24	25-34	35-44	45-54	55-64	65-74	75+
Yes	50	72	71	73	70	80	70
No	40	22	18	18	17	10	6
Don't know what a healthy diet is	5	2	3	2	3	3	13
Don't know if I have a healthy diet	6	4	8	6	10	8	12
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

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[10] Difference was statistically significant (χ^2 test, df=1, p=0.044).

[11] Difference was statistically significant with percentage increasing with age (χ^2 test for trend, p<0.001).

2.3.2 Area

Summary

- Riverside (48%), East and North Carr (both 47%) residents had the highest rates of smoking (daily and occasionally) followed by Park (45%) and Northern (42%). West and Wyke had the fewest smokers (both 39%).

- Approximately 3% thought that impact on health of quitting smoking would be very small (slightly lower in West at 1% and slightly higher in Wyke at 5%), except for Northern where 13% thought the impact would be very small. This increased to 30% in Northern if only smokers' responses were considered.

- The percentage of residents who ate fruit and/or vegetables every day or most days varied considerably among the area committees (50% for North Carr, approximately 60% for East, West and Park, 67% for Riverside and Wyke and 75% for Northern).

- North Carr had the highest percentage of residents who reported that they did not eat healthily (41%) compared to approximately 20% for all other areas (range 18% for West to 25% for East). However, North Carr residents appeared the most knowledgeable with 9% reporting they did not know what a healthy diet was compared to 18% of Northern residents. This finding could be associated with the age distribution with the area committees.

- The area analysis shows up some important differences in smoking behaviour with almost half of the people surveyed in the Riverside (48%), East and North Carr (both 47%) areas smoking daily or occasionally (***Table 30***).
- In addition, 19% of East residents and 18% of North Carr residents reported that giving up smoking would have a fairly or very small or no effect on health (***Table 31***), but only 13% of Riverside residents thought this.
- West and Wyke residents reported the lowest prevalence of smoking (39%) and also the smallest percentage thought that giving up smoking would have a fairly or very small or no effect on health (10%).
- Northern reported an intermediate rate of smoking (42%) relative to other areas, but had the highest percentage that thought giving up smoking would have a small effect on health (20%).
- However, any differences may be dependent on the age and sex differences among the areas, and it would be difficult to examine the areas in relation to both age and sex.

Table 30: Smoking status within each area committee

Smoking behaviour	Responses (in %)						
	East	North Carr	Northern	Park	Riverside	West	Wyke
I have never smoked	28	23	31	30	24	33	39
I used to smoke	25	30	28	26	28	28	22
I now smoke occasionally	13	12	8	12	8	8	6
I now smoke daily	34	35	34	33	40	31	33
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Table 31: Impact on health of giving up smoking for each area committee

Impact on health of quitting smoking	Responses (in %)						
	East	North Carr	Northern	Park	Riverside	West	Wyke
Very or fairly big effect	81	82	80	83	87	90	90
Fairly small effect	16	15	7	14	10	9	6
Very small or no effect	3	3	13	3	3	1	5
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Examining this data for smokers only, we find that 46% of Northern residents who smoke believe that giving up smoking will only have a very small or no effect on their health, in contrast with other areas where between 21% and 32% believe the impact to be relatively small (***Table 32***).

Table 32: Impact on health of giving up smoking for each area committee for daily or occasional smokers only

Impact on health of quitting smoking	Responses for smokers (in %)						
	East	**North Carr**	**Northern**	**Park**	**Riverside**	**West**	**Wyke**
Very or fairly big effect	68	73	54	71	78	79	78
Fairly small effect	27	23	16	23	17	19	19
Very small or no effect	5	4	30	6	5	2	11
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Table 33 illustrates the differences in fruit and/or vegetables consumption among the areas.
- Riverside residents are more likely to eat fruit and/or vegetables every day (31%) than those from other areas.
- Whereas those in North Carr are more likely to eat fruit and/or vegetables rarely or never (16%).
- Differences observed could be due to differences in the age structure within the areas, as there is a difference in the ages across the areas and age is also associated with consumption of fruit and/or vegetables.
- Additionally, these differences could be associated with many other individualistic factors relative to health, e.g. perceptions and attitudes to health and other factors associated with the area, e.g. availability and cost of fruit and vegetables.

Table 33: Consumption of fruit and/or vegetables within each area committee

Fruit and/or vegetables	Responses (in %)						
	East	**North Carr**	**Northern**	**Park**	**Riverside**	**West**	**Wyke**
Every day	24	16	19	21	31	15	27
Most days	35	35	46	40	35	45	40
Some days	31	33	28	32	29	35	27
Rarely	10	16	7	7	5	4	6
Never	<1	<1	<1	<1	<1	0	0
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

- West, Wyke, Northern, Riverside and Park areas all had very similar percentages of people reporting a healthy diet (62% to 65%).
- But the figures were lower in the East (59%) and North Carr (50%) areas (*Table 34*).

This may be linked to the findings that older people reported having a healthy diet and that the North Carr population is generally younger.

- The percentage of responders who did not know what a healthy diet was or if their diet was healthy was the smallest in North Carr (9%), which implies that an unhealthy diet may be through choice rather that lack of knowledge.
- Residents in Wyke also had a similar proportion with a lack of knowledge (10%), Park and Riverside residents were the next most knowledgeable (13% and 14% respectively), with East (16%), Northern and West (both 17%) having the highest percentage of residents with a lack of knowledge about a healthy diet

Table 34: Healthy diet for each area committee

Concept of healthy diet	Responses (in %)						
	East	North Carr	Northern	Park	Riverside	West	Wyke
Yes	59	50	64	62	63	65	65
No	25	41	19	22	22	18	24
Don't know what healthy diet is	8	1	7	7	4	6	2
Don't know if I have healthy diet	8	8	11	8	10	11	9
Total	100	100	100	100	100	100	100

2.3.3. Employment Status

Summary

- Those who were unemployed reported the highest levels of smoking with between 60% and 80% smoking daily or occasionally (depending on sex and age group). Young and middle-aged males who were not working due to long-term illness or disability also reported high levels of smoking (approximately 60%).

- Between 20% and 45% of those who were unemployed and males who were not working due to long-term illness or disability were more likely to report only a fairly or very small or no impact on health after quitting smoking. The figure was approximately 10% for other employment statuses with the exception of older men who looked after the home or were retired (20%) and young men who were on training schemes or in education (30%).

- Those who were unemployed or were not working due to long-term illness or disability were less likely to eat fruit and/or vegetables every day or most days compared to those of a similar age and the same sex who were working. This was also true for eating healthily and being knowledgeable about what a health diet consisted.

Comparison of lifestyle and health attitudes among different employment status groups is difficult in the same way as such a comparison is for area committees in that any differences observed could be due to differences in the age and sex differences. This could be particularly the case for employment status as we know that age and sex are both strongly associated with both employment status and lifestyle and health attitudes. It becomes very complicated to compare employment status, and lifestyle and health attitudes taking into account age and sex, and in addition the numbers of people in each category become too small. The figures in this section examine employment status for six groups (three age groups for both sexes).

The following groups have been excluded from the analysis as they contain less than 20 people:
- females 55 years and over working full-time;
- males 55 years and over and females 35 years and over in training or education;
- unemployed males and females 55 years and over;
- females 16-34 years with long-term illness or disability;
- retired males and females less than 35 years;
- males under 35 years looking after home or family;
- and all those in voluntary or other work except females 55 years or over.

Figure 27 illustrates the percentage of people who smoke occasionally or daily by employment status for three different age groups, and for males and females separately.

- For those who are working full-time or part-time or are self-employed, approximately 40% smoke occasionally or daily.
- There are slightly more occasional or daily smokers for those who are training or in education, and slightly fewer smokers who are retired, look after the home or family, or undertake voluntary or other work.
- The percentage of smokers is much higher for those who cannot work due to long-term illness or disability, with between 50% and 70% of men and women aged 35-54 years who smoke.
- The figure is lower for women aged 55 years or over (20%) who are not working due to long-term illness and disability and there are too few women aged 16-34 years to present their smoking status.
- However, the highest percentage of occasional or daily smokers occurs in the group who are unemployed. The percentages have not been given for men and women aged 55 years or over as there are too few of them. For those aged 16-54, approximately 70% smoke occasionally or daily.

Figure 27: Percentage smoking occasionally or daily by employment status for three different age groups and for males and females separately
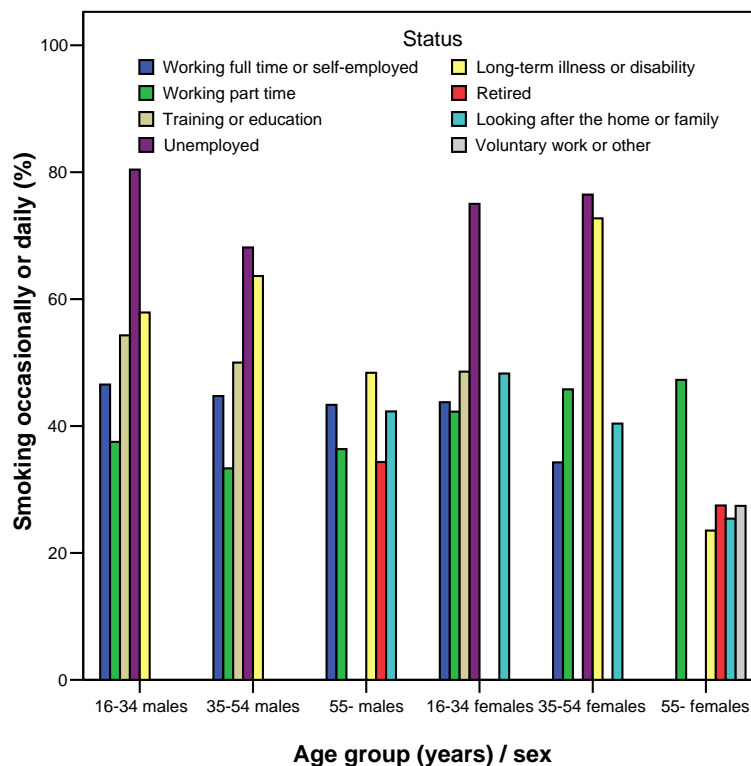
The perceived effect on health of quitting smoking differed depending on employment status (*Figure 28*).

- In general, approximately 10% of males and 5% of women who were working full-time thought that the effect on health of quitting smoking would be small (figures not given for women 55 years and over due to small numbers).
- The percentages who thought the impact of quitting smoking would be small were slightly higher for those working part-time.
- Approximately 30% of young men who were on training schemes or in education thought the impact of quitting would be small, and just over 20% of men who were not working due to long-term illness or disability.
- Those aged 16-54 years who were unemployed (figures not presented for those aged 55 years or over due to small numbers) had the highest percentage of people who thought that there would be a small impact on health after quitting smoking; the figures were just under 40% of men aged 35-54 years and just under 50% for those aged 16-34 years, and approximately 25% for women aged 16-54 years. As shown in Figure 27, the highest rates of smoking also occurred in this group.

Figure 28: Percentage reporting that the effect on health of quitting smoking would be fairly small, very small or there would be no effect by employment status for three different age groups and for males and females separately
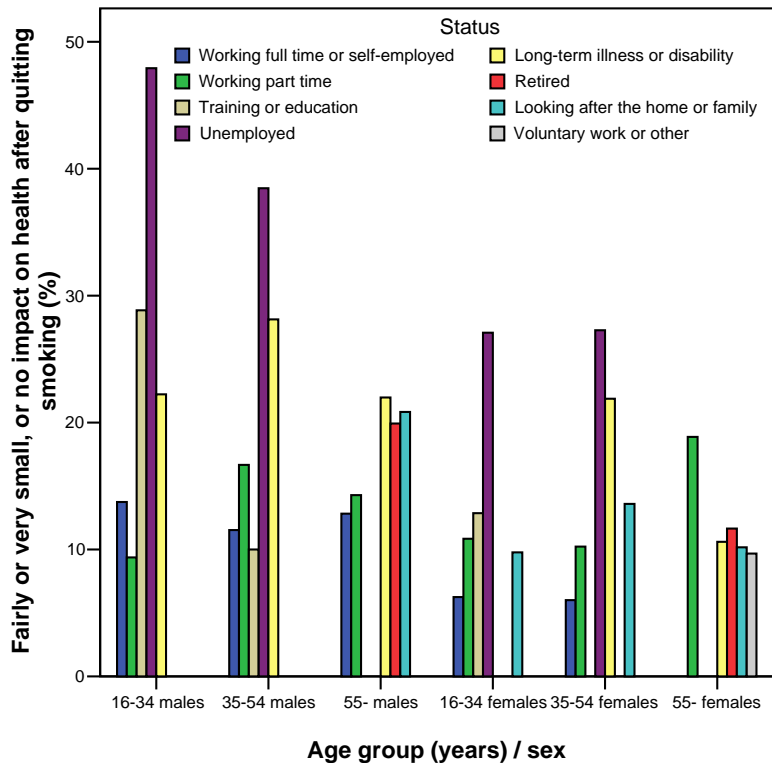
The consumption of fruit and/or vegetables differed by employment status (*Figure 29*).

- Of those who were working full-time, approximately 80% of women and 60% of men ate fruit and/or vegetables every day or most days.
- Similar percentages were reported for men who worked part-time, but for women who worked part-time their consumption of fruit and vegetables was less than their counterparts who worked full-time.
- Men aged 16-34 years who were on training schemes or in education, all those who were unemployed, and men aged 16-54 who were not working due to long-term illness or disability had the lowest fruit and/or vegetable consumption, with between 25% and 60% not eating fruit and/or vegetables most days or more frequently.

Figure 29: Percentage eating fruit and/or vegetables every day or most days by employment status for three different age groups and for males and females separately
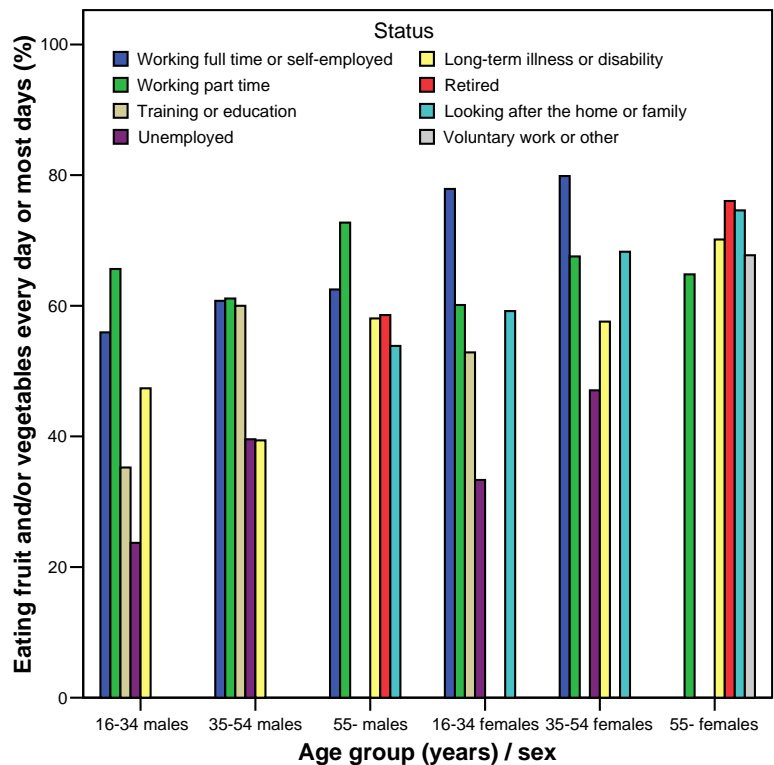
The percentage reporting that they did not eat a healthy diet is given in *Figure 30* by employment status. As noted earlier, young men eat healthily the least frequently. In relation to employment status, it can be seen that:

- Those more likely to eat healthily were:
  - o Retired.
  - o Looking after home (with exception of young women).
  - o Working full-time or self-employed.
- Those less likely to eat healthily were:
  - o On training schemes or in education.
  - o Unemployed.
  - o Not working due long-term illness or disability.

Figure 30: Percentage reporting that they do not eat healthily by employment status for three different age groups and for males and females separately
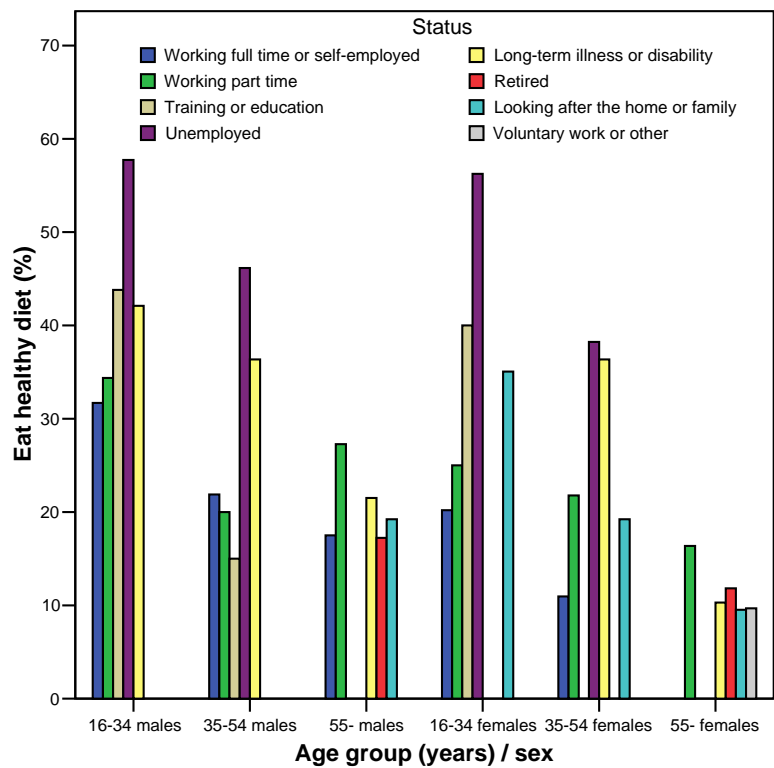
However, as noted earlier, there are a number of people who report that they don't know that a health diet is or that they don't know if their diet is healthy. *Figure 31* illustrates the percentages who fall into these categories.

- Don't know what a healthy diet is or if they have one:
  - o Those who are unemployed.
  - o Those who are not working due to long-term illness or disability.
  - o Older men who are retired.
  - o Older men who look after the home or family.
- More knowledgeable about healthily diet:
  - o Those who are working full-time or are self-employed (exception older men).
  - o Those who are working part-time.

Figure 31: Percentage reporting that they do not know what a health diet is or if they have a healthy diet by employment status for three different age groups and for males and females separately
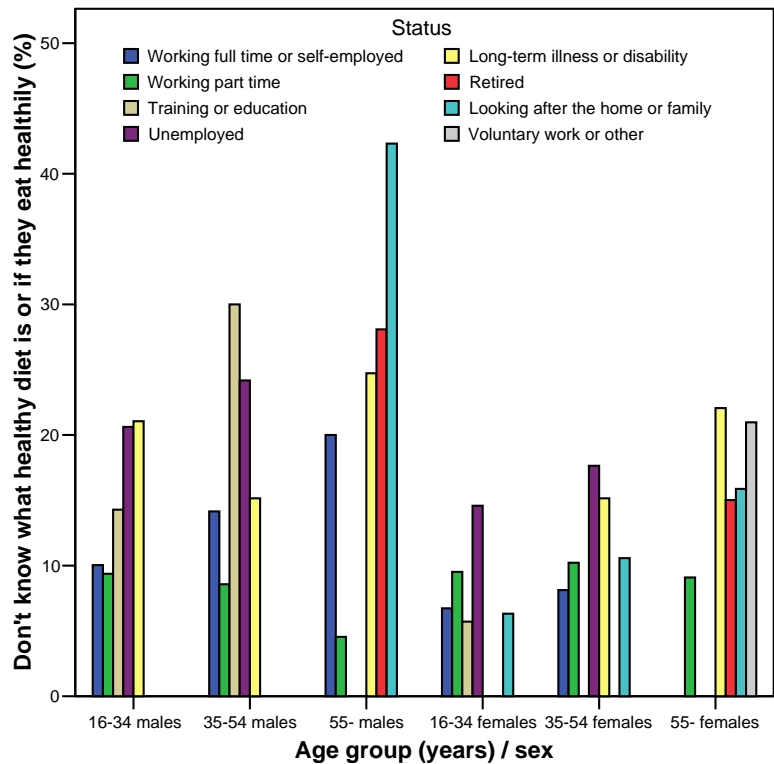
2.3.3   Conclusions

The percentage of young people who smoked was much higher than the national average, with 59% of men and 54% of women aged 16-24 years stating that they smoked occasionally or daily. Many of the youngest and oldest smokers (over 40% for men and over 25% for women) thought that giving up smoking would only have a fairly or very

small or no impact on health. This was particularly the case for Northern residents, and for those who were unemployed.

Young men and women were the least likely to eat fruit and/or vegetables every day or most days. However, there is a suggestion that this is by choice rather than through lack of knowledge of the benefit of fruit and vegetables in the diet, except for those who were unemployed or not working due to long-term illness or disability. More than 20% of men aged 55 years and older and more than 20% of women aged 75 years or older did not know what a health diet was, or whether they had such a diet.

3.   Social Capital

3.1   Civic Engagement

Why is civic engagement related to Social Capital?

This section looks at the degree to which people participate in community life, and the extent to which they feel empowered to change their society. The questions all relate to the local area in which the respondent lives.

Involvement in organisations is seen as important in creating Social Capital, as it allows people to interact with others. Through this people can learn more about their community, develop their sense of efficacy and promote trust, both between similar types of people (bonding Social Capital) and diverse types of people (bridging Social Capital). By working collectively, people can make improvements to their communities and solve local problems.

Civic engagement is both a community and an individual quality. Individuals differ in the degree to which they are civically minded, but the ability to which the community can work together to solve problems is a resource which people within that community can access. The measures reported here, however, refer only to the degree to which the respondent act and feel civically engaged, and are not measures of the neighbourhood they live in.

Summary

- Almost half of the people surveyed felt well informed about things which affect their area, and one in four felt they could influence decisions affecting their area.

- Ten percent had been involved with a local organisation within the last three years. Involvement increased with increasing age.

- East and North Carr residents felt the least informed about local issues and Northern and Wyke residents the most. This was also true for feeling able to influence decisions that affected the local area.

- Thirty percent of residents in East and North Carr had taken action to resolve a local problem compared to 10% of residents in West and Wyke, but it is not known if this is associated with increased problems or increased motivation to take action.

- People unemployed or on training schemes or in education felt the least informed about local issues (38%) and those who looked after the home or undertook voluntary work the most informed (58%). A similar pattern occurred for feeling able to influence local decisions.

3.1.1   Age and Gender

Almost half of the people surveyed felt well informed about things which affect their area, and one in four felt they could influence decisions affecting their area. When asked about action taken in the past three years to try and solve a local problem the following response was received (*Table 35*).

It is possible that many of the 61% of responders who took no action, did not need to take any action as they did not perceive there was a problem within the local area at the time.

Table 35: Action taken to solve a local problem

Any action taken to solve local problem	Responses (%)
None	60.7
Thought about it, but did not do anything about it	17.0
Some action taken	22.3

Table 36 illustrates the actions taken in more detail by the 883 (22.3%) people who took some action.

Table 36: Type of action taken to solve a local problem for those who undertook some kind of action

Type of action for those who undertook some kind of action to solve a local problem	Responses (%)
Written to local newspaper	4.2
Contacted appropriate organisation regarding problem e.g. council	7.6
Contacted a local councillor or MP	1.3
Attended a protest meeting or joined an action group	4.2
Other	1.1
Multiple actions taken:	
Newspaper & councillor/MP	0.1
Newspaper & meeting	0.1
Organisation & councillor/MP	1.2
Organisation & meeting	0.9
Organisation & other	0.1
Councillor/MP & meeting	0.1
Councillor/MP & other	0.1
Meeting & other	<0.1
Newspaper, organisation & councillor/MP	0.2
Newspaper, organisation & meeting	0.1
Newspaper, councillor/MP & meeting	<0.1
Organisation, councillor/MP & meeting	0.5
Organisation, meeting & other	<0.1
Newspaper, organisation, councillor/MP & meeting	0.4
Organisation, councillor/MP, meeting & other	<0.1
Newspaper, organisation, councillor/MP, meeting & other	0.1
Total	**22.3**

Overall, of the 883 individuals who undertook some action, half contacted an organisation, and only 17% contacted a local councillor or an MP (the totals add up to more than 100% as some individuals undertook more than one type of action) (***Table 37***).

Table 37: Type of action taken to solve a local problem for those who undertook some kind of action

Actions taken to solve local problem for 883 individuals who took some action	N	%
Written to local newspaper	206	23
Contacted appropriate organisation regarding problem e.g. council	441	50
Contacted a local councillor or MP	153	17
Attended a protest meeting or joined an action group	253	29
Other	55	6
Total	**1108**	**125**

- A similar percentage of men and women:
    - Took some action (23% and 22% respectively).
    - Thought about taking action (18% and 16% respectively).
- Similar proportions of men and women contacted an organisation and local councillor/MP, attended a meeting/joined an action group and undertook other types of action.
- However, men (7%) were more likely to write to a newspaper than women (4%)[12].

However, it is important at this point to recall that most of the respondents did not take any action, possibly because they did not identify any problems.

Not surprisingly, there was a difference in the percentages of people taking action among the age groups.
- The youngest (16-24 years) were least likely to take action with 16% undertaking some form of action.
- The percentage taking action increased to 21% for those aged 25-34 years, 23% for those aged 35-54, 28% for those aged 55-74 years.
- Those aged 75 years or more were also less likely to take action to resolve a local issues (the same percentage of the oldest residents undertook action as the youngest residents – 16%).

Only 10% of those surveyed had been involved in local organisations over the past 3 years (see ***Annex II of Appendix 6*** for this list, with the most common being community associations or neighbourhood watch).

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[12]The difference was statistically significant (χ^2 test, df=1, p<0.001)

The percentage of responders involved in local organisations was similar between the sexes, but differed among the age groups.

- The youngest age group (16-24 year olds) were least likely to be involved in local organisations (7%).
- Involvement increasing with age until retirement (9% for those aged 25-44 years, 11% for those aged 45-54 years and 13% for those aged 55-64 years).
- And then there was slightly smaller percentage involved in local organisations (11% for those aged 65-74 years and 10% for those aged 75 or more).

3.1.2   Area

Figure 32 illustrates the percentage of residents who felt well informed, felt they could influence local decisions and had taken action to resolve a local problem.

- Areas where residents felt more well-informed (53%):
    - Northern.
    - Wyke.
- Areas where residents felt less well-informed (42%):
    - East.
    - North Carr.
- Areas where residents felt more able to influence decisions:
    - Northern, West and Wyke (greater than 30%).
- Areas where residents felt less able to influence decisions:
    - East and Park (less than 20%)
    - North Carr (less than 10%).
- Areas where residents more likely to have taken action to solve local problem (greater than 30%):
    - North Carr.
    - East.
- Areas where residents less likely to have taken action to solve local problem (less than 15%):
    - West.
    - Wyke.

However, it is not known whether this is because there are more local problems in the East and North Carr areas or whether these residents are more likely to take action, or a combination of these factors.

Figure 32: Percentage of residents who felt well informed, who felt that they could influence local decisions and who had taken action to resolve a problem in local area for each area committee
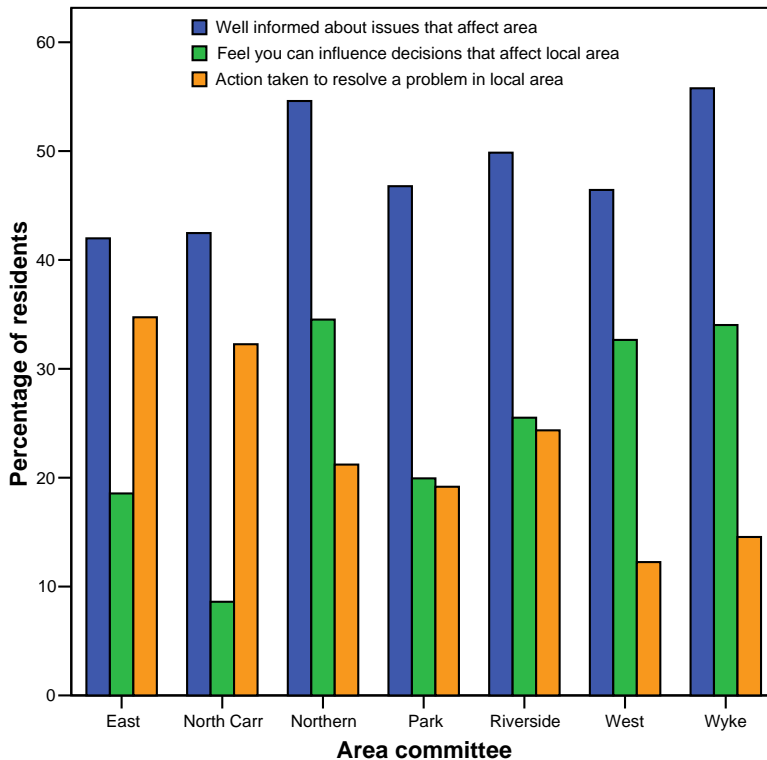
3.1.3   Employment Status

- Well-informed:
    - People unemployed or in training/education felt least informed about things which affected their areas (38%).
    - The figure was slightly higher for those working part-time and who had long-term illness or disability (44%),
    - Half of those working full-time and retired felt well informed.
    - Those who were looking after the home or family and those who undertook other or voluntary work felt the most informed (58%).

- Influence decisions:
    - Only 11% of unemployed people thought that they could influence decisions.
    - Approximately one quarter of those who were working full-time or part-time, on training schemes or in education, who had long-term illness or disability and who were retired felt they could influence decisions.
    - The figure was highest for those looking after the home or family (31%) or undertaking voluntary or other work (42%).

- Taken action to resolve local problems:
  - o Those on training schemes or in education were the least likely to have taken action to try to resolve a problem in the local area (16%).
  - o Between 20% and 26% of other groups had taken action.
  - o The exception was those undertaking voluntary or other work where the figure was much higher (36%).

3.1.4   Conclusions

Half of residents felt well-informed about local issues and one in four reported that they felt they could influence local decisions. Ten percent were members of a local organisation with the highest level of involvement for East residents and the lowest for those living in the Northern area committee. People who were unemployed felt the least likely to be able to influence local decisions.

3.2   Neighbourliness

Why is neighbourliness related to Social Capital?

This section examines the extent of interaction, trust and reciprocity between neighbours. Trust is seen as being linked to Social Capital, either as a source, an outcome, or both. Putnam sees reciprocity as an important aspect of Social Capital, as it measures people's willingness to 'co-operate for mutual benefit'. If people believe that others would be prepared to help them, then they will be willing to help others.

Summary

- Overall, 13% did not trust people in their neighbourhood. On the whole, females trusted their neighbours more than males. Those aged 16-34 expressed the least trust followed by those aged 75 years and above. A similar pattern occurred when asked if they felt their neighbours looked out for each other, with the lowest percentage reported by young men (40%) and the highest for women aged 65-74 years (75%).

- The majority of people spoke to their neighbours regularly.

- Residents of North Carr, Northern and Wyke were more likely to report they did not trust their neighbours (20%, 19% and 17% respectively). The lowest percentages occurred for West, Riverside and East (8%, 10% and 11% respectively).

- Two thirds of residents believed their neighbourhood was a place where neighbours looked out for one another except for Wyke (62%) and Northern (58%).

- Residents in Northern and Wyke were more likely to speak to neighbours infrequently.

- Those who were on training schemes or in education or who were unemployed were the least likely to trust most or many of their neighbours, most likely to disagree with the statement that neighbours looked out for one another, and less likely speak to neighbours at least weekly compared to other employment status groups.

3.2.1 Age and Gender

Overall, 13% of respondents reported not trusting people in their neighbourhood (*Table 38*).

Table 38: Percentage of people who feel that can trust other people within their area

People trust:	Responses (%)
Most of the people in your neighbourhood	21
Many of the people in your neighbourhood	22
A few of the people in your neighbourhood	44
You do not trust people in your neighbourhood	13
Total	**100**

There were some slight gender differences with more women expressing higher levels of trust (*Figure 33*).

Figure 33: Percentage of people who feel that can trust other people within their area for each sex separately
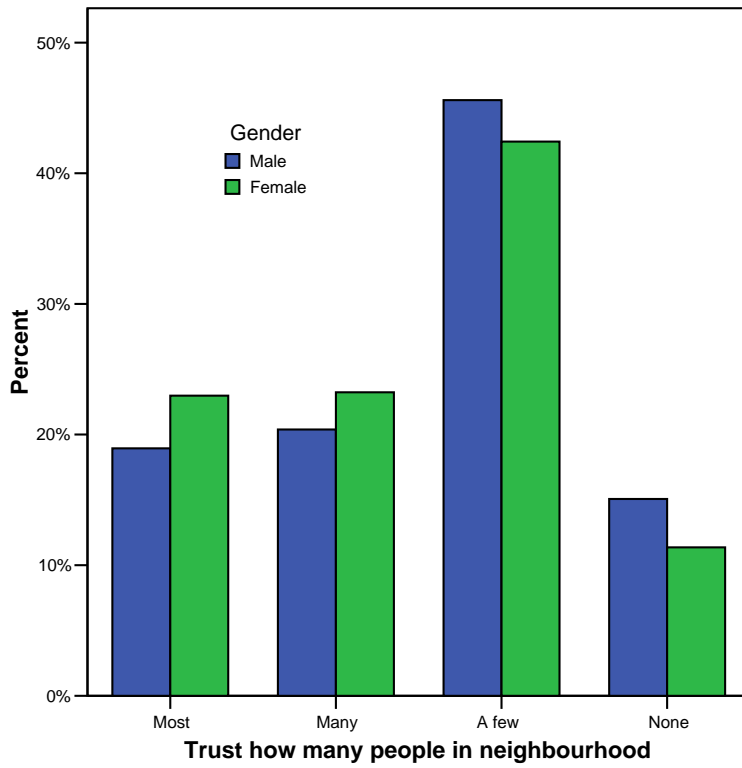
The level of trust also differed among the age groups (*Figure 34*).

- The youngest age group (16-24 years) had 68% who trusted "a few of the people in neighbourhood" or "do not trust people in neighbourhood".
- This gradually decreased as age increased to 49% in the 65-74 year age group.
- But increased in the oldest age group, with 60% not trusting people in their neighbourhood or only trusting a few people.

Figure 34: Percentage of people who feel that can trust other people within their area for each age group
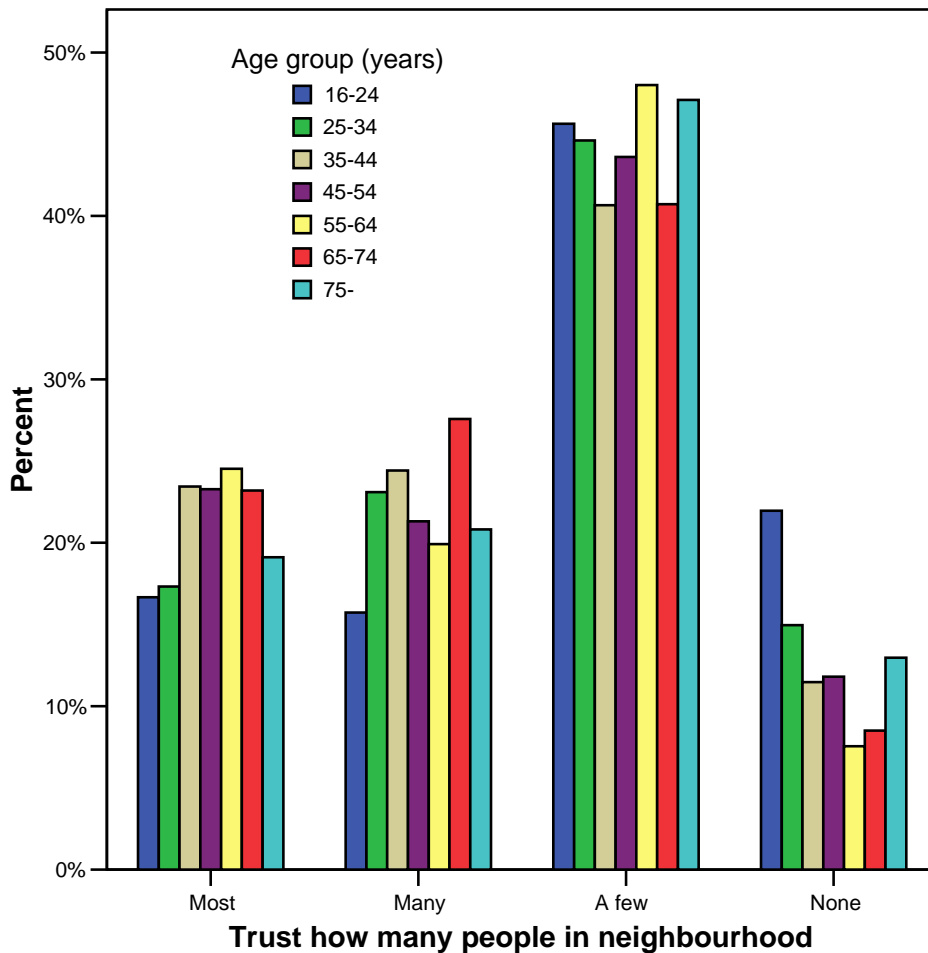
Residents were asked 'Would you say this neighbourhood is a place where neighbours look out for each other?'. Their responses differed depending on their sex and age group (*Figure 35*).

- A higher percentage of women tended to agree with the statement compared to men for all age groups except those aged 25-34 years.
- The lowest percentage who agreed with this statement occurred for the men aged 16-24 years (40%).
- More than half of older residents agreed with the statement.

Figure 35: Percentage agreeing that neighbours look out for each other for age group for each sex separately
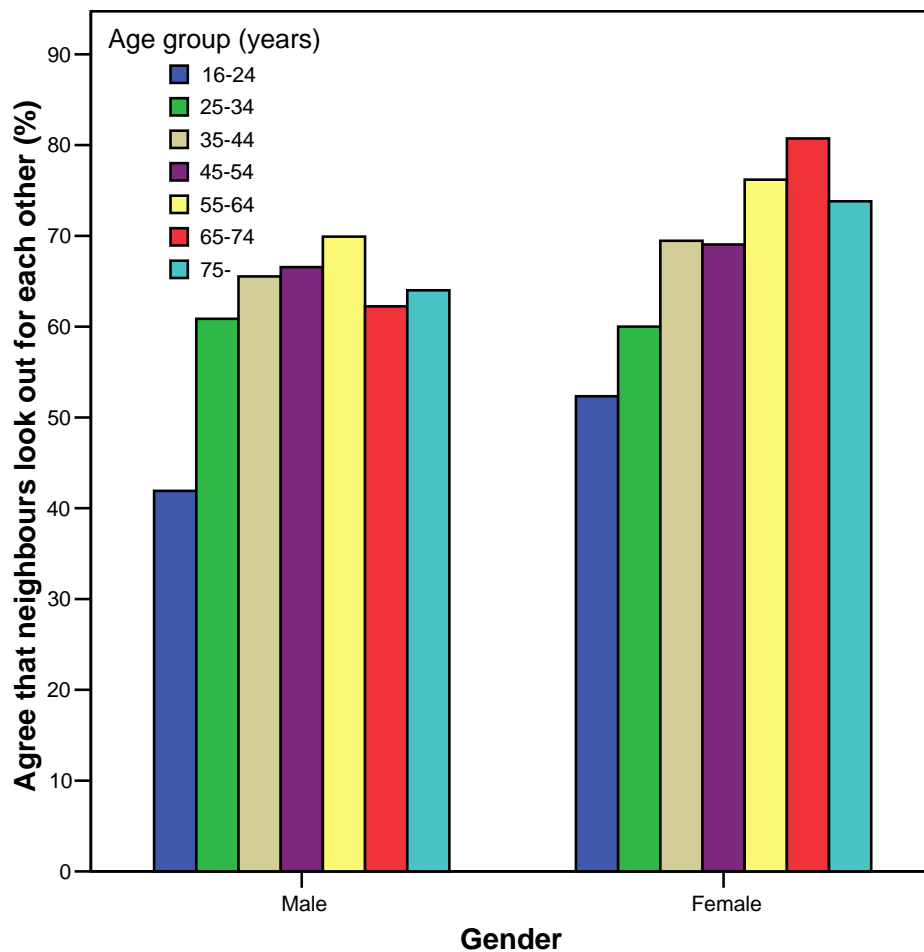
An analysis of how neighbourly 'look out' relates to level of trust indicates, not surprisingly, those who believe people look out more for each other tended to trust more people in their neighbourhood (***Table 39***).

Table 39: Relationship between level of trust and looking out for each other

Level of trust [of people in neighbourhood]	Look out for each other (in %)			
	Yes	**No**	**Don't know**	**Total**
Most of the people	93	4	3	**100**
Many of the people	88	5	7	**100**
A few of the people	57	22	21	**100**
You do not trust people	3	88	10	**100**
Total	**64**	**23**	**13**	**100**

The majority of people speak to their neighbours once or twice a week or more frequently (***Figure 36***).

Figure 36: Frequency of speaking to neighbours
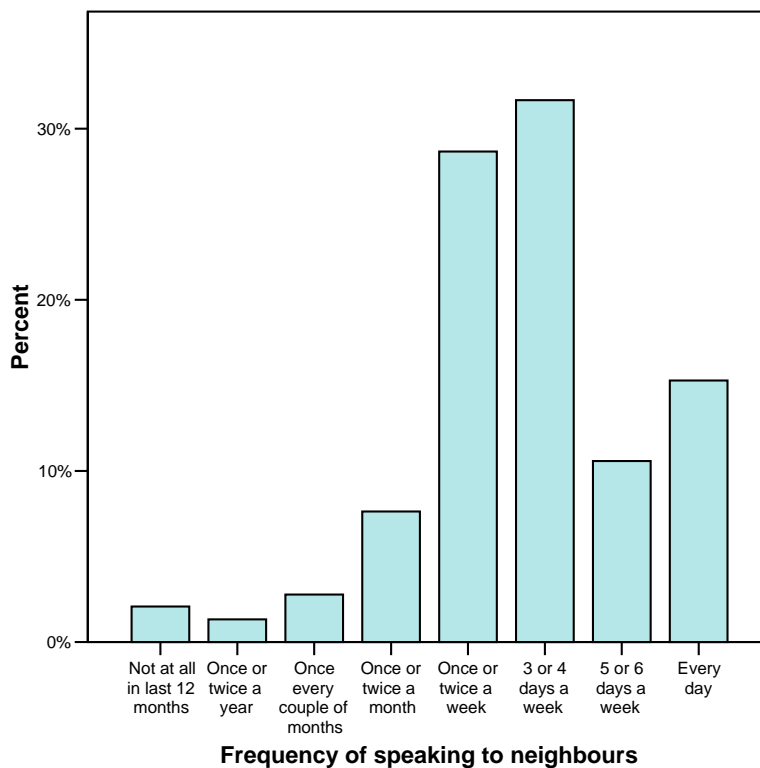
Figure 37 illustrates the frequency of speaking to neighbours daily or weekly for each sex and age group separately.

- Approximately nine out of every ten women over 25 years talked to their neighbours once or twice a week or more frequently (range 88-94% over age groups).
- The percentage was lower for men (82-90%).
- Those in the youngest age groups spoke to their neighbours less frequently (75% for women and 66% for men).

Figure 37: Frequency of speaking to neighbours at least weekly by age group for each sex
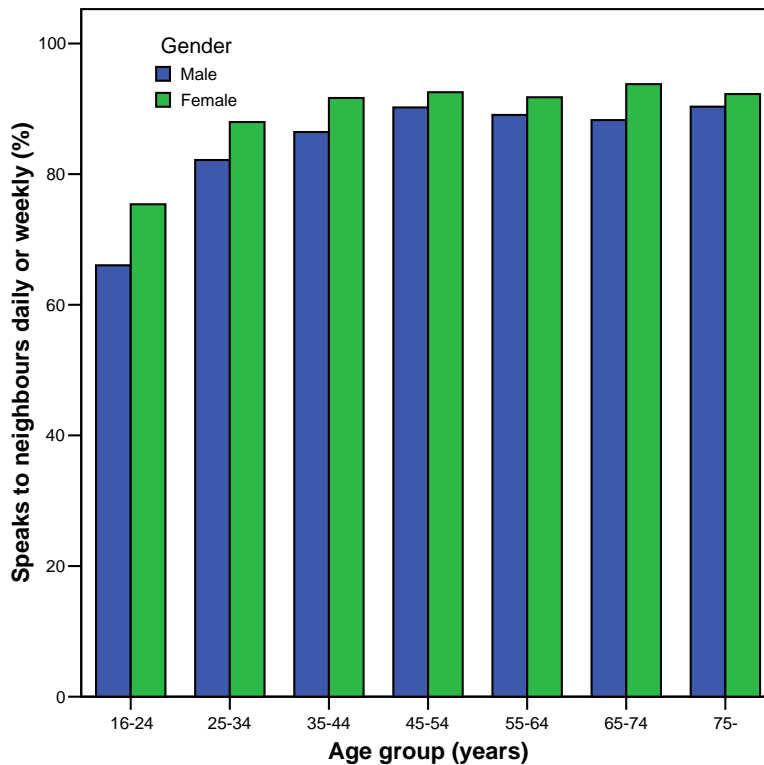
3.2.2   Area

The area analysis throws up some useful findings (***Table 40***).
- Highest percentages not trusting neighbours (17-20%):
  - o   Northern.
  - o   North Carr.
  - o   Wyke.
- Highest percentages trusting most of people in neighbourhood (28-29%):
  - o   East.
  - o   North Carr.

So North Carr has one of the highest percentages of residents who do not trust people in their neighbourhood as well as the highest percentage of residents who trust most of the people. This could be associated with the area's age distribution, or differences within smaller geographical areas.

Table 40: Level of trust in neighbourhood by area committee

Level of trust [of people in neighbourhood]	Responses (in %)							
	East	North Carr	Northern	Park	Riverside	West	Wyke	Total
Most of the people	29	28	17	19	23	17	15	**21**
Many of the people	17	13	22	21	24	25	28	**22**
A few of the people	43	39	42	48	44	50	40	**44**
You do not trust people	11	20	19	12	10	8	17	**13**
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

The differences in how much neighbours 'look out' for each other are less, although this time the level of non-responses is quite interesting with almost one in five of respondents in West area not being able to answer this question compared to less than one in twenty in North Carr (***Table 41***).

Table 41: Neighbourhood is a place where neighbours look out for each other for each area committee separately

Believe that neighbours look out for one-another	Responses (in %)						
	East	North Carr	Northern	Park	Riverside	West	Wyke
Yes	66	65	58	65	66	67	62
No	22	32	30	23	21	15	24
Don't know	12	3	13	12	13	17	14
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Figure 38 shows the percentages of residents in each area who speak to neighbours:

    (i)   once or twice a week, or more frequently;

    (ii)   once or twice a month, or once every couple of months;

    (iii)   once or twice a year, or not at all in the last 12 months.

It can be seen that the over 80% of residents, except those in Wyke (75%), speak to their neighbours daily or weekly (*Figure 38*).

- Only 1% of residents in North Carr speak with their neighbours once or twice a year or not at all in the last year.
- Whereas 6% of residents in the Wyke area spoke to their neighbours less frequently than twice per year.

Figure 38: Percentage of residents who speak with neighbours for each area committee separately
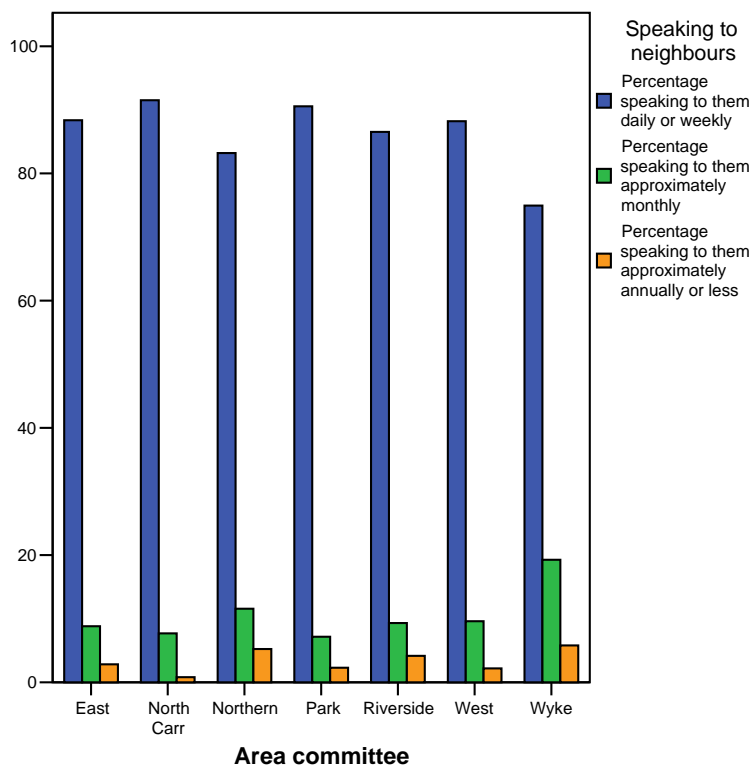
3.2.3   Employment Status

Figure 39 examines trust in the neighbourhood, looking out for one another and frequency of speaking with neighbours in relation to employment status.

- Trust in neighbourhood:
    - Between 45% and 50% of people who were working full-time or part-time or were self-employed or were retired trusted most or many of their neighbours.
    - The figures were considerably lower for those undertaking voluntary or other work (34%), on training schemes or in education (32%), and those who were unemployed (26%).
- Looking out for one another.
    - Over 60% feel that their neighbourhood is a place where neighbours look out for one another.
    - Except for those who are unemployed or who are not working due to long-term illness or disability where the figure is only 44%.
- Speaking to neighbours daily or weekly.
    - Approximately 90% of people speak with their neighbours daily or weekly,
    - Except those who are not working due long-term illness or disability (83%), are unemployed (72%) or are on training schemes or in education (68%).

Figure 39: Percentage trusting most or many of their neighbours, who agree that neighbours look out for one another and who talk to neighbours daily or weekly by employment status
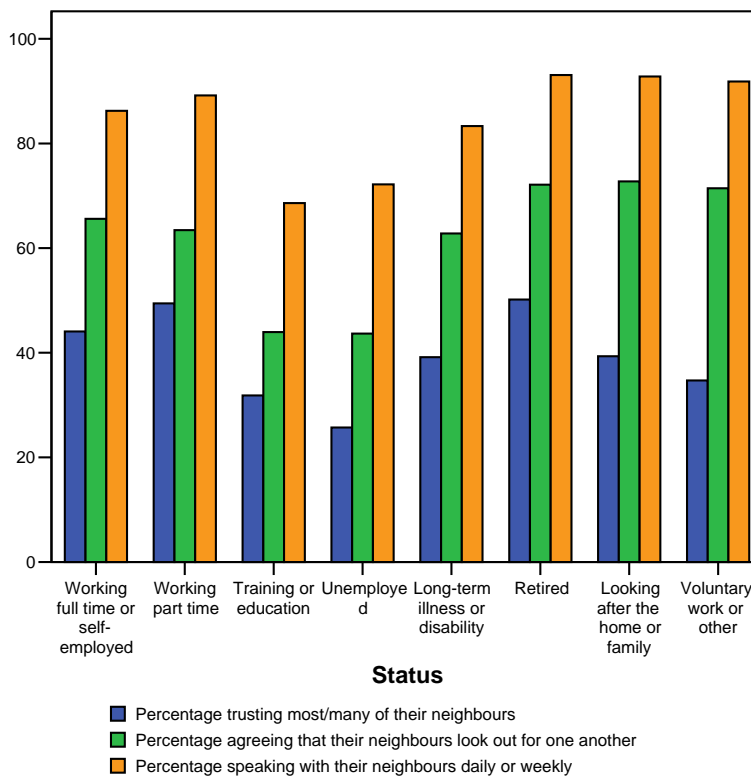
3.2.4.   Conclusions

Women tended to trust their neighbours more than men did, and the youngest age groups had the least trust. The majority of responders believed that neighbours tended to look out for one another except for men aged 16-24 years. The percentage believing this to be the case increased with age, and was higher for women than men for all age groups except those aged 25-34 years. Over 60% of people spoke to neighbours daily or weekly, even those in the youngest age groups. Those who were in training schemes or in education, who were unemployed or were not working due to long-term illness or disability were the least likely to trust their neighbours or agree that neighbours looked out for one another, and they were least likely to speak with their neighbours on a weekly basis.

3.3   Social Networks

Why are social networks related to Social Capital?

This section investigates social networks as an aspect of Social Capital. Social networks have been examined extensively as an area of research in their own right, particularly in relation to health. They are defined as the personal relationships which are accumulated when people interact with each other in families, neighbourhoods and elsewhere.

Responses to these questions may reflect the respondent's sense of belonging in that locality and their degree of access to immediate support networks. Social support is examined in more detail in section 3.4.

The questions provide information on the patterns of networks but not on the quality of contacts. For example, a telephone conversation could be a short call or an hour-long discussion and may serve as a duty or a pleasure.

Summary

- The majority of people speak to non-household family members frequently, but for a small group (5%) this is less than once every couple of months. A similar pattern occurs for frequency of speaking to friends.

- The frequency of speaking to family, friends and neighbours at least weekly differed depending on the person's age and sex. Over 90% of young men spoke to friends daily or weekly compared to 75% for family and neighbours. Whereas, the reverse pattern was true for those aged 55 years or more.

- Less than 4% spoke to family, friends and neighbours (each group considered separately) twice a year or less frequently, with the exception of men aged 16-34 years of whom 6% spoke with neighbours twice a year or less frequently and males aged 55 years or more of whom almost 10% spoke with friends twice a year or less frequently.

- North Carr had the highest percentage of residents who spoke with family at least weekly (89%) and the East had the lowest percentage (83%). The East also had the lowest percentage who spoke with friends at least weekly (78%) with Riverside having the highest percentage (86%). More of North Carr residents spoke to neighbours at least weekly (92%) compared to other areas with Wyke residents speaking to neighbours the least (75%).

- Between 0.7% and 1% of residents spoke to family, friends and/or neighbours (any of these groups) once or twice a month or less frequently, except for Riverside where the percentage was lower (0.3%) and Wyke where the percentage was higher (1.3%).

- The percentage of people in this potentially very isolated position is small, but this could equate to approximately 1,500 people within the city of Hull.

- Those who were unemployed and those who were on training schemes or in education spoke to family the least frequently (65%-70% speaking at least weekly compared to approximately 80% for other groups). Those who were not working due to long-term illness or disability, who were retired or were undertaking voluntary or other work spoke to friends the most infrequently (less than 70% speaking daily or weekly compared to around 75%-95% for other groups). The unemployed and those on training schemes or in education spoke with neighbours the most infrequently (approximately 70% speaking at least weekly compared to approximately 80% for other groups).

The majority of responders spoke to non-household family members daily or weekly (***Figure 40***) with almost one-quarter speaking daily, another 15% speaking with family 5 or 6 days per week and a further 27% speaking 3 or 4 days per week.

Figure 40: Frequency of speaking to non-household family members

Frequency of speaking with non-household family members
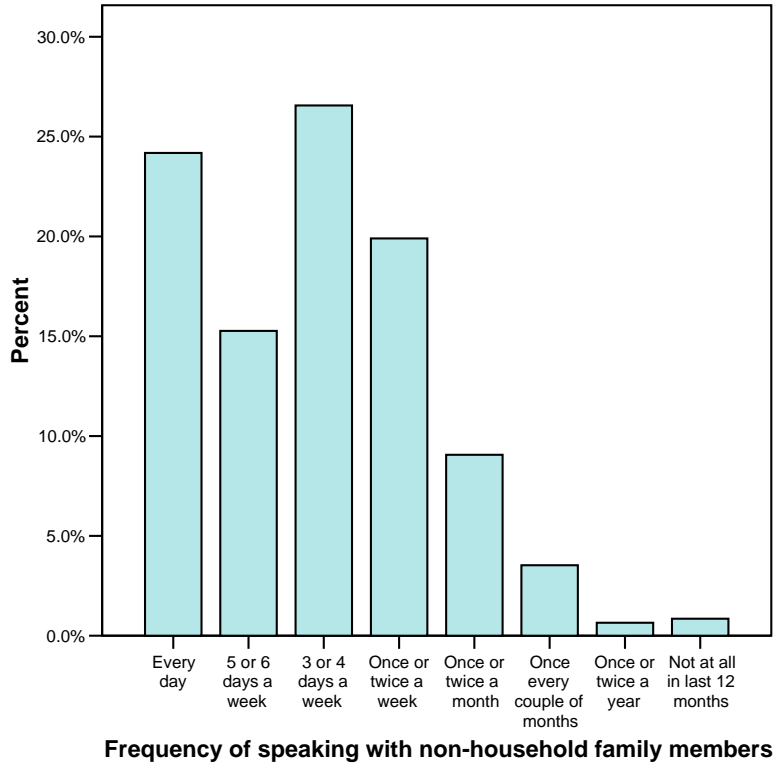
The majority of people also spoke with friends frequently (*Figure 41*). However, as with family, there was a very small percentage who spoke with friends only very rarely.

Figure 41: Frequency of speaking to friends
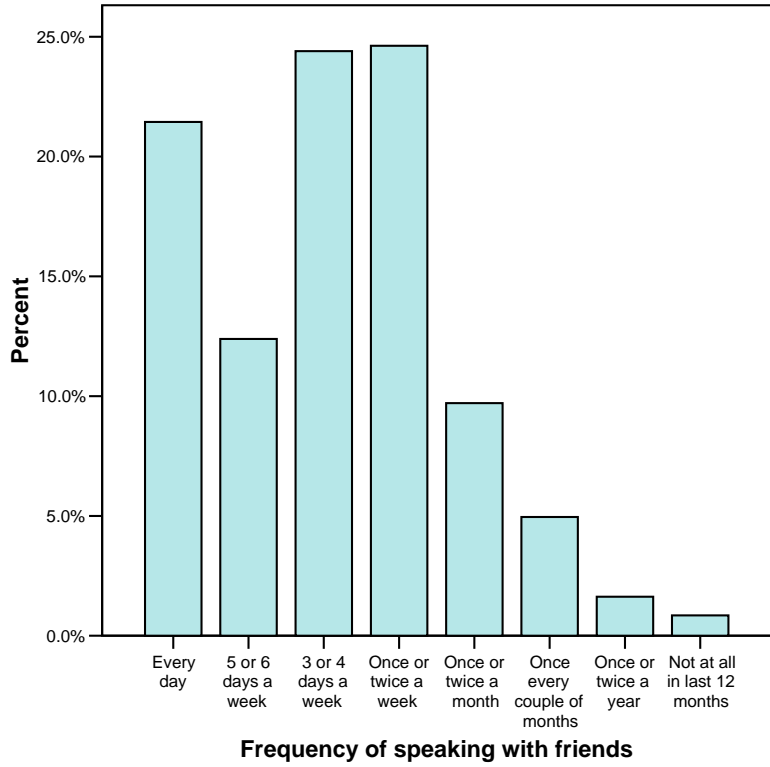
3.3.1   Age and Gender

Figure 42 shows the frequency of speaking to family, friends and neighbours at least weekly for each sex and three different age groups.

- Women spoke with non-household family members, friends and neighbours more frequently than men.
- Men and women 55 years or older were less likely to speak to friends daily or weekly, but more likely to speak with family and neighbours daily or weekly compared to all other age groups. Whereas men and women aged 16-34 years were more likely to speak to friends at least weekly compared to either family or neighbours, particularly men.

Figure 42: Percentage speaking with family, friends and neighbours daily or weekly for each sex and for three different age groups
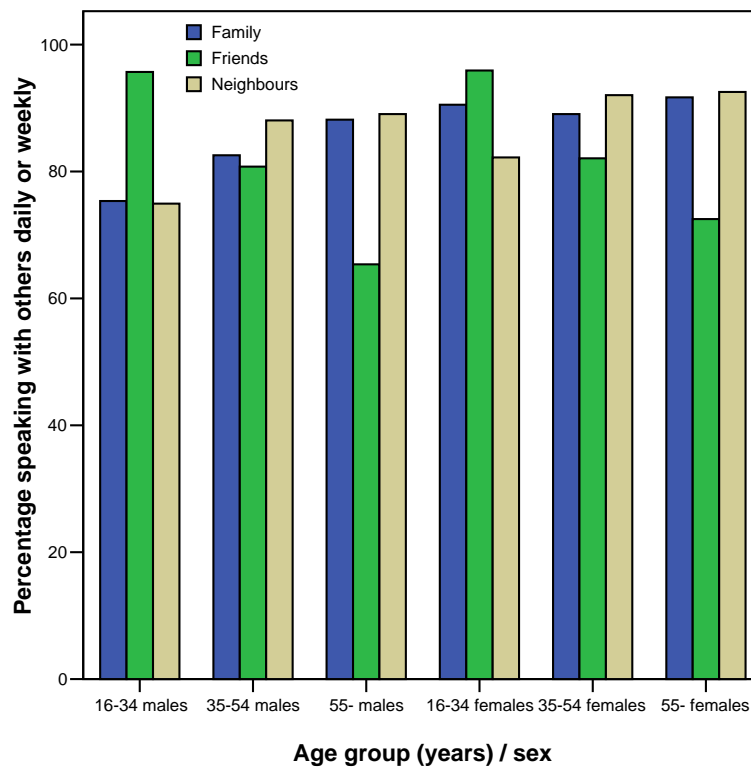
However, whilst the majority spoke to non-household family members, friends and neighbours daily or weekly, there was a small minority who spoke with these groups twice a year or less frequently (***Figure 43***).

- This was particularly the case for men aged 16-34 with regard to speaking with neighbours (6%).
- And men aged 55 years and over with regard to speaking with friends (10%).

Figure 43: Percentage speaking with family, friends and neighbours twice a year or less frequently for each sex and for three different age groups
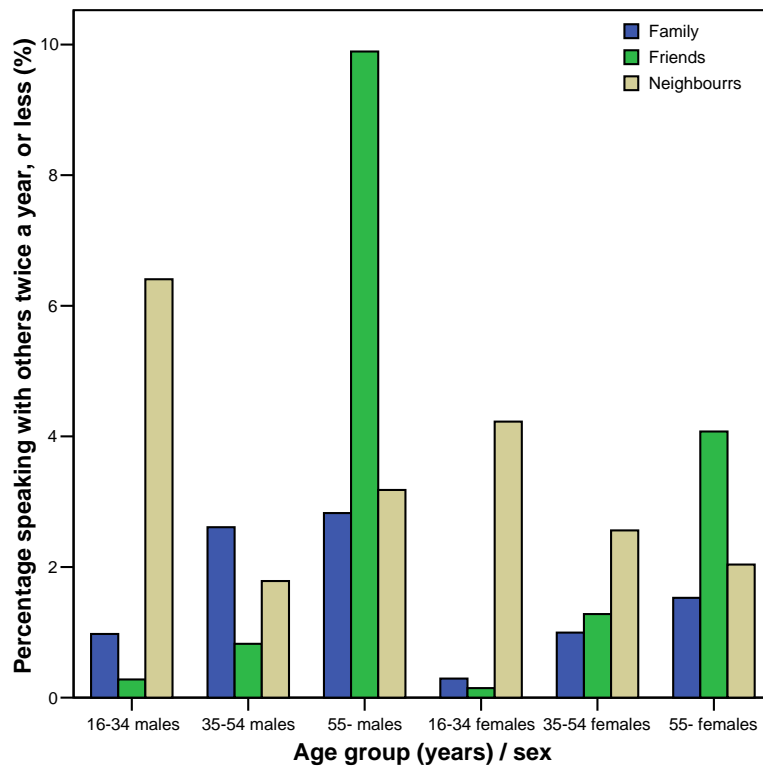
3.3.2   Area

The area analysis show some small variation in the frequency of talking to non-household family members, friends and neighbours daily or weekly (***Figure 44***).

- Frequency of speaking to family.
  - o North Carr had the highest percentage of residents who spoke with family at least weekly (89%).
  - o East had the lowest percentage (83%).
- Frequency of speaking to friends.
  - o The East also had the lowest percentage of residents who spoke with friends at least weekly (78%).
  - o With Riverside having the highest percentage (86%).
- Frequency of speaking to neighbours.
  - o More of North Carr residents spoke to neighbours at least weekly (92%).
  - o Compared to other area with Wyke residents speaking to neighbours the least (75%).

Figure 44: Frequency of speaking to non-household family, friends and neighbours on a daily or weekly basis by area committee
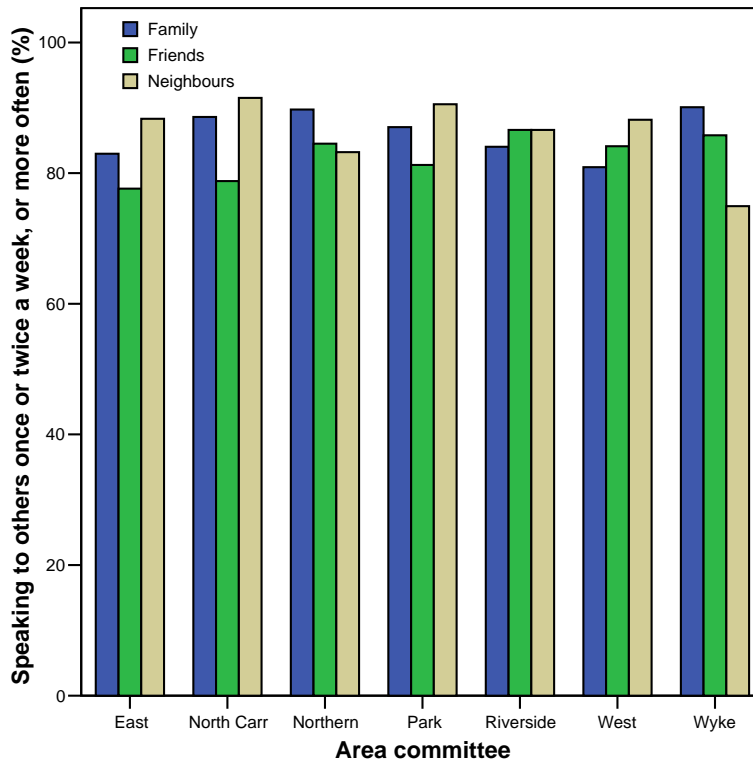
There is only a small proportion (<6%) who speak with non-household family, friends and neighbours twice a year, or less frequency (*Figure 45*). This is particularly the case for talking to neighbours in the Northern and Wyke areas.

Figure 45: Percentage of residents who talk to family, friends and neighbours twice a year, or less frequently by area committee
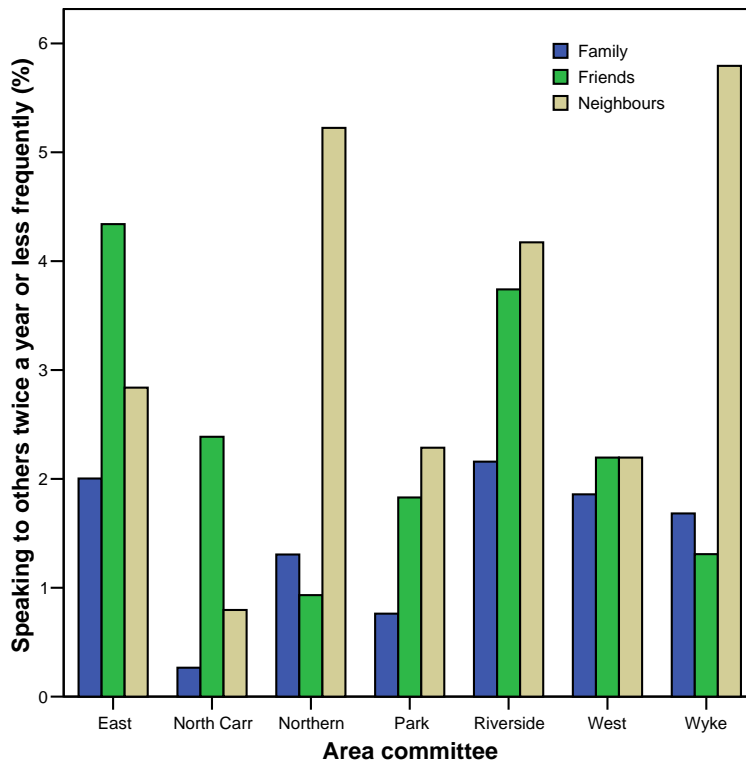
However, Figure 45 shows the frequency of talking to each group separately, and suggests that people do not talk to all these groups with equal frequency. It would be interesting to examine the percentage of people who speak infrequently to family, friends **and** neighbours (i.e. who speak infrequently to all of these three groups).

Figure 46 shows the percentage of people who talk to none of these groups once or twice a week, or more frequently. It can be seen that percentage of people in this potentially very isolated position varies between 0.3% in Riverside to 1.3% in Wyke.

Figure 46: Percentage of residents who talk to family, friends and/or neighbours once or twice a month, or less frequently by area committee
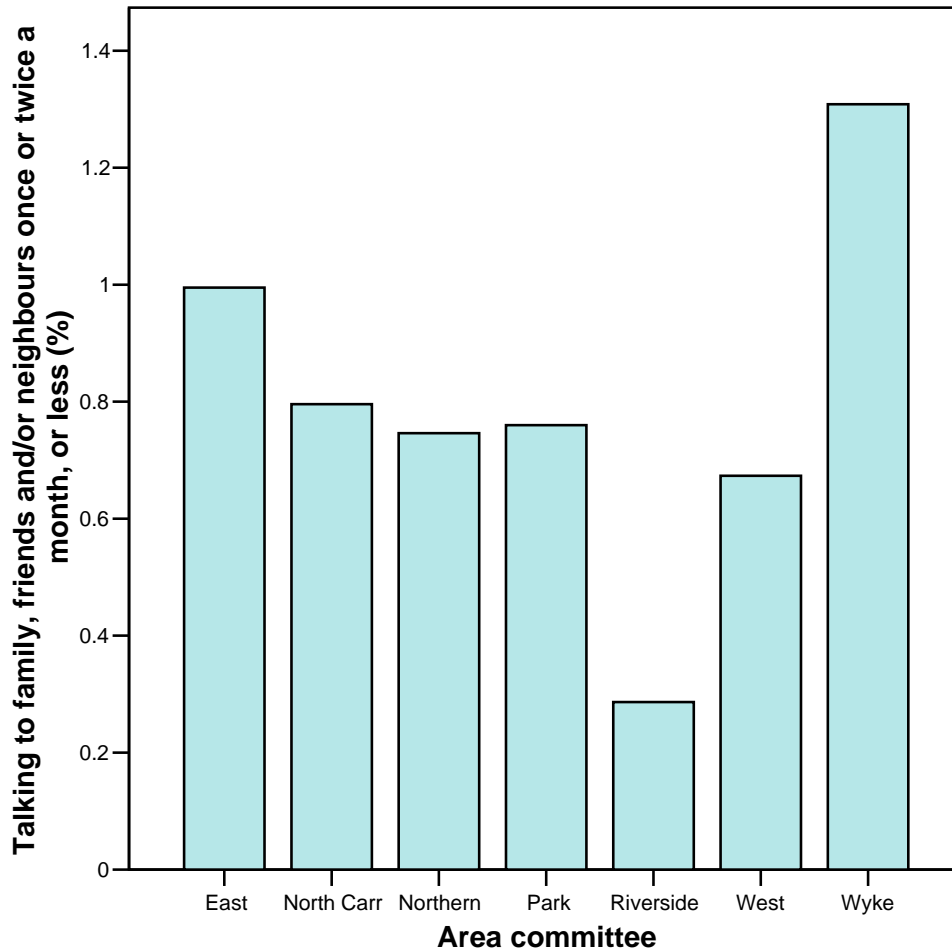
Whilst these percentages are relatively low, if multiplied by the number of residents in each area it is possible that a relatively large number of people may be in this possibly isolated position.

Table 42 gives estimates of the percentage of people throughout Hull who might be in this potentially very isolated position. It can be seen that the percentages are based on a very small number of people in the survey in this situation (there was only three people in the survey of 4,001 who spoke with family, friends and/or neighbours once or twice a year or less frequently). Therefore, the percentages presented below should be used as a guide rather than a robust estimate. However, whilst these percentages are small, if multiplied by the total population of Hull, it represents a relatively large number of people in this potentially very isolated position (possibly a total of 1,500 people).

Table 42: Estimated percentage of people aged 16 years and over throughout Hull who speak to family, friends and/or neighbours infrequently

Area committee	Estimated percentage who speak to family, friends and/or neighbours	
	Once-twice per month or once every two months	Once or twice a year or not at all within last year
East	0.83	0.17
North Carr	0.80	0.00
Northern	0.56	0.19
Park	0.60	0.15
Riverside	0.29	0.00
West	0.67	0.00
Wyke	1.31	0.00
Hull	**0.70**	**0.07**

3.3.3   Employment Status

It can be seen from the ***Figures 47 and 48*** that there is a difference in the contact with family, friends and neighbours depending on employment status.

Figure 47 illustrates the frequency of speaking to family, friends and neighbours at least weekly.

- People who are working tend to speak to family, friends and neighbours with similar frequency with more than 80% speaking to all these groups daily or weekly.
- Whereas a higher percentage of those on training schemes or in education tend to speak to friends daily or weekly (96%), but a lower percentage of them speak to family and neighbours daily or weekly (74% and 68% respectively).
- A higher percentage of those who are unemployed also speak to friends more frequently than family or neighbours, but the reverse is true for those with long-term illness or disability, those who are retired, those looking after the home or family and those who are undertaking voluntary or other work.

Figure 47: Frequency of speaking to non-household family, friends and neighbours on a daily or weekly basis by employment status
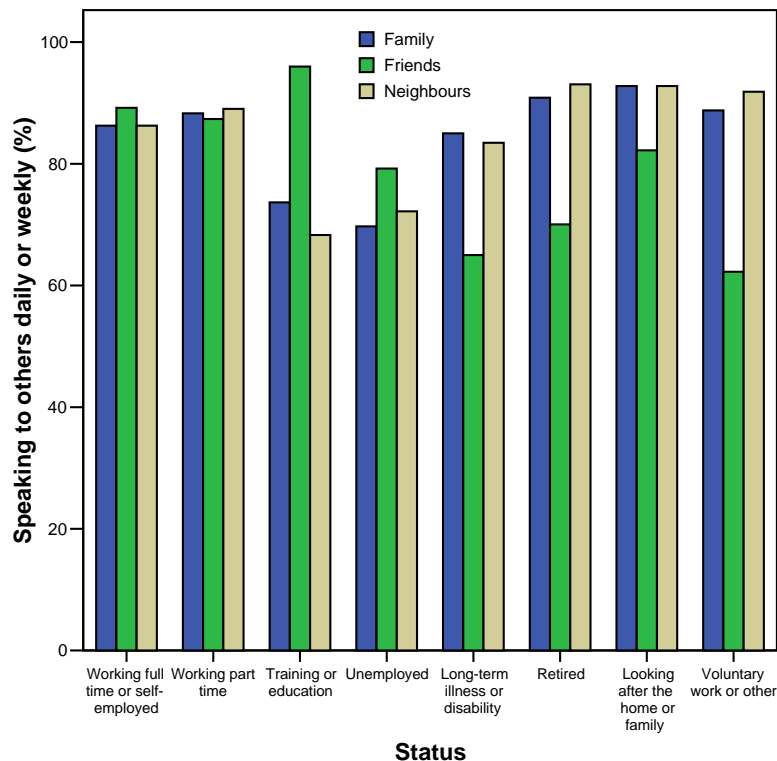
Figure 48 illustrates that very few of those who are working do not speak with family or friends twice a year, or less frequently (<1%), and that more than 97% of them speak to neighbours more than twice a year.

- Approximately 6% of those who are unemployed speak to family and neighbours twice a year, or less frequently.
- Just over 7% of those on training schemes or in education speak with neighbours twice a year or less frequently. This figure is 9% for those who are not working due to long-term illness or disability.
- Whereas, almost all of those who are retired speak to family and neighbours more than twice a year (98%), but the figure falls to 91% for friends.

Figure 48: Percentage of residents who talk to family, friends and neighbours twice a year, or less frequently by employment status
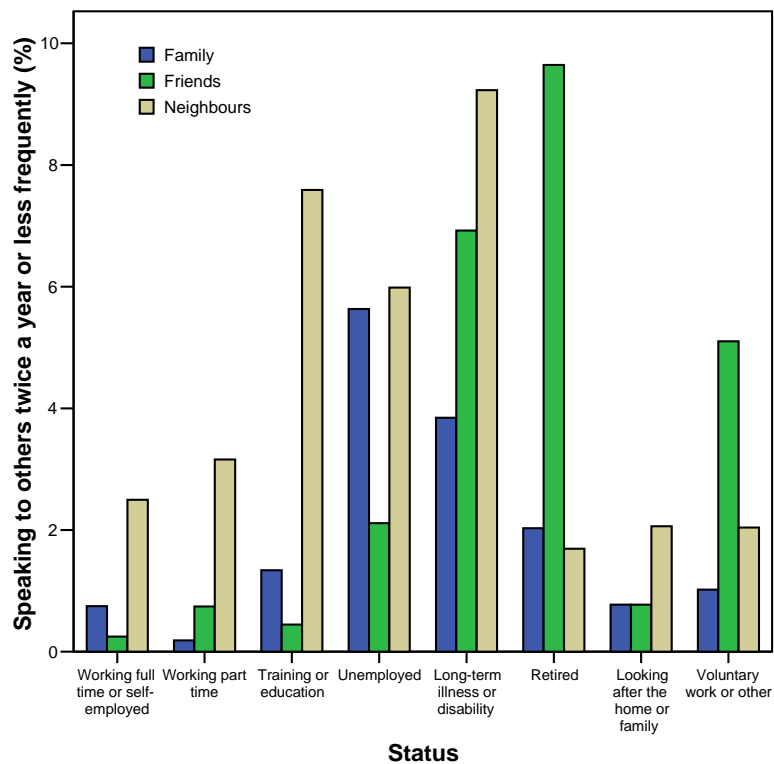
The percentages involved in local organisations also differed depending on employment status with those unemployed or with long-term illness or disability being the least likely to be involved (7%) increasing to 13% for those working part-time or who were retired (and 25% for those undertaking voluntary or other work).

3.3.4   Conclusions

Men and women aged 16-34 years spoke more frequently to friends compared to family or neighbours and the reverse was true for those aged 55 years and over. Residents of East, North Carr and Park spoke with friends less frequently than family and neighbours. Those on training schemes or in education spoke to friends more frequently, whereas those who were unemployed, were retired, looked after the family or home, and were undertaking voluntary or other work were more likely to speak on a daily basis with family and neighbours more frequently. Less than 1%, except for Wyke residents, spoke to family, friends and/or neighbours once or twice a month, or less frequently. Whilst this is a small percentage, if this is representative of the city of Hull, this means that approximately 1,500 people are potentially very socially isolated.

3.4   Social Support

Why is social support related to Social Capital?

Whereas the previous section investigated the frequency of social contacts and the number of people that respondents could turn to, this section focuses on functional support and the quality of social contacts.

The first set of questions looked at practical support. People were asked if they could request help if they were ill in bed and needed help at home, and who they would ask for help.

The second set of questions focused on emotional support. Respondents were asked how many people they could turn to for comfort and support if they had a serious personal crisis.

Summary

- Overall, 94% had someone they could ask for help if ill in bed with a further 4% stating that they did not know or that it "depends".

- Approximately 10% of those in the oldest age groups (65 years and over) did not have anyone to help or they weren't sure.

- Two thirds of those who had someone to ask would feel able to ask a non-household relative and 58% felt able to ask a wife, husband or partner. Of those living with a partner, over 95% of them aged 25-64 years would ask their partner for help, but the figure was lower in the youngest (86%) and oldest (89%) age groups.

- The number of close relatives or friends that lived nearby differed depending on age, with 11% of those aged 16-24 years having no-one nearby compared to 19% for those aged 75 years and over.

- Less than 1% of those aged 16-24 years had no-one to turn to in a serious crisis and this rose to 3% for those aged 75 years or more.

- North Carr residents were more likely to have someone to ask if they were ill in bed (98%) whereas Northern (91%) and Wyke (88%) were the least likely to have someone to help. A similar pattern occurred for number of close friends and relatives living nearby and number of people who could be relied upon in a serious crisis.

- Over 95% of those who were working or looking after the home or family had someone they could ask for help, but only 88% of those who were unemployed and 90% of those who were not working due to long-term illness or disability.

- Those who were unemployed, long-term sick or retired were more likely to have no close relatives or friends nearby (more than 20%).

- Those undertaking voluntary or other work had the lowest number of people to turn to in a serious crisis.

3.4.1   Age and Gender

All age groups had similarly high rates of being able to ask someone for help if they were ill at home although this was slightly more qualified for elderly people (**Table 43**).

Table 43: Whether or not responder could ask someone for help if ill in bed

Help available when ill in bed?	Responses (in %) by age in years							
	16-24	25-34	35-44	45-54	55-64	65-74	75+	Total
Yes	95	93	95	95	96	91	90	**94**
No	2	4	2	2	1	3	2	**2**
Don't know/depends	3	4	3	2	3	6	7	**4**
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

There was a difference[13] in the percentages of men (93%) and women (95%) who had someone they could ask someone for help, and 3% and 2% respectively feeling that they did not have anyone to ask, with remaining people stating that they did not know or that it "depends".

Table 44 gives the type of person that they would ask for help if ill in bed (for those 3,756 people who stated they had someone to ask). Note that it is possible to specify more than one person to help so that the percentages may add to more than 100%.
- More than two-thirds of people aged 25 to 64 years who ask for help would ask their wife, husband or partner.
- The youngest people were more likely to ask household members, relatives or friends, whereas the eldest people were more likely to ask relatives.
- As age increased, people were more likely to ask neighbours or organisations for help.
- Of those who stated they had someone they could ask for help, very few of them (less than 1%) went on to state that they would prefer not to ask for help.

Table 44: Type of person to ask for help if ill in bed by age group

Help available from whom when ill in bed	Responses (in %) by age in years							
	16-24	25-34	35-44	45-54	55-64	65-74	75+	Total
Wife/husband/partner	29	65	72	70	65	49	32	**58**
Other household member	57	22	37	50	33	16	24	**36**
Non-household relative	71	59	62	72	70	66	70	**66**
Friend	62	51	52	54	47	33	29	**50**
Neighbour	16	24	30	36	40	36	37	**30**
Organisation	1	<1	2	2	9	14	19	**4**
Would prefer not to ask	0	<1	<1	1	<1	1	1	**<1**

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[13] The difference was statistically significant (χ^2 test, p=0.014).

It should be noted that this table does not reflect whether the responder has a partner, has anyone else in their household or has any relatives, etc. However, survey responders were asked if they were living with a partner, so this can be examined in relation to whether or not, the responder feels if they can ask their wife, husband or partner for help if they were ill in bed.

Of those who stated they did live with a partner (*Figure 49*):
• Over 95% of them aged 25 to 64 years were willing to ask their partner for help if they were ill in bed.
• The figure asking their partner for help was lower for those in the youngest age group (86%).
• And those who were older (89% for those aged 65-74 years and 75% for those aged 75 years or more) were the least likely to ask their partner for help compared to other age groups.

Figure 49: Of those living with partners, percentage who would ask their partner for help when ill in bed
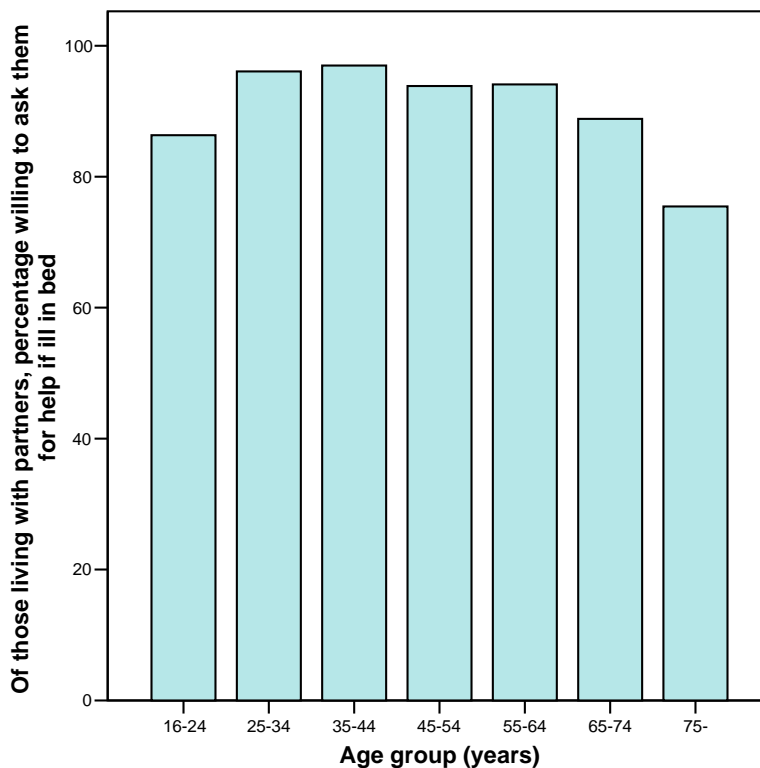
The number of close relatives or friends who live nearby decreased as age increased (*Table 45*).

Table 45: Number of relatives or friends that live nearby for each age group

Number of close relatives/friends who live nearby	Responses (in %) by age in years						
	16 to 24	25 to 34	35 to 44	45 to 54	55 to 64	65 to 74	75+
None	11	13	14	14	15	18	19
One or two	33	37	37	34	34	43	41
Three or four	33	33	30	33	30	25	29
Five or more	23	17	19	19	21	13	11
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Additionally, the number of relatives or friends who are close and live nearby differed between the sexes.

- Sixteen percent of men had no close relatives or friends nearby compared to 13% of women.
- 39% of men had only one or two nearby compared to 34% of women.
- 29% of men had three or four nearby compared to 33% of women.
- 17% had five or more close relatives or friends living nearby compared to 20% for women.

When asked about being able to rely on support in a crisis those aged 75+ years had the lowest level of support with the youngest people (16-24 years) having the highest (*Table 46*). This is likely to be associated with the expected fall in the number of close relatives and friends as age increases.

Table 46: Number of people to turn to when in a serious crisis by age group

Number of people to turn to when in serious crisis	Responses (in %) by age in years						
	16 to 24	25 to 34	35 to 44	45 to 54	55 to 64	65 to 74	75+
None	<1	2	1	3	2	3	3
One or two	15	20	19	17	16	27	36
Three or four	17	25	20	17	22	22	17
Five or more	67	53	60	63	60	60	43
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

The number of people also differed slightly between the sexes with:
- 2% of women and 1% of men having no-one to rely on when in a serious crisis.
- 22% of women and 20% of men had one or two people to rely on.
- 20% of women and 21% of men had three or four people they could rely on.
- The majority (56% of women and 60% of men) had five or more people they could rely on.

3.4.2   Area

On an area basis asking for help when ill was high across Hull and a varied pattern of family and friends emerges when examining the person who would be asked (*Table 47*).
- Do not have anyone to ask for help (or not sure):
  - o   Lowest percentage in North Carr (1%).
  - o   Highest percentage in Wyke (7%).
- Have someone to ask for help:
  - o   For most areas, more than 95% of residents felt that they had someone to ask for help.
  - o   Except for Northern (91%) and Wyke (88%),

Table 47: Whether or not responder could ask someone for help if ill in bed by area

Help available when ill in bed?	Response (in %) by area committee						
	East	North Carr	Northern	Park	Riverside	West	Wyke
Yes	96	98	91	96	95	95	88
No	2	1	3	1	2	2	5
Don't know/depends	2	1	5	3	3	4	7
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Table 48 illustrates the type of person to ask for help by area.

- Half of those living in the East area would be willing to ask a neighbour for help if they were ill in bed and the figure was slightly lower for Park (38%).
- These percentages were considerably higher than other areas, in particular North Carr where only 15% felt able to ask a neighbour for help.
- Residents in Wyke were the least likely to ask another member of the household (26%) for help compared to those in the East (42%) and West (44%). However, this may reflect the size of the households rather than lack of willingness to ask.

Table 48: Type of person to ask for help if ill in bed by area

Person to Assist	Responses (in %) by area committee						
	East	North Carr	Northern	Park	Riverside	West	Wyke
Wife/husband/partner	54	61	65	57	51	63	55
Other household member	42	30	40	39	30	44	26
Non-household relative	75	57	72	74	65	65	50
Friend	58	30	47	59	48	54	44
Neighbour	44	15	23	38	28	30	23
Organisation	10	2	1	4	7	3	2
Would prefer not to ask	<1	<1	1	<1	<1	1	<1

The number of close relatives or friends who lived nearby differed among the areas (*Table 49*). North Carr and Northern areas tended to have the fewest close relatives or friends who lived nearby with 56% and 58% having two or fewer close relatives or friends living nearby respectively.

Table 49: Number of relatives or friends that live nearby for each area

Number of close relatives/friends nearby	Responses (in %) by area committee						
	East	North Carr	Northern	Park	Riverside	West	Wyke
None	15	21	19	10	14	11	13
One or two	30	35	39	35	39	40	36
Three or four	35	27	27	37	27	33	28
Five or more	19	17	15	18	19	16	24
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Table 50 gives the number of people a person could turn to in a serious crisis.
- Over 95% of people could turn to at least one person for comfort and support.
- Over half of people could rely on five or more relatives or friends, except in the Wyke area where 39% could rely on five or more people.

Table 50: Number of people to turn to when in a serious crisis by area

Number of people who could be relied on in serious crisis	Responses (in %) by area committee						
	East	**North Carr**	**Northern**	**Park**	**Riverside**	**West**	**Wyke**
None	2	<1	2	1	1	2	4
One or two	11	16	23	15	20	22	32
Three or four	13	28	23	18	20	20	25
Five or more	73	55	52	65	60	56	39
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

3.4.3   Employment Status

Figure 50 illustrates the relationship between whether or not a person has someone else to rely on if they were ill in bed and employment status. Over 95% of those who were working or looking after the home or family had someone they could ask for help compared to:
- 88% of those who were unemployed and
- 90% of those who were not working due to long-term illness or disability.

Figure 50: Percentage of responders who have someone they could ask for help if they were ill in bed, by employment status
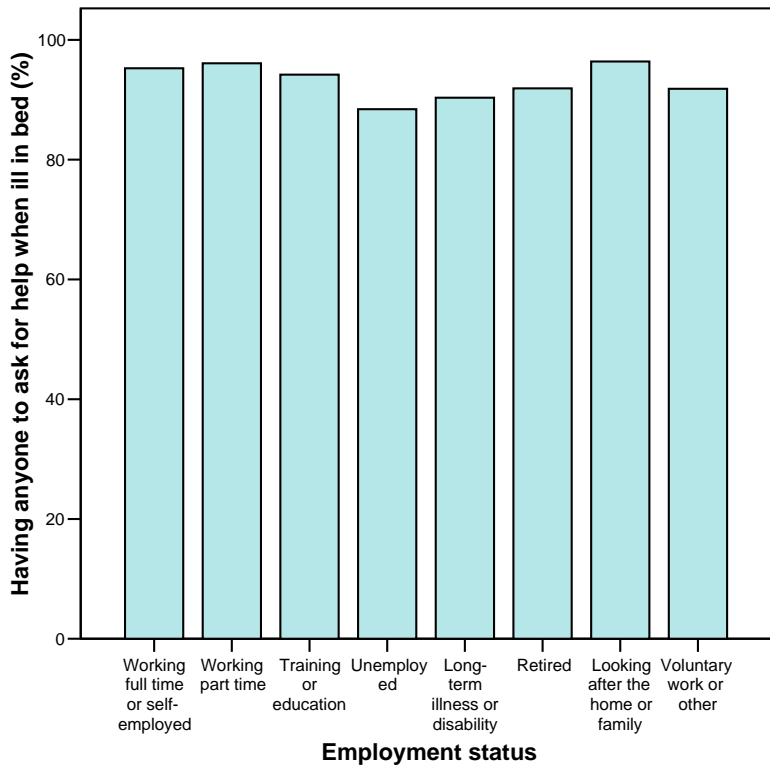
Of those who had someone to ask for help, the type of person differed depending on employment status as illustrated in *Figure 51*.

- Although, the percentages were relatively small, those who were undertaking voluntary or other work were much more likely to state that they would prefer not to ask anyone for help (5.6%) compared to other employment status groups (0.3%).

- Those who were retired and not working due to long-term illness or disability had the highest percentage who would ask an organisation for help (18% and 15% respectively).

- The lowest percentage willing to ask for help from a partner was for those who were retired (43%), who were not working due to long-term illness or disability (43%) and those on training schemes or in education (37%), but this may reflect the lack of a partner rather than unwillingness to ask.

- Over 60% of people in all groups except on training schemes or in education (58%) were prepared to ask a relative (outside the house) for help when ill in bed.

Figure 51: Person to ask for help if ill in bed by employment status of those who state they have someone to ask
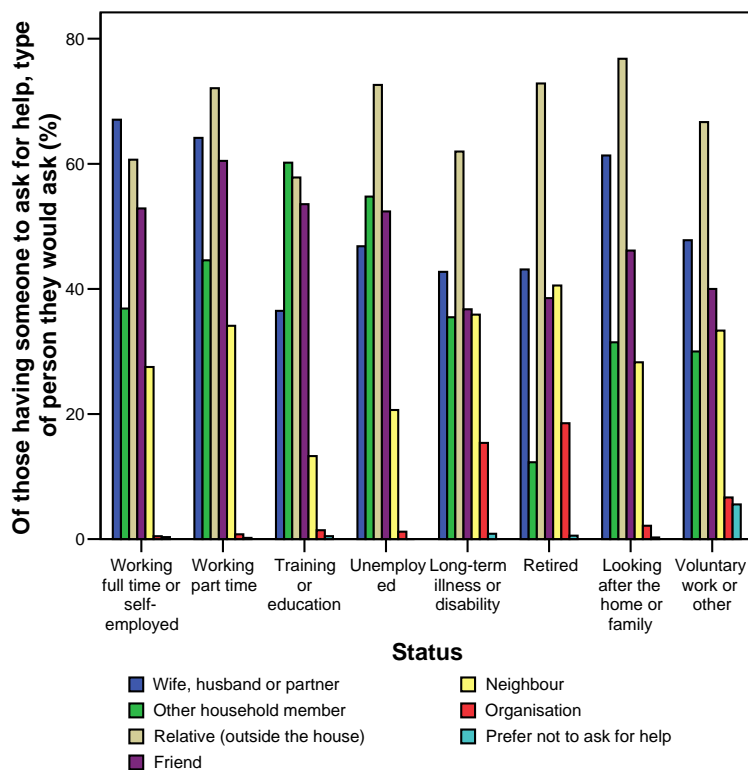
The number of close relatives or friends who lived nearby differed depending on employment status (***Table 51***).

- Approximately 20% or more had five or more close relatives or friends living nearby except for those who were working full-time or were self-employed (17%), were retired (15%) or not working due to long-term illness or disability (15%).
- In addition for these two latter groups together with those unemployed, 20% or more had no close relatives or friends living nearby.

Table 51: Number of relatives or friends that live nearby by employment status

Number of close relatives or friends nearby	Responses (in %) by age in years							
	Working full-time or self-employed	Working part-time	Training or education	Unemployed	Long-term illness or disability	Retired	Looking after home or family	Voluntary or other work
0	12	11	13	21	24	20	7	9
1–2	38	35	37	33	31	37	38	44
3–4	33	31	29	28	31	28	29	29
>4	17	23	21	19	15	15	26	18
Total	100	100	100	100	100	100	100	100

Figure 52 illustrates the number of relatives or friends that people could turn to for comfort and support when they were in a serious crisis. Note that the maximum number is 15 (i.e. all values higher than 15 were coded as exactly 15).

- It can be seen that 25% of people (bottom line of box) have two or three people to rely on, except for those who are undertaking voluntary or other work where 25% of them only have one person they can rely on.
- It can also be seen that 25% of people have 10 or more people they can rely on (top line of box), except for those who have long-term illness or disability (25% of them have eight or more people they can rely on) and those who are undertaking voluntary or other work (where 25% of them have seven or more people they can rely on).

Figure 52: Boxplot illustrating the number of people a person could turn to if they had a serious crisis by employment status
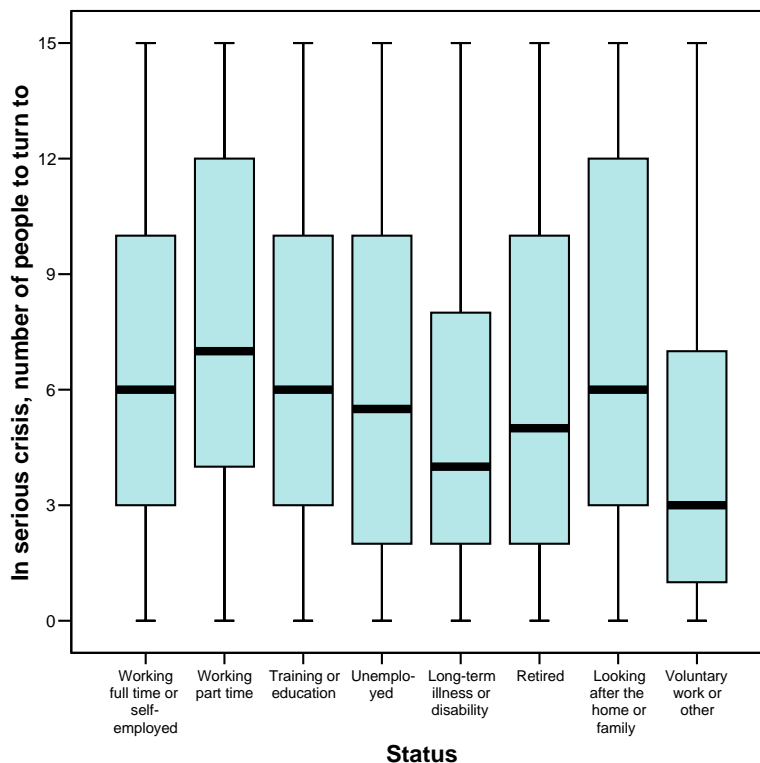
3.4.4   Conclusions

Overall, 94% had someone they could rely on if they were ill in bed, and two-thirds of responders stated that they would ask a relative. Of those living with a partner, over 80% would ask their partner for help with the exception of those aged 75 years and older when this fell to 75%. Ninety-five or more percent of residents had someone to ask with the exception of those living in Northern (91%) and Wyke (88%). Similar percentages of people had someone they could rely on in a serious crisis, but this differed depending on employment status, with those who were unemployed, not working due to long-term illness or disability or undertaking voluntary or other work having the fewest people they could rely in a serious crisis.

4   Social Capital and Health

Summary

- Examining Social Capital in relation to health is complicated:
  - there are many inter-relationships which may mean that an association is observed but only through another factor, for example, involvement with a local organisation might be associated with worse health, but this may only be because older people are more likely to be involved with a local organisation and also more likely to have worse health, therefore analysing factors singly may not tell the whole story;
  - the statistical analyses become more complicated and therefore more difficult to explain;
  - the numbers of people within a particular group become small the more groups that are considered, for example, there are only eight people who are aged 35-54 who are retired;
  - if an association if found to exist it cannot be assumed to be causal;
  - difference in health status, for example, on the Visual Analogue Scale / Health Thermometer scale may be small relative to the range of the score, but it is not known how small a difference on this scale is important, for example, what difference would have a noticeable effect on people's health, involve more GP consultations, increase the risk of a disease or medical condition, etc.

- Those who felt better informed about local issues and felt they could influence local decisions tended to report better health. Whereas those who had taken action to resolve a local problem tended to report worse health.

- People who did not trust their neighbours or did not believe that their neighbours looked out for one another tended to report worse physical and mental health. People who spoke to their neighbours more regularly tended to report better physical and mental health and less stress than those who spoke infrequently. A similar finding was observed for frequency of speaking to (non-household) family members. However, the pattern differed for frequency of speaking to friends with no relationship observed for stress or mental health, but a higher percentage reporting long-term illness/disability for those who spoke with friends infrequently although it is possible that the association is confounded by age (retired persons spoke with friends less frequently).

- The relationship between health and having someone to rely on when ill in bed was strong. Those who did not have anyone to rely on had more stress, and were more likely to report long-term illness or disability, and worse physical and mental health.

- People who had more than two close relatives or friends nearby and who had more than two people they could rely on in a crisis were less likely to suffer from stress, and had better physical and mental health.

Ideally, it would be useful to examine Social Capital and health within each area committee. However, since there is a very strong association between age and health, and various aspects of Social Capital are associated with age, it is very important to take age into consideration when examining the relationship between health and Social Capital. Failure to do so could be potentially misleading. If presenting the percentages of people with poor health or the median of a particular health score, it is not easy to present this information for each age group and each area committee separately. In addition, the numbers of people within each age and area committee combination become smaller the larger the number of categories used in the analysis. Therefore, this report will examine the relationship between Social Capital and health taking into account age group, and not examine the relationship for different area committees. These results, however, meet the original requirement for the report in terms of providing a benchmark of Social Capital within each area committee.

It is easier to allow for age, sex and area committee and other confounders when examining health and Social Capital in more sophisticated analysis, for example, analysis of variance (ANOVA), linear regression or logistic regressions, but explaining the results becomes more complicated and is not covered in this report (except to report if an association exists adjusting for some potential confounders). The ANOVA included in this report assesses differences in the Visual Analogue Scale (VAS) / Health Thermometer and Mental Health Inventory score between different levels/categories of the factor of interest after adjusting for age group (10-year bands), sex, smoking status (never or ex versus daily or occasional), healthy diet (yes versus no or don't know), the seven area committees and employment status (categories as used earlier in this report). The 95% confidence intervals (CIs) for the difference in the (adjusted) means are included in this report. There is approximately 95% confidence that this range of values includes the true underlying difference in means between the two groups. Further work will examine more sophisticated approaches exploring the relationship between Social Capital and health taking into consideration other factors, such as age, sex, area committee, smoking status, diet, etc. Such analyses will be included in further publications.

4.1   Civic Engagement

4.1.1   Well-informed About Local Decisions

There was a statistically significant relationship between the percentage of people reporting a long-standing illness or disability and whether a person felt well-informed about local issues for those aged 55 years or older[14] but not for those younger than 55 years of age. The difference in percentages were approximately 14% with a lower percentage reporting ill health for those who felt well-informed (55-64 years: 29% v 43%; 65-74 years: 34% v 49%; and 75 years or more: 52% v 65%). This relationship needs to be assessed in more sophisticated analyses.

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[14]The difference in the percentages was statistically significant (χ^2 tests: 55-64 years, p=0.004; 65-74 years, p=0.002; and 75 years or older, p=0.026),

Those who felt least informed about local issues had a lower or worse health score in terms of the VAS Health Thermometer (which ranged from 0 to 100)[15]. However, the difference was only very small (95% CI for difference 0.3 to 2.1 on a scale from 0 to 100), and therefore probably not of particular interest.

After taking into consideration the effect of age, sex, smoking status, healthy diet, area committee and employment status, there was no statistically significant difference in the Mental Health Inventory score between those who felt well-informed about local issues and those that did not or did not know[16].

There was a statistically significant association between the percentage of responders who reported a large/moderate amount of stress or pressure and whether they felt informed about local issues or not for all age groups except the oldest[17]. A higher percentage of those who were well-informed felt a large or moderate amount of stress or pressure than those who were not as well informed, except for the youngest age group where the reverse was true (*Figure 53*). Again, this relationship needs to be assessed in more sophisticated analyses.

Figure 53: Percentage feeling under a large or moderate amount of stress or pressure by whether or not person feels well-informed about local issues for each age group

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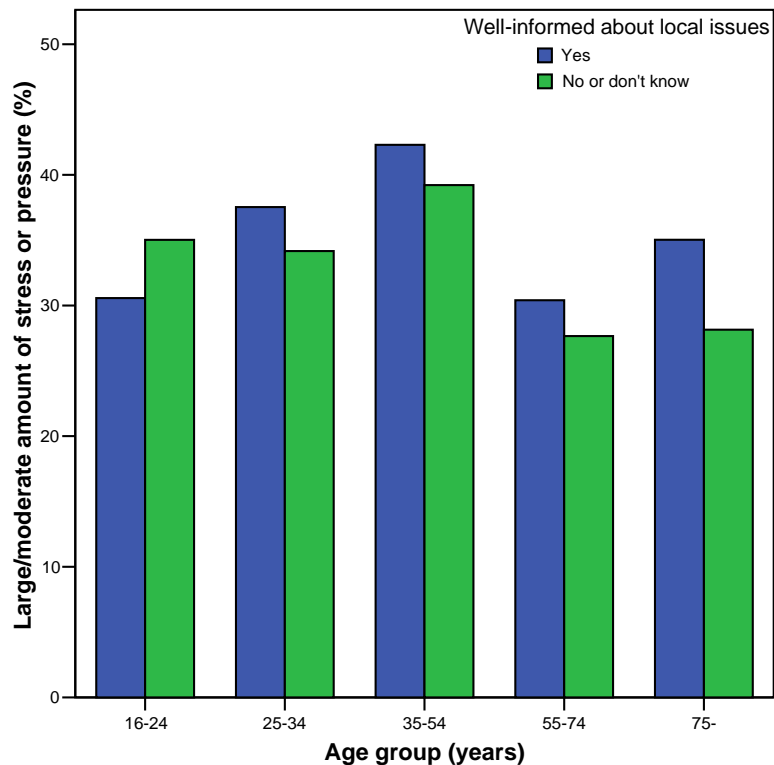
[15] The relationship was examined with ANOVA after adjusting for age, sex, smoking status, healthy diet, area committee and employment status (p=0.006).
[16] Adjusted ANOVA, p=0.85.
[17] The differences in the percentages were statistically significant (χ^2 tests: 16-24 years, p=0.043; 25-34 years, p=0.019; 35-54 years, p<0.001; 55-74 years, p=0.003; and 75 years or more, p=0.069).

4.1.2   Influencing Local Decisions

There was not an association between the percentage of responders reporting a long-standing illness or disability and feeling that the responders could influence local decisions, except in the 55-64 age group[18].

People who felt they could not influence decisions or did not know if they could influence decisions had a lower VAS Health Thermometer score (worst health) than those who felt they could influence decisions[19]. However, the difference was only very small (95% CI for difference 0.4 to 2.5 on a scale from 0 to 100), and therefore probably not of particular interest.

After taking into consideration the effect of age, sex, smoking status, healthy diet, area committee and employment status, there was no statistically significant difference in the Mental Health Inventory score between those who felt well-informed about local issues and those that did not or did not know[20].

The percentage of people reporting a large or moderate amount of pressure or stress was similar for those who felt they could influence local decisions and those who felt they could not, for the seven age groups.

4.1.3   Action Taken to Resolve a Local Problem

There was a relationship between the percentage of reporting a long-standing illness or disability and whether action had been taken to resolve a local problem[21] with 22% of those taking action reporting a long-standing illness or disability compared to 19% of those who thought about taking action but did not, and 17% for those who did not take any action. As mentioned earlier, it is possible that those who did not take action did not have any local problems to resolve, and those that did take action lived in conditions less conducive to good health, for example, damp housing.

After taking into consideration the effect of age, sex, smoking status, healthy diet, area committee and employment status, there was no statistically significant difference in the Health Thermometer score between those who had taken some action to resolve a local problem, those who had not and those who had thought about it but had not actually taken any action[22].

However, using ANOVA model, there was a statistically significant difference in the Mental Health Inventory score between those who had taken some action to resolve a local problem, those who had not and those who had thought about it but had not actually taken

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[18] χ^2 test, p=0.003 with 26% reporting ill health for those feeling they could influence decisions compared to 40% of those feeling they could not or did not know if they could influence decisions
[19] ANOVA after adjusting for age, sex, smoking status, healthy diet, area committee and employment status, p=0.007.
[20] Adjusted ANOVA, p=0.32.
[21] The difference in the percentages was statistically significant (χ^2 test, p=0.002).
[22] Adjusted ANOVA, p=0.11.

any action[23]. However, again the differences were relatively small, with those who had taken action having the lowest score (worse mental health) and those who had thought about taking action the highest scores (better mental health). The 95% CI for those who had taken action relative to those who had not was –0.6 to –0.1, and relative to those who had thought about taken action was –1.2 to –0.5, and on a scale from 5 to 30 these differences are relatively small.

There was no significant difference in the percentage of responders who reported that they were under a large or moderate amount of stress or pressure between those who had taken action to resolve local issues, those that had thought about it and those who had taken no action except in the oldest age group[24]. Fifty people aged 75 year or more had thought about taking action to resolve a local problem of whom 16% had felt under a large or moderate amount of pressure, but the percentage was higher (26%) for the 46 people who had taken action, and even higher (38%) for the 189 who had taken no action in this age group.

4.1.4   Membership of a Local Organisation

There was no relationship between the percentage reporting that they suffered from a long-standing illness or disability and membership of a local organisation. In addition, after adjusting for age, sex, smoking status, healthy diet, area committee and employment status, there was no statistically significant difference in the VAS Health Thermometer score or the Mental Health Inventory score[25] between people who had been involved with local organisations and those that had not. In general, a slightly higher percentage of people who were involved with local organisations reported a large or moderate amount of stress or pressure for persons aged less than 55 years, whereas the reverse was true for those aged 55 years and over. The differences were only statistically significant in the 34-44 year age group[26] where 53% of those involved with an organisation reported stress compared to 39% of those not involved.

4.2   Neighbourliness

4.2.1   Trust of Neighbours

For those aged 16-64 years, there was a higher percentage of responders who trusted most or many or their neighbours who reported that they suffered from a long-standing illness or disability. The reverse was true for those aged 65 years or older. The only age group where the difference was statistically significant[27] was for those aged 25-34 years,

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[23] ANOVA after adjusting for age, sex, smoking, healthy diet, area committee and employment status, p<0.001.
[24] Difference in percentages was statistically significant for those aged 75 years and older (χ^2 test, p=0.007).
[25] Adjusted ANOVA p=0.27 and p=0.71 for VAS Health Thermometer and Mental Health Inventory respectively.
[26] Difference in percentages was statistically significant for those aged 34-44 years (χ^2 test, p=0.027).
[27] Difference in percentages was statistically significant for those aged 25-34 years (χ^2 test, p=0.029).

where 10% who trusted reported a long-standing illness or disability compared to 5% of those who trusted few neighbours or did not trust their neighbours.

After adjusting for age, sex, smoking status, healthy diet, area committee and employment status, there was a statistically significant difference in the VAS Health Thermometer score[28] between those who trusted most or many or their neighbours and those who trusted few or none of their neighbours. Those who trusted more reported better health, but the difference was small (95% CI for difference 0.7 to 2.4).

Using the same ANOVA model, there was also a statistically significant difference[29] in the Mental Health Inventory score depending on trust of neighbours, with those trusting the least having the lower scores denoting worse mental health. However, again the differences were small (95% CI for difference in means 0.1 to 0.6).

For those aged less than 65 years, there was a difference[30] in the percentage of people reporting a large or moderate amount of stress or pressure between those who trusted most or many of their neighbours and those who trusted only a few or did not trust their neighbours, with the least trusting reporting more stress. The difference in the percentages ranged from 12% (25% v 37% in the 55-64 year age group) to 28% (26% v 54% in the 35-44 year age group). The effect was still present for those aged 65 years or older but it was not statistically significant. This relationship needs to be assessed in more sophisticated analyses.

4.2.2   Neighbours Looking Out For One Another

There is no evidence of a relationship between the percentage of responders reporting a long-standing illness or disability and whether responders feel that neighbours look out for one another or not.

After adjusting for age, sex, smoking status, healthy diet, area committee and employment status, there was a statistically significant difference in the VAS Health Thermometer score[31] between those who felt their neighbours looked out for one another, those that did not know and those that felt their neighbours did not. Those who felt their neighbours looked out for one another or did not know had the highest scores denoting better health and those who felt neighbours did not look out for each other had lower scores. Again the differences were relatively small (95% CI for "no" versus "yes" –2.7 to –0.5; for "no" versus "don't know" –3.5 to –0.5).

A very similar pattern emerged for the Mental Health Inventory score[32].

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[28] ANOVA after adjusting for age, sex, smoking, healthy diet, area committee and employment status, p=0.001.
[29] Adjusted ANOVA, p=0.004.
[30] Differences in percentages was statistically significant (χ^2 test, p<0.01).
[31] Adjusted ANOVA, p=0.005.
[32] Adjusted ANOVA, p<0.001, 95% CI for "no" versus "yes" –1.2 to –0.6; for "no" versus "don't know" –1.2 to –0.5.

Those who felt that their neighbourhood was not one where neighbours looked out for each other had the highest percentage suffering from a large or moderate amount of stress. Those that felt their neighbourhood was a place where neighbours looked out for each other reported the lowest percentage with stress, and those who 'did not know' if neighbourhood was such a place had a percentage in-between these two percentages. The strongest association occurred for the youngest age groups[33]. The difference in the percentage suffering stress varied between 11% for those feeling neighbours looked out for one another and those that did not (32% v 43% for those aged 25-34 and 39% v 50% for those aged 45-54 years) to 20% (35% v 55% for those aged 35-44 years old).

4.2.3 Speaking to Neighbours

No significant difference was observed in the percentage reporting long-standing illness or disability and whether or not people spoke to their neighbours at least weekly, except for the 35-44 year age group (with 17% reporting illness who spoke to their neighbours less frequently than weekly and 8% for those who spoke with neighbours daily or weekly)[34].

There was a strong association between the VAS Health Thermometer and frequency of speaking with neighbours even after adjusting for age, sex, smoking status, healthy diet, area committee and employment status[35]. Those who spoke to neighbours less frequently reported a lower (worse) health score, and this was particularly noticeable in the oldest age groups. Over all age groups, the 95% CI for the difference in the mean Health Thermometer score was 0.1 to 3.0 worse for those speaking to neighbours monthly and 4.3 to 9.0 worse for those speaking to neighbours annually or never, both compared to those speaking to neighbours at least weekly.

There was also a difference in the Mental Health Inventory depending on how frequently responders spoke to their neighbours[36]. The score was lower for those speaking to neighbours monthly (95% CI for difference in means 1.3 to 2.0) or annually or never (95% CI for difference in means 2.3 to 3.5) compared to those who spoke with neighbours on a daily or weekly basis.

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[33] Difference in percentages was statistically significant (χ^2 test, p<0.01 for those aged 16-44 years, and p<0.09 for those aged 45 years and older).

[34] Differences in percentages was statistically significant for those aged 35-44 years (χ^2 test, p=0.009).

[35] ANOVA after adjusting for age, sex, smoking, healthy diet, area committee and employment status, p<0.001.

[36] Adjusted ANOVA, p<0.001.

There was an association between reporting a large or moderate amount of stress or pressure and speaking to neighbours (***Table 52***) with a much higher percentage reporting stress for those who spoke to neighbours infrequently. This relationship will be examined in more detail in further work.

Table 52: Percentage reporting large or moderate stress or pressure for those speaking to neighbours daily or weekly compared to those speaking to neighbours less frequently by age group

Frequency of speaking to neighbours	Reporting stress or pressure by age in years (%)							
	16-24	25-34	35-44	45-54	55-64	65-74	75+	Total
Daily or weekly	26	32	38	39	29	24	30	**32**
Less frequently	53	58	61	62	52	54	60	**56**
χ^2 test, p	<0.001	<0.001	<0.001	0.002	0.003	<0.001	0.004	**<0.001**

4.3   Social Networks

4.3.1   Speaking to Family

There is no evidence to suggest that the percentage reporting a long-standing illness or disability differs between those who speak with family at least weekly and those that do not.

A similar but smaller difference occurred in the Health Thermometer with frequency of talking to family members who are not part of the household as occurred for speaking to neighbours[37]. The health scores were lower (worse) for those who had less frequent contact (95% CI for difference in means 1.0 to 3.7 lower and 1.4 to 8.6 lower for monthly contact and annual or no contact respectively compared to those who had daily or weekly contact).

There was also a difference in the Mental Health Inventory score[38] with lower (worse) for those who had least frequent contact (95% CI for difference in means: between 0.1 lower and 0.5 higher for monthly contact and between 0.9 and 2.8 lower for annual or no contact compared to those who had daily or weekly contact).

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[37] ANOVA after adjusting for age, sex, smoking, healthy diet, area committee and employment status, p<0.001.
[38] Adjusted ANOVA, p<0.001.

The percentage reporting stress or pressure was higher in those who spoke to family (non-household members) less frequently than weekly. However, the difference was not statistically significant except in the eldest age group (***Table 53***). This relationship needs to be assessed in more sophisticated analyses.

Table 53: Percentage reporting large or moderate stress or pressure for those speaking to family daily or weekly compared to those speaking to family less frequently by age group

Frequency of speaking to family	Reporting stress or pressure by age in years (%)							
	16-24	25-34	35-44	45-54	55-64	65-74	75+	Total
Daily or weekly	33	35	39	38	30	24	31	**34**
Less frequently	36	44	49	56	42	50	47	**45**
χ^2 test, p	0.56	0.088	0.080	0.002	0.105	0.003	0.116	**<0.001**

4.3.2 Speaking to Friends

There was strong evidence of an association between the percentage reporting a long-standing illness or disability and frequency of speaking to friends (***Table 54***) with those who spoke to friends less frequently than weekly more likely to report a long-standing illness or disability. Further work is needed to assess this potential relationship, but it is possible that age is a confounder (as retired people tended to speak with friends less frequently and were more likely to report long-term illness or disability).

Table 54: Percentage reporting long-term illness or disability for those speaking to friends daily or weekly compared to those speaking to friends less frequently by age group

Frequency of speaking to friends	Reporting long-term illness or disability by age in years (%)							
	16-24	25-34	35-44	45-54	55-64	65-74	75+	Total
Daily or weekly	3	6	8	13	28	31	49	**14**
Less frequently	22	24	14	22	54	67	73	**43**
χ^2 test, p	<0.001	<0.001	0.055	0.009	<0.001	<0.001	<0.001	**<0.001**

A relationship occurred for the VAS Health Thermometer and speaking to friends similar to that observed for speaking to family, but it was slightly stronger[39] and more pronounced in the youngest age groups. The health scores were lower (worse) for those who had less frequent contact (95% CI for difference in means 3.0 to 5.5 lower and 5.9 to 11.6 lower for monthly contact and annual or no contact respectively compared to those who had daily or weekly contact).

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[39] ANOVA after adjusting for age, sex, smoking, healthy diet, area committee and employment status, p<0.001.

However, no such relationship was observed for the Mental Health Inventory score and frequency of speaking to friends after adjusting for age, sex, smoking status, healthy diet, area committee and employment status[40].

There was no evidence that whether or not people spoke with friends daily or weekly was associated with reporting a moderate or large amount of stress or pressure.

4.4 Social Support

4.4.1 Available Help if Ill in Bed

There is a tendency for a higher percentage of people to report a long-standing illness or disability who have no-one to help if ill in bed or those who responded "don't know/depends", with the exception of the 45-54 year age group where the reverse is true. However, since the number of people reporting that there is no-one to help is relatively small, there is a lack of statistical power to compare the groups.

Table 54: Percentage reporting long-term illness or disability for those who have someone to help if ill in bed compared to those who do not by age group

Someone to help if ill in bed	Reporting long-term illness or disability by age in years (%)							
	16-24	25-34	35-44	45-54	55-64	65-74	75+	Total
Yes	3	7	8	14	37	40	58	**18**
No or don't know/depends	6	14	15	39	29	41	61	**27**
Fisher's exact test, p	0.26	0.053	0.14	0.001	0.50	0.99	0.84	**0.001**

After adjusting for the effects of age, sex, smoking status, healthy diet, area committee and employment status, there was an association[41] between the VAS Health Thermometer score and whether or not the person had help if they were ill in bed. The score was lower for those who did not have any help (95% CI for difference in means 5.1 to 8.7 lower than those who had help).

A similar pattern occurred[42] for the Mental Health Inventory which was lower for those who had no help available (95% CI for difference 3.3 to 4.2). The mean difference in the Mental Health Inventory score between those who did and did not have help show a relatively small difference (3 to 4 points on a 25 point scale).

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[40] ANOVA after adjusting for age, sex, smoking, healthy diet, area committee and employment status, p=0.26.
[41] Adjusted ANOVA, p<0.001.
[42] Adjusted ANOVA, p<0.001.

There was strong evidence of an association between whether or not there was someone to help if a person was ill in bed and reporting a large/moderate amount of stress or pressure (***Table 55***). Overall one third of those who had someone to help if they were ill in bed reported a moderate or large amount of stress or pressure compared to two-thirds of people who had no help. This relationship needs to be assessed in more sophisticated analyses.

Table 55: Percentage reporting large or moderate stress or pressure for those who have someone to help if ill in bed compared to those who do not by age group

Someone to help if ill in bed	Reporting stress or pressure by age in years (%)							
	16-24	25-34	35-44	45-54	55-64	65-74	75+	Total
Yes	31	33	40	39	30	25	29	**34**
No or don't know/depends	81	68	49	82	62	46	61	**64**
Fisher's exact test, p	<0.001	<0.001	0.38	<0.001	0.005	0.012	0.002	**<0.001**

4.4.2   Number of Close Relatives and Friends Living Nearby

There was no evidence to suggest that there was a difference in the percentage reporting a long-standing illness or disability between those who had less than three close relatives or friends living nearby and those who had more.

The VAS Health Thermometer was significantly lower[43] for those who only had 0-2 close relatives or friends that lived nearby compared to those that had more nearby (95% CI for difference 0.7 to 2.4).

A similar pattern occurred for the Mental Health Inventory[44] with a lower score for those with the fewest friends and relatives living nearby (95% CI 0.7 to 1.1) with more pronounced differences for the oldest people.

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[43] ANOVA after adjusting for age, sex, smoking, healthy diet, area committee and employment status, p<0.001.
[44] Adjusted ANOVA, p<0.001.

In general, a higher percentage of those who had few close relatives or friends (0-2) living nearby reported stress or pressure, but the difference did not reach statistical significance except in the oldest age groups (**Table 56**). Logistic regression will be used in further work to examine this in more detail.

Table 56: Percentage reporting large or moderate stress or pressure for who have 0-2 close friends and relatives living nearby compared to those who have more than 2 friends and relatives nearby by age group

Number of close friends and relatives living nearby	Reporting stress or pressure by age in years (%)							
	16-24	25-34	35-44	45-54	55-64	65-74	75+	Total
0-2	35	38	43	45	34	33	41	**39**
>2	33	34	38	37	29	16	19	**32**
χ^2 test, p	0.62	0.32	0.22	0.044	0.27	0.001	<0.001	**<0.001**

4.4.3   Number of People Can Rely on in a Serious Crisis

For the younger people surveyed, there was no relationship between the number of people a person could rely on in a crisis (0-2 v >2) and the percentage reporting long-standing illness or disability. However, for those 55 years and older, there was a tendency for those with fewer people to rely on to have a higher percentage of reported illnesses or disability (**Table 57**).

Table 57: Percentage reporting long-term illness or disability who have 0-2 people to rely on in a crisis compared to those who have 2 or more people to rely on by age group

Number of people can rely on in serious crisis	Reporting long-term illness or disability by age in years (%)							
	16-24	25-34	35-44	45-54	55-64	65-74	75+	Total
0-2	4	7	9	17	30	37	55	**19**
>2	3	7	9	14	41	45	62	**18**
χ^2 test, p	0.64	0.79	0.96	0.37	0.016	0.13	0.23	**0.49**

Those who had only 0-2 people they could rely on in a serious crisis had a lower VAS Health Thermometer score than those who had more people to rely on[45] (95% CI for difference 1.4 to 3.2 lower). The difference was more evident in the youngest and oldest age groups.

A similar pattern occurred for the Mental Health Inventory which was lower for those who had fewer people to rely on[46] (95% CI 1.3 to 1.7 lower compared to those with more people to rely on).

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[45] ANOVA after adjusting for age, sex, smoking, healthy diet, area committee and employment status, p<0.001.
[46] Adjusted ANOVA, p<0.001.

For the all age groups, there was a statistically significant relationship between the number of people a person could rely on in a crisis (0-2 v >2) and the percentage reporting a large or moderate amount of stress or pressure (***Table 58***). This relationship needs to be assessed in more sophisticated analysis.

Table 58: Percentage reporting a large or moderate amount of stress or pressure for who have 0-2 people to rely on in a crisis compared to those who have 2 or more people to rely on by age group

Number of people can rely on in serous crisis	Reporting stress or pressure by age in years (%)							
	16-24	25-34	35-44	45-54	55-64	65-74	75+	Total
0-2	44	43	49	48	42	31	40	**43**
>2	28	30	35	37	24	21	21	**30**
χ^2 test, p	<0.001	<0.001	<0.001	0.011	<0.001	0.035	0.001	**<0.001**

4.5   Conclusions

Those who felt better informed about local issues and felt they could influence local decisions tended to report better health.

Those who had taken action to resolve a local problem tended to report worse health. It is not known whether those who had not taken any action had not taken action because they felt there was no local problem or whether they were not the type of person to take action. However, those that did take action clearly felt that there was a local problem to resolve and this problem may have had health implications, for example, housing conditions.

People who did not trust their neighbours or did not believe that their neighbours looked out for one another tended to report worse physical and mental health. People who were not sure if neighbours looked out for one another in their area tended to report similar health scores as those that believed neighbours did look out for each other. A similar finding occurred for those who did not know if their neighbourhood was one where neighbours looked out for one another or not.

People who spoke to their neighbours more regularly tended to report better physical and mental health than those who spoke infrequently to neighbours. There was a relatively large difference in the Health Thermometer and Mental Health Inventory scores between those who spoke to their neighbours weekly and those who spoke only annually or less, with the latter group having a score on average adjusting for other health-related factors of 7% and 10% lower respectively. Those who spoke to neighbours infrequently were more likely to report they suffered from stress. A similar pattern was observed for speaking to family (non-household family members) with associations between reported

stress, the Health Thermometer (mean 6% lower) and Mental Health Inventory (mean 7% lower).

The relationship between health and speaking to friends differed slightly to that observed for neighbours and friends. No relationship was observed for stress, but a relationship was observed for reporting long-term illness or disability. The Health Thermometer was reduced (mean 9% less) for those who spoke to friends more infrequently, but there was no difference for the Mental Health Inventory.

The relationship between health and having someone to rely on when ill in bed was strong. Those who did not have anyone to rely on had more stress, more long-term illness and disability, and worse Health Thermometer (7% lower) and Mental Health Inventory scores (15% lower).

People who had more than two close relatives or friends nearby and who had more than two people they could rely on in a serious crisis were less likely to suffer from stress, and had better physical and mental health scores but the differences in the scores were relatively small considering the scales of the indices.

4.6   Interpretation of Results

There are a few statistical issues that should be considered when interpreting the above results.

Firstly, whilst the differences mentioned above are statistically significant, the actual differences in the Health Thermometer and Mental Health Inventory score are only very small being only one or two points on the scale. On the Health Thermometer scale which ranges from 0 to 100, and even on the Mental Health Inventory score which ranges from 5 to 30, these differences are relatively small and they may not be very important clinically. The exceptions are the relationship with the frequency of speaking with others and having someone to rely on or not when ill in bed, where these differences were larger.

However, even though the differences on the physical and mental health scales are relatively small, this does not necessarily mean that the implications are small. It is possible that even very small difference on these scales, could have noticeable effects on the quality of life and perceptions of health for the person involved, more GP consultations or hospital admissions, increased risk of or occurrence of diseases and medical conditions, etc. It is also not known how a small difference for a particular age group can change as the person ages. Therefore, it is not possible to exclude possible effects from only small differences in reported health status.

Secondly, this is not a complete and comprehensive analysis. This report meets and exceeds the original requirements of the initial report in terms of providing a benchmark of Social Capital within different areas of Hull, but further analysis is required. More

complex statistical methods need to be used on this data to examine the effect of potential confounders. This analysis follows in the next section.

Thirdly, a number of statistical tests have been undertaken on the data. Even if there were no underlying associations present, one in twenty statistical tests would produce a p-value below the traditional 5% level simply by chance.

5.   Econometric Analysis

5.1   Aims

In order to alleviate problems identified in the previous section, where in a descriptive graphical analysis or an analysis of variance it is not possible to control for all confounding factors, cross-sectional regression analysis was undertaken.

The aim of this analysis is to examine the relationships between a number of variables relating to Social Capital, personal consumption, etc and health outcomes. The advantage of this approach is that we may examine the relationships as they are with all other factors / variables held constant, thereby controlling for confounding effects and biases due to different age, gender, social class, and other variations between areas.

5.2   Methodology Issues

Because the main approach within this project is to benchmark Social Capital, the analysis does not make many definite conclusions with respect to potential interventions. The aim here is to measure current levels and patterns of Social Capital as a way of identifying areas where further work might take place.

5.2.1   Individual Heterogeneity

The problem of individual heterogeneity relates to the fact that people have different views of what constitutes good health, and also that these views may be influenced by social, cultural or gender groupings. In order to correct for this it is necessary to use time series cross-sectional analysis using two cross-sectional datasets separated by a reasonable time period (Jones, 2000). In this analysis we have one year of cross-sectional data, so this approach is not open to us

5.2.2   Causality

Because we only have one time period, we are not able to say that one event causes the other, because we would need to identify that one event preceded another in order to be sure that it influenced a second event (World Bank 2005).   Also we are unable to account for dynamic effects which happen through time.

In order to clarify the difficulties here we could consider the 'speak to friends' variable. It might be thought that if we were to promote 'friendliness' in some way, by for example, providing extra leisure facilities, this would have a direct effect on health. It might be, however, that causality is also running in the opposite direction – that people who are healthier are able to meet their friends more often.

Another example might be the relationship between good mental health and the 'frequency of meeting with friends'. It might be that a person develops mental health problems due to social isolation. Another explanation might be that those people with poor mental health are less likely to sustain social relationships. It is possible that one or both of these form the 'correct' causal link.

It is likely that causality is complex and we argue that further qualitative research may be needed to explore relationships and to identify initiatives which would impact on Social Capital and health.

5.2.3   Lack of Evidence of a Statistical Relationship

In the case where there does not appear to be any statistically significant relationship between variables, it might be for various reasons.

1. There actually is no relationship or association
2. There is a relationship, but statistical methods are not able to detect it, possibly to confounding influences, or lack of statistical power.

These difficulties in interpretation and estimation would be removed if the survey were to be repeated approximately two years after the first one. These comments should not be considered to infer any defect in this research. On the contrary, the study has been very careful in design, sampling and planning. The results give a robust descriptive analysis of current levels of Social Capital and the factors which are actually impacting on health in Hull.

5.2.4   The Dependent Variables

Three measures of health are used: -

*   **A visual analogue scale** (VAS) or 'health thermometer' where a person is asked to point out where, on a scale between 0 (representing death) and 100 (representing perfect health). The analysis was undertaken within the Stata Statistical Software Package using the regress sub-program.

*   **The Euroqol**, a widely used measure of health related quality of life (hrql), which measures the 'utility', 'satisfaction' or 'pleasure' associated with the current state of health. The analysis was undertaken within the Stata Statistical Software Package using the regress sub-program.

- **The Mental Health Index** (MHI5), an established outcome measure of current mental health state. The analysis was undertaken within the Stata Statistical Software Package using the regress sub-program.

The explanatory variables and a justification for their involvement are discussed first. In general the methodological justification for inclusion is drawn from a body of work in health economics on household health production models, in particular that of Grossman (1972). This approach has been used during a long time period, and is still felt to be appropriate, within mainstream econometric analysis. (Jones 2000)

5.2.5   The Explanatory Variables

- **Smokes** – A variable which indicates if a person is currently a smoker. Smoking is a major cause of illness and bad health in the UK.

- **Education** – A set of variables, named NVQ1 – 4 which describe the highest qualification which a person has achieved. More education is often thought to be a factor likely to improve health outcomes. Grossman (1972) predicted, in a household production model, that, as people became better educated, they would be better at becoming and keeping healthy.

- **Employed** – A variable which indicates whether a person is employed or not. It might be expected, from examining previous studies, that people who are employed might be more likely to be in better health.

- **Being skilled** – This variable represents the category of people who do not have formal qualifications, but may feel that they are skilled in a trade, etc, developed within the working environment.

- **Having help when ill** – A variable which indicates whether the person has someone they can call on in a time of illness – a proxy for Social Capital, therefore expected to have a positive relationship with good health.

- **Trust** – Whether people trust other people – the expectation being that trust would have a positive association with good health.

- **Speaking to family, neighbours** or **friends** – Three variables, thought to be proxies for Social Capital, which would all be expected to be positively associated with good health.

- **Having family near** – Considered to be an indicator of Social Capital and a positive relationship expected with good health.

- **Feeling safe walking in the area after dark** – An indicator of Social Capital, again expected to show a positive relationship with good health.

- **Membership of organisations** – An indicator of Social Capital with a hypothesised positive relationship with good health.

- **Male** – Included as a sorting variable, in order to test whether outcomes are different for men (when compared with women).

- **Age** - It being expected that as people become older, their health would deteriorate.

- **Deprivation** – The index of multiple deprivation. We would expect that there would be a negative sign for this variable, indicating that as deprivation becomes greater, good health would be less likely.

5.3 Interpretation

Within the tables, the grey cells which contain an X represent those where no statistically significant relationship was found within this dataset.

The yellow cells with a positive sign indicate that there is a positive association or relationship between the variable and the outcome measure.

The green cells with a negative sign represent cases where there is a negative relationship between the variable and the health outcome measure.

5.3.1 Tests

The variables were tested for multicollinearity, using the Stata 'Collin' program. In all cases the Variance Inflation Factor was close to 1, indicating that there are no estimation difficulties in this respect. The F statistics are reproduced in each table, all showing satisfactory values. The Adjusted R-Squared values are given, mostly being around the 0.34 mark, indicating a good level of fit for a model using cross-sectional data. The R-Squared values for the mental health analysis are slightly lower, but still acceptable.

5.4 Econometric Results - Visual Analogue Score (Health Thermometer)

Table 59 Results for Visual Analogue Score

Visual Analogue Score (self-reported health)	All Hull	East	North Carr	Northern	Park	Riverside	West	Wyke
Smokes	-	-	-	-	-	X	-	-
Employed	X	-	X	X	X	+	X	X
Nvq4	X	X	X	X	X	X	X	X
Nvq3	X	X	X	X	X	X	X	X
Nvq2	X	X	X	X	X	X	X	X
Nvq1	X	X	X	X	X	X	X	X
Skilled	-	X	-	X	X	X	X	-
Has help when ill	+	X	X	X	-	+	X	+
People look out for each other	X	X	X	X	X	X	X	X
People trust each other	-	-	X	X	X	X	+	X
Speaks to family regularly	+	X	X	+	X	X	X	X
Speaks to friends	+	+	+	+	+	X	+	+
Speaks to neighbours	+	+	X	X	X	X	X	X
Friends & family near	X	+	X	X	X	+	X	X
Feels safe after dark	+	+	+	+	+	+	X	+
Membership of organisations	X	X	-	X	X	X	X	+
Male	X	X	X	X	X	X	X	X
Age	-	-	-	-	-	-	-	-
Deprivation	-	X	-	+	X	X	X	X
Adjusted R-Squared	0.33	0.45	0.28	0.59	0.48	0.25	0.34	0.35
Prob > F	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000

5.4.1 All Hull

The first results, represented in *Table 59*, are those where a person was asked to indicate their current state of health on scale where 0 represented death and 100 perfect health. The column with a red border represents the analysis for the whole of Hull. The results for Hull as a whole may be considered the most robust, due to the larger sample size.

It can be seen that if a person smokes they are less likely to report good health, as would be expected.

The employed variable does not achieve statistical significance within this sample; therefore there is no evidence for any relationship between this and the dependent variable.

In the case of education, there is no evidence of any relationship between it and good health. The education variable has not achieved statistical significance or has been contradictory in sign in a number of studies. Grossman, (1998) suggested that education was a proxy for human capital, a person's endowment of skills, knowledge, etc, and that greater human capital helped people to develop better health.

The skilled variable is interesting, in that it indicates that being skilled, but not having formal qualifications brings a negative relationship with good health. This might be explained by the consideration that this group of people may have acquired their skills in an industrial environment, where hazards to health from industrial processes, accidents, etc may be more prevalent.

Four of the Social Capital variables show a statistically significant and positive relationship with the VAS self reported Health. People who have help when ill, speak to friends, neighbours, and those who feel safe walking alone after dark all report better self-reported health.

The Trust variable, thought by some to be a very important indicator of Social Capital, shows a negative relationship with good health. This seemingly counter-intuitive outcome might be explained if social trust is associated with negative or malign Social Capital. For example, trusting people's opinion that smoking will not harm health might encourage smoking. Similarly, greater trust in other people within a particular social group might facilitate trading of smuggled tobacco. Consumption of drugs and alcohol might also be encouraged within an atmosphere of trust.

As people become older, they report worse health and as would be expected, living in a deprived area achieves statistical significance within the sample, indicating that deprivation is a determinant of poor health.

5.4.2   Area

The analysis shows variations in the results by area committee. Certain variables show consistent results across the different area committees. Smoking is a consistent negative influence on health outcomes, except in Riverside area, where the variable did not achieve statistical significance. Age is the most consistent influence on health outcomes, where in all cases self reported health is lower as people get older. Within the Social Capital variables, 'feeling safe walking alone after dark' is the most common factor which is associated positively with good health, the variable achieving statistical significance in all areas except West. 'Speaking to friends' also appears to have a strong positive association with health, being statistically significant in all cases except Riverside.

5.5 Econometric Results – EUROQOL

Table 60: Results for Euroqol EQ5D

Euroqol EQ5D	All Hull	East	North Carr	Northern	Park	Riverside	West	Wyke
Smokes	-	-	-	X	X	X	-	-
Employed	+	X	X	X	X	X	X	+
Nvq4	X	X	X	+	X	X	X	X
Nvq3	X	X	X	X	X	X	X	X
Nvq2	X	X	X	X	X	X	X	-
Nvq1	X	X	X	X	X	+	X	X
Skilled	X	X	-	X	X	X	X	-
Has help when ill	+	X	X	X	X	+	X	+
People look out for each other	-	-	X	X	X	X	X	X
People trust each other	X	-	X	X	X	X	X	X
Speaks to family regularly	-	-	-	X	X	X	X	X
Speaks to friends	+	X	+	+	X	X	+	X
Speaks to neighbours	+	+	X	X	-	X	X	X
Friends & family near	+	+	X	X	-	+	X	X
Feels safe after dark	+	+	+	+	+	+	+	+
Membership of organisations	-	X	-	X	X	X	X	X
Male	X	X	X	X	X	X	X	X
Age	-	-	-	-	-	-	-	-
Deprivation	-	X	X	+	X	X	X	X
Adjusted R-Squared	0.34	0.35	0.23	0.30	0.24	0.30	0.19	0.23
Prob >F	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000

5.5.1 All Hull

The results for the Euroqol for all of Hull (*Table 60*) show similar results to those obtained for the Visual Analogue Scale. The Euroqol is an outcome measure with a solid acceptance in current research. The results once again show that smoking is a negative effect on peoples health related quality of life (hrql) in Hull. Being employed has a positive association with good health.

With regard to the Social Capital variables, there is a strong positive association between hrql and speaking to friends, neighbours, having friends and family near, feeling safe walking alone after dark and having help when ill.

The Social Capital question which asks whether people 'feel that people look out for each other' was statistically significant, but with a negative sign. This result shows an inconsistency with our expectations.

The 'membership of organisations' variable reached statistical significance, but with a negative sign, raising the possibility that those who are members of organisations are more likely to be influenced by negative Social Capital. We might consider, however,

that many organisations within the area are related to illness and disability. A surprising result is that speaking to family regularly appears to have a negative relationship with hrql. This, of course, might be explained by people who are in poorer health purposefully having more contact with their family, being in need of support.

Once again, the male variable does not achieve statistical significance indicating similar outcomes between men and women.

As in all the results, age and deprivation are associated with a worse hrql state.

5.5.2   Area

Once again we see different patterns within different area committees. Feeling safe walking alone after dark and age are again consistently associated with good hrql.

5.6   Econometric Results – Mental Health

Table 61: Results for MHI-5 Mental Health

Mental Health Index	All Hull	East	North Carr	Northern	Park	Riverside	West	Wyke
Smokes	-	-	-	-	-	-	-	-
Employed	+	+	X	X	X	X	X	X
Nvq4	-	X	-	X	X	X	X	X
Nvq3	X	X	X	X	X	X	X	X
Nvq2	X	X	X	X	X	X	X	X
Nvq1	X	X	X	X	X	X	X	X
Skilled	X	X	-	X	X	X	X	X
Has help when ill	+	+	+	+	X	+	+	+
People look out for each other	X	X	X	-	X	X	X	X
People trust each other	X	X	X	X	X	X	+	X
Speaks to family regularly	-	X	X	X	X	+	X	X
Speaks to friends	-	X	X	X	X	X	+	X
Speaks to neighbours	+	X	+	X	+	X	X	+
Friends & family near	+	X	X	X	+	X	X	X
Feels safe after dark	+	+	+	X	+	+	X	+
Membership of organisations	+	X	-	X	-	X	+	X
Male	-	X	+	X	X	+	X	X
Age	-	+	X	-	-	X	X	+
Deprivation	-	X	-	+	-	-	-	X
Adj R-Sq	0.18	0.16	0.23	0.11	0.17	0.21	0.14	0.29
Prob > F	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000

5.6.1   All Hull

This section refers solely to mental health as measured by the MHI-5 outcome measure. There is strong evidence that smoking is associated with worse mental health (***Table 61***).

This may be because smoking itself has a negative impact on mental health, but also may be because those with poorer mental health are more likely to smoke.

Being employed has a positive relationship with mental health. Again, this might be explained by work being protective of mental health, or also that those with worse mental health are less likely to be employed.

Having help when ill appears to have a consistent positive relationship with good mental health.

Speaking to family and friends regularly appears to have a negative relationship with mental health, but as with previous analyses, it may be that those with worse mental health have more contact with family and friends due to their difficulties.

The four other Social Capital variables, speaking to neighbours, having friends and family near, feeling safe after dark, and being member of organisations all exhibit a positive association with good mental health.

Being male, in Hull as a whole, is associated with worse mental health than being female.

In common with the other results for health and hrql, age and deprivation are associated with worse mental health.

5.6.2   Area

Across the area committees we see the most consistent negative influence with good mental health is smoking. Having help when ill appears to be consistently positively associated with good mental health, with the exception of the Park area. The Social Capital variables once again exhibit a complex pattern which should be interpreted with great care, but give a good indication of future work.

5.7   Conclusions

These results give a rich analysis of the relationships between Social Capital variables, lifestyle variables and health/mental health.

There is strong evidence that Social Capital variables do impact on health within the Kingston upon Hull area. There is also strong evidence that the pattern of the relationship is very complex and is very different between different area committees, due to their individual characteristics.

Very consistent evidence is found for the importance of people feeling safe as they walk alone after dark. This relationship might be taken up in initiatives aiming to enhance health and Social Capital in the area.

Having help when ill is very important for all categories, but especially for fostering good mental health.

5.8   References

Grossman, M. On the concept of health capital and the demand for health. *Journal of Political Economy*, 1972. 80: 223-55.

Jones, A.M. *Health Econometrics* in A.J. Culyer and J.P. Newhouse, Handbook of Health Economics, Volume 1, 2000. Amsterdam, Elsevier Science.

World Bank, Multivariate analysis of health data: General issues, World Bank Quantitative issues bulletin, accessed Feb 2005 http://siteresources.worldbank.org/INTPAH/Resources/Publications/Quantitative-Techniques/health_eq_tn10.pdf

Section 3 : Overall survey conclusions and recommendations

1. Overall survey comments and conclusions

- The study provides information:
  - about the Social Capital within the city of Hull;
  - about the health status, lifestyle behaviour and health perceptions of people within the city;
  - that will be useful in the planning and provision of local services.

- The study provides a means to involve community interests in public health initiatives.

- Comparisons between different area committees are difficult as there is a difference in age and sex structure among the areas and Social Capital and health are related to both age and sex. So any differences which are observed could be due to these factors, or many of the other, so called, confounding factors, such as smoking status, diet, employment status, etc. More sophisticated analyses can adjust or take into consideration other factors which were collected as part of the study.

- Social Capital could have a positive or negative effect on lifestyle, health perceptions and health, and the relationship could differ depending on the age, sex or area committee for a particular person. For example, increased interactions and trust within the neighbourhood could be improve health, but increased interactions with smokers who do not fully recognise the harm of smoking behaviour on their health, may have a very negative impact on the health of social peers. Certain factors within the area can also have a negative impact on health, for example, the provision of cheap, fresh fruit and vegetables at local shops.

- If an association is found to exist between Social Capital and health then it cannot be assumed to be causal. Similar information needs to be collected in the future to examine the relationships over time. The potential positive and negative Social Capital has been mentioned in the previous paragraph. In order for a factor to be causal it must proceed the outcome, for example, a deterioration in Social Capital must occur before a deterioration in health in order for it to be causal (and even if the order is established it still does not mean it is necessarily causal). However, it is possible that a deterioration in health could cause a reduction in Social Capital, and this may particularly be the case for mental health. This illustrates that the relationship between Social Capital and health could be very complex.

- Whilst the sample represents the population of the city of Hull in terms of age, sex, area and employment status, this does not necessarily mean they are representative of the residents of Hull. People agree to participate in surveys for many reasons, and if these reasons are associated with the questions asked in the survey, then it is possible that biases can occur. Within each age group, sex, area and employment status group, it is possible that people who have participated have more Social Capital than those who refused to participate. For example, those who are a member of a local organisation or speak regularly to family, friends and neighbours may be more likely

to participate in such a survey. However, given that the sample represents the population structure of the city from the way in which the sample was derived, potential biases are less of a problem than may have been the case if the sample was derived by more frequently used methods of survey selection.

2. Recommendations

1. The benchmark study should be used to point the way for individual projects and qualitative research work.

2. From lifestyle behaviour and health perceptions it may be possible to prioritise the targeting of certain individuals and areas where there is evidence or malign or negative Social Capital with the aim of changing attitudes towards smoking, alcohol and poor diet. This could be also considered at the area committee level.

3. Future work on building Social Capital in the area should consider using the techniques, tools and outcome measures of this project as a baseline when evaluating local projects.

4. Further research in this area should investigate ways in which Social Capital may be built or enhanced.

5. Care should be taken to ensure that local decisions do not destroy current levels of Social Capital.

6. Recognising the unique characteristics of this project and the foresightedness of the funding body, the steering group should widely disseminate the findings.

7. The dataset should be made available for further work by interested groups, subject to the agreement of the steering group being satisfied with the robustness of the proposed methodology.

8. The steering group recommend repeating this work in two years in order to use time series cross-sectional analysis, enhancing the reliability of the results.

Questionnaire Structure and Sources

The questionnaire was largely based on that used by the South Yorkshire Coalfields (SYC) survey (Green et al 2000). The following table provides a breakdown of the source of each question, as well its relevance to social capital. The questionnaire itself is also contained in Appendix 2.

As in the SYC study, the survey questionnaire was based on a core set of questions derived from the social capital module piloted by the Office of National Statistics (ONS) for the General Household Survey (GHS), together with additional questions identified by SYC study researchers and by the Hull Social Capital Steering Group (HSCSG).

The final questionnaire was 10 pages long, with 35 questions (some with multiple components) - requiring 76 responses (or pieces of information) in total.

Final questionnaire structure & content

Section	Q	Question	Source	No. of Variables
Demographics	4	Postcode / area		1
		Age group		1
		Sex (M/F)		1
	1a, 1b, 2	Household structure		7
Transport	7	Main form of transport		1
Local area / neighbourhood	3	Tenure home	Census	1
	5a	How long lived in area	SYC / GHS	1
	5b	Enjoy living in area	SYC / GHS	1
	6a-h	Local services	SYC	8
Local area: Safety issues	8a, 8b	Safe at home	BCS	2
Problems	11a-h	Problems in area	ONS	8
Trust	14	Neighbourhood trust	SYC	1
Crime	12a-f	Victim of crime	ONS	7
Local area: Involvement & Efficacy	9a	Informed about things	ONS	1
	9b	Influence decisions		1
	10	Involved in local organisations	ONS	1
	13a-g	Taken action about local issues	SARP	7
Reciprocal help and support	15	Neighbours look out for each other	ONS	1
	20	Help when ill	ONS	1
	21	Ask for help	ONS	1
	22	Crisis support		1
Social networks and support	16	Contact family	SYC	1
	17	Contact friends	SYC	1
	18	Contact neighbours	SYC	1
	19	Close friends / neighbours	SYC	1
Health	23a	Long term illness	Census / GHS	1
	23b-f,	State of health	EQ-5D	6
	24	Mental well-being	SF-36 (MHI)	5
	25a-c	Stress	HEA	1
	26			
Lifestyle	27	Smoking	SARP	u
	29	Diet	SARP	
	31	Healthy diet	SARP	
Qualifications/ occupational status	32	Skills & qualifications	SYC	1
	33	Economic / occupation status	Census	1

Key: Census=UK 1991 Census; SYC=Coalfield Community Survey: SARP=Social Action Research Project; ONS=Office of National Statistics Core Social Capital questions; HEA= 1992 Health Survey; EQ-5D=EuroQol; SF-36(MHI)=Short Form 36(Mental Health Index); BCS=British Crime Survey; GHS=General Household Survey

Social Capital Survey Questionnaire

Interviewer Initials	Date Interviewed Day Month Year	Label Reference
	☐☐ / ☐☐ / ☐☐☐☐	☐☐☐☐☐

Good morning/afternoon my name is …………………………………..from Andrew Gibson Consulting Ltd and we are carrying our a survey in Hull on behalf of the NHS Primary Care Trusts / Health Action Zone. All your answers will be treated with the strictest confidence.

Q1 a) How many people live in this household?

Adults (18+) ☐   Children ☐   Total ☐

Q1 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 year ☐   15 – 17 year ☐

Q2 Do you live with a partner   *(Mark one box only)*

Yes ☐   No ☐

Q3 Is the house/flat in which you live? *(Mark one box only)*

Rented from Housing Association ☐   Owned ☐

Rented from Council ☐   Rented from private landlord ☐

Other ☐   Don't know ☐

Q4   What is the postcode?   ☐

Q5   Now I would like to ask you some questions about your local area
     (By area I mean within a 15 – 20 minute walk or a 5 – 10 minute drive from your home)

a.   How many years have you lived in this area ☐

b.   Would you say this is an area you enjoy living in

Yes ☐   No ☐   Don't know ☐

Q6 Thinking generally about what you expect of local services how would you rate the following:
(Please mark one box for each line)

Show card A

		1 Very good	2 Good	3 Average	4 Poor	5 Very poor	6 Don't Know
a	Social/ leisure facilities for people like yourself	☐	☐	☐	☐	☐	☐
b	Facilities for young children up to the age of 12	☐	☐	☐	☐	☐	☐
c	Facilities for teenagers (aged 13 to 17)	☐	☐	☐	☐	☐	☐
d	Rubbish collection	☐	☐	☐	☐	☐	☐
e	Local health services	☐	☐	☐	☐	☐	☐
f	Local public transport	☐	☐	☐	☐	☐	☐
g	Local schools, colleges and adult education	☐	☐	☐	☐	☐	☐
h	Local police service	☐	☐	☐	☐	☐	☐

Q7 What is your main form of transport? *(Mark one box only)*
Interviewer to ask question and mark box

Car / ☐
Motorcycle / Moped ☐
Public transport (Buses and trains) ☐
Cycling ☐
Walking ☐
Other ☐
Never goes out ☐

Q Safety in your local area *(Please mark only one box for each line)*

8 Show Card B

		1 Very safe	2 Fairly safe	3 A bit unsafe	4 Very unsafe	5 Never goes out
a	How safe do you feel walking alone in this area during daytime?	☐	☐	☐	☐	☐
b	How safe do you feel walking alone in this area after dark?	☐	☐	☐	☐	☐

Q9 Thinking of the same local area *(Please mark one box for each line*

a	Would you say that you are well informed about things which affect your area?	Yes ☐	No ☐	Don't know ☐
b	Do you feel you can influence decisions that affect your area?	Yes ☐	No ☐	Don't know ☐

Q10   Organisations

Have you been involved in any local organisation over the
past 3 years?   Yes ☐   No ☐

If yes please say what organisation

Q 11 Still thinking about the same area, can you tell me how much of a problem these things are?
(Please mark one box for each line)
(Show card C)

	1 Very big problem	2 Fairly big problem	3 Minor problem	4 Not a problem	5 Don't know
a The speed or volume of road traffic	☐	☐	☐	☐	☐
b Parking in residential streets	☐	☐	☐	☐	☐
c Car crime (e.g. damage, theft and joyriding)	☐	☐	☐	☐	☐
d Rubbish and litter lying around	☐	☐	☐	☐	☐
e Dog mess	☐	☐	☐	☐	☐
f Graffiti or vandalism	☐	☐	☐	☐	☐
g Level of noise	☐	☐	☐	☐	☐
h Alcohol or drug use	☐	☐	☐	☐	☐

This section is potentially distressing for some participants and as such it is important that the showcard is used if people answer yes in order to minimise this and allow them to answer by just giving a letter.

Have you personally been a victim of crime in the past 12 months?

Q12   Yes ☐   No ☐

If Yes Answer parts a to f using Card D   **If No go to Q13**

a Theft or break-in to house or flat	☐
b Theft or break-in to car parked in the area	☐
c Personal experience of theft or mugging in the area	☐
d Physical attack in the area (i.e. hit or kicked in a way that hurt you)	☐
e Racist attack in the area (either verbal or physical)	☐
f Other	☐

The emphasis in this question is taking action about a local issue. For example, 'contacted a local councillor or MP' would include writing to an MP about a local issue such as plans to close the accident and emergency unit of the local hospital, but excludes writing to an MP about a national issue.

Q13 **In the past 3 years have you taken any of the following actions in an attempt to solve a local problem?**

a Written to local newspaper ☐

b Contacted the appropriate organisation to deal with the problem e.g. the council ☐

c Contacted a local councillor or MP ☐

d Attended a protest meeting or joined an action group ☐

e Thought about it, but did not do anything about it ☐

f None of these ☐

g Other ☐

Q14 Would you say that you trust…. *(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 ☐

You do not trust people in your neighbourhood ☐

Q15 Would you say this neighbourhood is a place where neighbours look out for each other?

(Mark one box only) Yes ☐ No ☐ Don't know ☐

The next few questions are about how often you see or speak to your relatives and friends.

These questions are about relatives or friends living outside the respondent's household. Interviewers may need to probe to ensure that respondents are not counting the same people twice; someone may be a friend and a neighbour but should only be coded once.

Q16 Not counting the people you live with, how often do you speak to family members?

(Mark one box only) ***Interviewer to ask question and mark box***
May use Card E if difficulties

1 Every day ☐

2 5 or 6 days a week ☐

3 3 or 4 days a week ☐

4 Once or twice a week ☐

5 Once or twice a month ☐

6 Once every couple of months ☐

7 Once or twice a year ☐

8 Not at all in last 12 months ☐

	Not counting the people you live with, how often do you speak to friends? (who are not family or neighbours)
Q17	*(Mark one box only) Interviewer to ask question and mark box*
	May use Card E if difficulties
1	Every day
2	5 or 6 days a week
3	3 or 4 days a week
4	Once or twice a week
5	Once or twice a month
6	Once every couple of months
7	Once or twice a year
8	Not at all in last 12 months

	How often do you speak to neighbours? *(Mark one box only) Who are not family members or friends*
Q18	*Interviewer to ask question and mark box*
	May use Card E if difficulties
1	Every day
2	5 or 6 days a week
3	3 or 4 days a week
4	Once or twice a week
5	Once or twice a month
6	Once every couple of months
7	Once or twice a year
8	Not at all in last 12 months

	How many relatives or friends that you feel close to live within a 15 – 20 minute walk or 5 – 10 minute drive if any?: Don't include people who live in the same house *(Mark one box only)*
Q19	*Interviewer to ask question and mark box*
	One or two
	Three or four
	Five or more
	None

	Q20	**You are ill in bed and need help at home. Could you ask anyone for help? (including those you live with)**

(Mark one box only) Yes ☐ No ☐ Don't know/ ☐ Depends

If answer is Yes, please ask Question 21
If not go to Question 22

Q21	**Can you look at the card (F) and tell me who you would ask for help if ill in bed?** *(Mark those identified)* **(Show card F)**	
A	Husband/wife/partner	
B	Other household member	
C	Relative (outside the house)	
D	Friend	
E	Neighbour	
F	Community, Voluntary or other organisation	
G	Would prefer not to ask for help	

This question needs to be dealt with sensitively, as it can be upsetting for people who are socially isolated. Examples included bereavement, or a partner leaving. If respondents have difficulty in giving a number for this, the interviewer should ask them to give an estimate.

Q22	**In general, if you had a serious crisis, how many people, if any, do you feel you could turn to for comfort and support?**	
	RECORD NUMBER 0..15 IF MORE THAN 15 CODE AS 15	

Now I am going to ask a number of questions about your health

Q23a	**Do you suffer from any long standing illness, health problem or disability which limits your daily activities** *(Mark one box only)*	Yes ☐ No ☐

With these questions it is important if the respondent states that one category does not describe the full situation, that they choose the one which is nearest to their current state.

Please ask each question in order to confirm the current state of health even if answered No to Q23

b	**Which of these describes your usual state**	**Mobility** *(Mark one box only)*	
	I have no problems with walking about		
	I have some problems with walking about		
	I can't walk about		

c	**Which of these describes your usual state**	**Self Care** *(Mark one box only)*	
	I have no problems with self care		
	I have some problems with washing or dressing myself		
	I am unable to wash or dress myself		

d	**Which of these describes your usual state**	**Usual activities** *(i.e. work, study, housework, family or leisure activities) (Mark one box only)*	
	I have no problems with performing my usual activities	☐	
	I have some problems with performing my usual activities	☐	
	I am unable to perform my usual activities	☐	

e	**Which of these describes your usual state**	**Pain/Discomfort** *(Mark one box only)*
	I have no pain or discomfort	☐
	I have some pain or discomfort	☐
	I have extreme pain or discomfort	☐

f	**Which of these describes your usual state**	**Anxiety/Depression** *(Mark one box only)*
	I am not anxious or depressed	☐
	I am moderately anxious or depressed	☐
	I am extremely anxious or depressed	☐

Q24	To help people say how good or bad a health state is, we have drawn a scale 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
	Indicated number ☐☐☐

Q25 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)* **(SHOW CARD G)**

		1 All of the time	2 Most of the time	3 A good bit of the time	4 Some of the time	5 A little of the time	6 None of the time
a	Have you been a very nervous person?	☐	☐	☐	☐	☐	☐
b	Have you felt so down in the dumps that nothing could cheer you up?	☐	☐	☐	☐	☐	☐
c	Have you felt calm and peaceful	☐	☐	☐	☐	☐	☐
d	Have you felt downhearted and low	☐	☐	☐	☐	☐	☐
e	Have you been a happy person	☐	☐	☐	☐	☐	☐

Q26 *(*SHOW CARD H)
Which of these sentences best describes the amount of stress or pressure you experienced in the past 12 months? *(Mark one box only)*

a   I have been completely free of stress or pressure ☐

b   I have experienced a small amount of stress or pressure ☐

c   I have experienced a moderate amount of stress or pressure ☐

d   I have experienced a large amount of stress or pressure ☐

e   Don't know ☐

Q27   **Which statement do you think best describes your smoking behaviour?**
(Mark one box only)

I have never smoked ☐

I used to smoke ☐

I now smoke occasionally ☐

I now smoke daily ☐

Q28   **Please say if you think that any of the following would generally improve peoples health**

a   More Exercise ☐

b   A Healthier diet ☐

Q29   **How often do you include fruit and/or vegetables in the food you eat?** *(Mark one box only)*

Every Day   Most Days   Some days   Rarely   Never
☐   ☐   ☐   ☐   ☐

Q30   **Show Card I**
In general if a person gives up smoking how big an impact is it likely to have on their health

Very big effect   Fairly big effect   Fairly small effect   Very small effect   No Effect
☐   ☐   ☐   ☐   ☐

Q31   **Generally speaking, do you think that you have a healthy diet?** *(Mark one box only)*

Yes   No   Don't know what a   Don't know if I have
                             healthy diet is   a healthy diet
☐   ☐   ☐   ☐

Q32	**What is your highest qualification or skill?** *(mark one box only)* *Can show card J if needed.*			
	Have skills but no formal qualifications	-	Such skills as childcare, gardening Cooking, knitting, DIY, typing, car maintenance, using computer.	☐
	NVQ4+	or	HNC, HND, higher BTEC Teaching qualification First Degree NVQ5 Higher Degree Nursing Qualification Other professional qualification	☐
	NVQ3 qualifications	or	Apprenticeship Qualification (Advanced) A'level BTEC National/ONC/OND, etc GNVQ – Advanced level	☐
	NVQ2 qualifications	or	City & Guilds, GCSE at A-C, 0'level BTEC General Diploma RSA Diploma Apprenticeship Qualification (Basic) GVNQ – Intermediate	☐
	NVQ1 qualifications	or	CSE Ungraded GSCE D – G	☐
	Other (Please specify) ☐		Verbatim Response	
	None ☐			

Q33	**Are You**:　　　　　　　*(Mark one box only)* *Can Show Card K if needed*	
A	Working full time (30 hours or more a week)	☐
B	Working part time (up to 30 hours a week)	☐
C	Self employed	☐
D	On a government training scheme	☐
E	Unemployed and looking for a job	☐
F	Unable to work because of long term sickness or disability	☐
G	At school or in other full time education	☐
H	Retired from paid work	☐
I	Looking after the home or family	☐
J	Voluntary Work	☐
K	Other *(please write in box below)*	☐
L		

Gender   M   F

Age (please circle the appropriate age group)

16 – 19
20 – 24
25 – 29
30 – 34
35 – 39
40 – 44
45 – 49
50 – 54
55 – 59
60 – 64
65 – 69
70 – 74
75 +

Thank you very much for helping us by taking part in this survey. Etc

Map of Area

Linkage Between Demographic Classifications

The questionnaire employed a breakdown of occupational status and age used in the census, whereas locally provided statistics were based on slightly different categories. The linkage between these two classifications is set out below:

Age			
Variable	**Questionnaire Fields**	**Local Fields**	**Mapping**
1	16 to 19	16-24	1, 2
2	20 to 24	25-34	3, 4
3	25 to 29	35-44	5, 6
4	30 to 34	45-54	7, 8
5	35 to 39	55-64	9, 10
6	40 to 44	65-74	11, 12
7	45 to 49	75	13
8	50 to 54		
9	55 to 59		
10	60 to 64		
11	65 to 69		
12	70 to 74		
13	75 +		

Occupational Status			
Variable	**Questionnaire Fields**	**Local Fields**	**Mapping**
1	Work full time	Part time	2
2	Work part time	Full time	1
3	Self Employed	Self employed	3
4	Government training sheme	Unemployed	5
5	Unemployed	Full time student	7
6	Sick	Retired	8
7	Full time education	Student	11
8	Retired	Look after home	9
9	Home	Perm sick / disabled	6
10	Voluntary	Other	11, 10, 4
11	Other		

Comparison of Target Quota and Sample Achieved

Age – gender profile

Gender	Age (years)	East Quota	East Actual	East % +/-	North Carr Quota	North Carr Actual	North Carr % +/-	Northern Quota	Northern Actual	Northern % +/-	Park Quota	Park Actual	Park % +/-	Riverside Quota	Riverside Actual	Riverside % +/-	West Quota	West Actual	West % +/-	Wyke Quota	Wyke Actual	Wyke % +/-
Male	16-24	46	42	-8.7	34	35	2.9	58	54	-6.9	54	54	0.0	61	48	-21.3	36	38	5.6	58	51	-12.1
	25-34	48	53	10.4	38	37	-2.6	54	46	-14.8	57	60	5.3	88	71	-19.3	48	58	20.8	74	73	-1.4
	35-44	53	49	-7.5	37	42	13.5	50	51	2.0	69	66	-4.3	82	85	3.7	57	58	1.8	51	62	21.6
	45-54	51	54	5.9	27	28	3.7	38	43	13.2	53	53	0.0	60	55	-8.3	43	47	9.3	39	38	-2.6
	55-64	41	46	12.2	24	24	0.0	30	27	-10.0	41	42	2.4	47	44	-6.4	37	42	13.5	27	22	-18.5
	65-74	31	26	-16.1	15	19	26.7	25	29	16.0	29	31	6.9	32	39	21.9	31	34	9.7	18	18	0.0
	75+	25	25	0.0	7	7	0.0	14	18	28.6	21	21	0.0	22	24	9.1	24	20	-16.7	14	10	-28.6
	Total	295	295		182	192		269	268		324	327		392	366		276	297		281	274	
Female	16-24	43	44	2.3	34	37	8.8	61	61	0.0	53	51	-3.8	54	42	-22.2	37	37	0.0	62	49	-21.0
	25-34	45	46	2.2	37	37	0.0	47	50	6.4	55	55	0.0	65	65	0.0	49	49	0.0	52	65	25.0
	35-44	52	52	0.0	34	37	8.8	44	45	2.3	66	72	9.1	61	73	19.7	54	54	0.0	42	75	78.6
	45-54	50	50	0.0	28	29	3.6	35	35	0.0	49	45	-8.2	48	59	22.9	42	42	0.0	34	35	2.9
	55-64	39	43	10.3	25	24	-4.0	30	42	40.0	39	39	0.0	38	34	-10.5	38	33	-13.2	24	16	-33.3
	65-74	39	29	-25.6	15	15	0.0	29	25	-13.8	35	35	0.0	31	31	0.0	37	42	13.5	20	16	-20.0
	75+	40	44	10.0	12	6	-50.0	22	10	-54.5	34	34	0.0	36	29	-19.4	40	40	0.0	27	5	-81.5
	Total	308	308		185	185		268	268		331	331		333	333		297	297		261	261	
Grand Total		603	603		367	377		537	536		655	658		725	699		573	594		542	535	

Target Quota: **4002**
Achieved Sample: **4002**

Comparison of Target Quota and Sample Achieved

Occupational Status

Gender	Eco status	Area																			
		East			North Carr			Northern			Park			Riverside			West			Wyke		
		Quota	Actual	%	Quota	Actual	%	Quota	Actual	%	Quota	Actual	%	Quota	Actual	%	Quota	Actual	%	Quota	Actual	%
Male	F/T	153	153	0.0	91	95	4.4	111	107	-3.6	170	154	-9.4	184	162	-12.0	152	154	1.3	124	137	10.5
	F/T student	5	3	-40.0	3	3	0.0	8	7	-12.5	5	5	0.0	6	11	83.3	4	6	50.0	13	15	15.4
	Home	3	6	100.0	4	1	-75.0	6	6	0.0	5	8	60.0	7	4	-42.9	3	3	0.0	4	3	-25.0
	Not given	0	1	0.0	0	0	0.0	0	1	0.0	0	0	0.0	0	0	0.0	0	1	0.0	0	1	0.0
	Other	17	17	0.0	13	5	-61.5	38	36	-5.3	24	27	12.5	33	24	-27.3	13	14	7.7	52	5	-90.4
	P/T	9	11	22.2	5	14	180.0	9	8	-11.1	10	9	-10.0	14	14	0.0	9	12	33.3	11	22	100.0
	Sick/disabled	25	28	12.0	19	8	-57.9	25	21	-16.0	26	26	0.0	42	37	-11.9	19	19	0.0	15	6	-60.0
	Retired	39	34	-12.8	17	32	88.2	32	30	-6.3	34	37	8.8	40	67	67.5	37	42	13.5	22	32	45.5
	Self-employ	21	22	4.8	11	9	-18.2	17	13	-23.5	20	19	-5.0	24	20	-16.7	23	29	26.1	20	24	20.0
	Unemployed	22	20	-9.1	19	25	31.6	23	39	69.6	27	42	55.6	42	27	-35.7	16	17	6.3	21	29	38.1
	Total/Mean %	294	295	7.7	182	192	9.2	269	268	-0.9	321	327	11.2	392	366	0.4	276	297	13.8	282	274	5.4
Female	F/T	70	59	-15.7	40	41	2.5	49	49	0.0	75	73	-2.7	83	83	0.0	78	78	0.0	68	97	42.6
	F/T student	7	7	0.0	3	3	0.0	9	10	11.1	7	8	14.3	7	9	28.6	6	6	0.0	16	16	0.0
	Home	40	40	0.0	34	38	11.8	40	40	0.0	52	52	0.0	50	50	0.0	33	36	9.1	25	54	116.0
	Not given	0	1	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0	0.0
	Other	20	20	0.0	16	11	-31.3	40	36	-10.0	25	25	0.0	31	21	-32.3	18	17	-5.6	47	5	-89.4
	P/T	78	78	0.0	43	49	14.0	54	56	3.7	80	80	0.0	66	66	0.0	76	77	1.3	49	42	-14.3
	Sick/disabled	20	29	45.0	15	5	-66.7	19	17	-10.5	21	21	0.0	27	21	-22.2	15	14	-6.7	11	9	-18.2
	Retired	59	57	-3.4	22	26	18.2	43	44	2.3	52	52	0.0	47	60	27.7	55	55	0.0	30	25	-16.7
	Self-employ	5	5	0.0	2	2	0.0	3	3	0.0	5	5	0.0	6	5	-16.7	6	6	0.0	7	3	-57.1
	Unemployed	10	12	20.0	9	10	11.1	11	13	18.2	15	15	0.0	18	18	0.0	9	8	-11.1	9	10	11.1
	Total/Mean %	309	308	4.6	184	185	-4.0	268	268	1.5	332	331	1.2	335	333	-1.5	296	297	-1.3	262	261	-2.6
Grand Total / % +/-		603	603	6.1	366	377	2.6	537	536	0.3	653	658	6.2	727	699	-0.5	572	594	6.3	544	535	1.4

Target Quota: **4002**
Achieved Sample: **4002**

Annexes to Main Findings

Annex I   : Responses to Survey Questionnaire

Annex II : Comparisons of Survey Questions

Annex III : Additional Analyses From Section 2

Annex I - Responses of the Social Capital Survey Questionnaire

Area of Survey

Area	Responses	%
East	603	15
North Carr	377	9
Northern	536	13
Park	658	16
Riverside	699	17
West	594	15
Wyke	535	13
Total	**4002**	**100**

Q1a. How many people live in this household (Adults 18+)

Adults in Household	Responses	%
1	1047	26
2	1906	48
3	814	20
4	199	5
5	13	<1
6	5	<1
8	1	<1
9	1	<1
No information provided	*16*	*<1*
Total	**4002**	**100**

Q1a. How many people live in this household (Children)

Children in Household	Responses	%
1	810	45
2	672	37
3	271	15
4	44	2
5	6	<1
7	2	<1
Total	**1805**	**100**

Q1b. If living with children, how many are there in each of the following age groups? (0 - 4 years)

Children 0-4 years	Responses	%
1	483	79
2	123	20
3	2	<1
Total	608	100

Q1b. If living with children, how many are there in each of the following age groups? (5 - 14 years)

Children 5-14 years	Responses	%
1	605	55
2	428	39
3	61	6
4	5	<1
5	1	<1
Total	1100	100

Q1b. If living with children, how many are there in each of the following age groups? (15 - 17 years)

Children 15-17 years	Responses	%
1	508	85
2	91	15
Total	599	100

Q2. Do you live with a partner?

Live with a partner	Responses	%
Yes	2301	57
No	1672	42
No information provided	29	1
Total	4002	100

Q3. Is the house/flat in which you live?

House/Flat	Responses	%
Rented from Housing Association	170	4
Owned	2273	57
Rented from Council	1122	28
Rented from private landlord	354	9
Other	61	2
Don't Know	8	<1
No information provided	*14*	*<1*
Total	4002	100

Q4. What is the postcode?

Postcodes	Responses	%
HU1	55	1
HU2	42	1
HU3	337	8
HU4	618	15
HU5	585	15
HU6	490	12
HU7	503	13
HU8	798	20
HU9	530	13
No Information provided	*44*	*1*
Total	4002	100

Q5a. How many years have you lived in this area?

Years lived in area	Responses	%
<5 years	1144	29
6 - 10 years	1017	25
11 - 20 years	1105	28
21 - 30 years	338	8
31 - 40 years	207	5
41 - 50 years	95	2
51 - 60 years	36	1
61+ years	36	1
No information provided	*24*	*1*
Total	4002	100

Q5b. Would you say that this is an area you enjoy living in?

Area enjoy living	Responses	%
Yes	3560	89
No	321	8
Don't know	96	2
No information provided	*25*	*1*
Total	**4002**	**100**

Q6a. Rating of social/leisure facilities for people like yourself

Rating of social/leisure facilities	Responses	%
Very good	436	11
Good	1456	36
Average	1154	29
Poor	656	16
Very poor	186	5
Don't know	107	3
No information provided	*7*	*<1*
Total	**4002**	**100**

Q6b. Rating of facilities for young children up to the age of 12

Rating of facilities for young children	Responses	%
Very good	182	5
Good	1086	27
Average	1130	28
Poor	526	13
Very poor	263	7
Don't know	809	20
No information provided	*6*	*<1*
Total	**4002**	**100**

Q6c. Rating of facilities for teenagers (aged 13 to 17)

Rating of facilities for teenagers	Responses	%
Very good	142	4
Good	730	18
Average	1014	25
Poor	846	21
Very poor	461	12
Don't know	801	20
No information provided	*8*	*<1*
Total	**4002**	**100**

Q6d. Rating of rubbish collection

Rating of rubbish collection	Responses	%
Very good	450	11
Good	2104	53
Average	1245	31
Poor	97	2
Very poor	21	1
Don't know	76	2
No information provided	*9*	*<1*
Total	**4002**	**100**

Q6e. Rating of local health services

Rating of local health services	Responses	%
Very good	511	13
Good	1996	50
Average	1166	29
Poor	172	4
Very poor	46	1
Don't know	101	3
No information provided	*10*	*<1*
Total	**4002**	**100**

Q6f. Rating of local public transport

Rating of local public transport	Responses	%
Very good	583	15
Good	1962	49
Average	1135	28
Poor	110	3
Very poor	32	1
Don't know	167	4
No information provided	*13*	*<1*
Total	**4002**	**100**

Q6g. Rating of local schools, colleges and adult education

Rating of local schools, colleges & adult education	Responses	%
Very good	321	8
Good	1645	41
Average	1274	32
Poor	188	5
Very poor	53	1
Don't know	511	13
No information provided	*10*	*<1*
Total	**4002**	**100**

Q6h. Rating of local police services

Rating of local police services	Responses	%
Very good	123	3
Good	1094	27
Average	1686	42
Poor	557	14
Very poor	245	6
Don't know	282	7
No information provided	*15*	*<1*
Total	**4002**	**100**

Q7. What is your main form of transport?

Main form of transport	Responses	%
Car	2399	60
Motorcycle/Moped	82	2
Public transport (Buses and trains)	862	22
Cycling	82	2
Walking	446	11
Other	80	2
Never goes out	47	1
No information provided	*4*	*<1*
Total	**4002**	**100**

Q8a. How safe do you feel walking alone in this area during daytime?

Safety when walking during daytime	Responses	%
Very safe	1763	44
Fairly safe	1783	45
A bit unsafe	337	8
Very unsafe	51	1
Never goes out	63	2
No information provided	*5*	*<1*
Total	**4002**	**100**

Q8b. How safe do you feel walking alone in this area after dark?

Safety when walking after dark	Responses	%
Very safe	871	22
Fairly safe	1560	39
A bit unsafe	858	21
Very unsafe	354	9
Never goes out	353	9
No information provided	*6*	*<1*
Total	**4002**	**100**

Q9a. Would you say that you are well informed about things which affect your area?

Well informed	Responses	%
Yes	1936	48
No	1734	43
Don't know	329	8
No information provided	*3*	*<1*
Total	**4002**	**100**

Q9b. Do you feel you can influence decisions that affect your area?

Influence decisions	Responses	%
Yes	1013	25
No	2195	55
Don't know	783	20
No information provided	*11*	*<1*
Total	4002	100

Q10a. Have you been involved in any local organisations over the past 3 years?

Involved in local organisations	Responses	%
Yes	391	10
No	3578	89
No information provided	*33*	*1*
Total	4002	100

Q10b. Organisations with which involved

Q11a. Problem with the speed or volume of road traffic

Speed/volume of road traffic	Responses	%
Very big problem	231	6
Fairly big problem	481	12
Minor problem	972	24
Not a problem	2277	57
Don't know	30	1
No information provided	*11*	*<1*
Total	4002	100

Q11b. Problem with parking in residential streets

Parking in residential streets	Responses	%
Very big problem	233	6
Fairly big problem	558	14
Minor problem	889	22
Not a problem	2239	56
Don't know	71	2
No information provided	*12*	*<1*
Total	4002	100

Q11c. Problem with car crime (e.g. damage, theft and joy riding)

Car crime	Responses	%
Very big problem	331	8
Fairly big problem	610	15
Minor problem	1151	29
Not a problem	1565	39
Don't know	327	8
No information provided	*18*	*<1*
Total	**4002**	**100**

Q11d. Problem with rubbish and litter lying around

Rubbish and litter lying around	Responses	%
Very big problem	163	4
Fairly big problem	323	8
Minor problem	915	23
Not a problem	2515	63
Don't know	70	2
No information provided	*16*	*<1*
Total	**4002**	**100**

Q11e. Problem with dog mess

Dog mess	Responses	%
Very big problem	174	4
Fairly big problem	394	10
Minor problem	1133	28
Not a problem	2190	55
Don't know	98	2
No information provided	*13*	*<1*
Total	**4002**	**100**

Q11f. Problem with graffiti or vandalism

Graffiti or vandalism	Responses	%
Very big problem	180	4
Fairly big problem	422	11
Minor problem	919	23
Not a problem	2232	56
Don't know	231	6
No information provided	*18*	*<1*
Total	**4002**	**100**

Q11g. Problem with the level of noise

Level of noise	Responses	%
Very big problem	89	2
Fairly big problem	262	7
Minor problem	787	20
Not a problem	2802	70
Don't know	46	1
No information provided	*16*	*<1*
Total	**4002**	**100**

Q11h. Problem with alcohol or drug use

Alcohol or drug use	Responses	%
Very big problem	290	7
Fairly big problem	585	15
Minor problem	883	22
Not a problem	1694	42
Don't know	538	13
No information provided	*12*	*<1*
Total	**4002**	**100**

Q12. Have you personally been a victim of crime in the past 12 months?

Victim of crime	Responses	%
Yes	638	16
No	3344	84
No information provided	*20*	*<1*
Total	**4002**	**100**

Q12. Types of crime that respondents have experienced

Type of crime	Responses	%
Theft or break-in to house or flat	240	6
Theft or break-in to car parked in the area	233	6
Personal experience of theft or mugging in the area	65	2
Physical attack in the area (i.e. hit or kicked in a way that hurt you)	60	2
Racist attack in the area (either verbal or physical)	24	1
Other	63	2

Q13. In the past 3 years have you taken any of the following actions in an attempt to solve a local problem?

Actions taken to solve local problem	Responses	%
Written to local newspaper	206	5
Contacted the appropriate organisation to deal with the problem e.g. the council	441	11
Contacted a local councillor or MP	153	4
Attended a protest meeting or joined an action group	253	6
Thought about it, but did not do anything about it	694	17
None of these	2411	60
Other	55	1

Q14. Would you say that you trust

People trust	Responses	%
Most of the people in your neighbourhood	836	21
Many of the people in your neighbourhood	870	22
A few of the people in your neighbourhood	1757	44
You do not trust people in your neighbourhood	528	13
No information provided	*11*	*<1*
Total	**4002**	**100**

Q15. Would you say this neighbourhood is a place where neighbours look out for each other?

Neighbours look out for each other	Responses	%
Yes	2556	64
No	931	23
Don't know	501	13
No information provided	*14*	*<1*
Total	**4002**	**100**

Q16. Not counting the people you live with, how often do you speak to family members?

Speaking to family members	Responses	%
Every day	966	24
5 or 6 days a week	610	15
3 or 4 days a week	1061	27
Once or twice a week	795	20
Once or twice a month	362	9
Once every couple of months	141	4
Once or twice a year	26	1
Not at all in last 12 months	34	1
No information provided	*7*	*<1*
Total	**4002**	**100**

Q17. Not counting the people you live with, how often do you speak to friends?

Speaking to friends	Responses	%
Every day	857	21
5 or 6 days a week	495	12
3 or 4 days a week	975	24
Once or twice a week	984	25
Once or twice a month	388	10
Once every couple of months	198	5
Once or twice a year	65	2
Not at all in last 12 months	34	1
No information provided	*6*	*<1*
Total	**4002**	**100**

Q18. How often do you speak to neighbours?

Speaking to neighbours	Responses	%
Every day	611	15
5 or 6 days a week	423	11
3 or 4 days a week	1266	32
Once or twice a week	1146	29
Once or twice a month	305	8
Once every couple of months	111	3
Once or twice a year	53	1
Not at all in last 12 months	83	2
No information provided	*4*	*<1*
Total	**4002**	**100**

Q19. How many relatives of friends that you feel close to live within a 15-20 minute walk or 5-10 minute drive if any?

Amount of relatives of friends who live close by	Responses	%
One or two	1457	36
Three or four	1230	31
Five or more	740	18
None	568	14
No information provided	*7*	*<1*
Total	**4002**	**100**

Q20. You are ill in bed and need help at home. Could you ask anyone for help?

Ask for help when ill	Responses	%
Yes	3756	94
No	96	2
Don't know/Depends	144	4
No information provided	*6*	*<1*
Total	**4002**	**100**

Q21. Persons can ask for help if ill in bed

Persons can assist for help	Responses	%
Husband/wife/partner	2212	55
Other household member	1381	35
Relative (outside the house)	2535	63
Friend	1895	47
Neighbour	1131	28
Community, voluntary or other organisation	175	4
Would prefer not to ask for help	69	2

Q22. In general, if you had a serious crisis, how many people, if any, do you feel you could turn to for comfort and support?

Amount of people could turn to for comfort and support	Responses	%
0	74	2
1	334	8
2	454	11
3	391	10
4	422	11
5	293	7
6	340	8
7	177	4
8	225	6
9	55	1
10	372	9
11	11	<1
12	155	4
13	3	<1
14	5	<1
15	671	17
No information provided	*20*	*<1*
Total	**4002**	**100**

Q23a. Do you suffer from any long standing illness, health problem or disability which limits your daily activities?

Long standing illness, health problem or disability	Responses	%
Yes	739	18
No	3252	81
No information provided	*11*	*<1*
Total	**4002**	**100**

Q23b. Which of these describes your usual state - Mobility

Mobility	Responses	%
I have no problems with walking about	3377	84
I have some problems with walking about	549	14
I can't walk about	71	2
No information provided	*5*	*<1*
Total	**4002**	**100**

Q23c. Which of these describes your usual state - Self Care

Self Care	Responses	%
I have no problems with self care	3727	93
I have some problems with washing or dressing myself	236	6
I am unable to wash or dress myself	31	1
No information provided	*8*	*<1*
Total	**4002**	**100**

Q23d. Which of these describes your usual state - Usual activities

Usual activities	Responses	%
I have no problems with performing my usual activities	3462	87
I have some problems with performing my usual activities	469	12
I am unable to perform my usual activities	63	2
No information provided	*8*	*<1*
Total	**4002**	**100**

Q23e. Which of these describes your usual state - Pain/Discomfort

Pain/Discomfort	Responses	%
I have no pain or discomfort	3200	80
I have some pain or discomfort	671	17
I have extreme pain or discomfort	122	3
No information provided	*9*	*<1*
Total	**4002**	**100**

Q23f. Which of these describes your usual state - Anxiety/Depression

Anxiety/Depression	Responses	%
I am not anxious or depressed	3527	88
I am moderately anxious or depressed	411	10
I am extremely anxious or depressed	50	1
No information provided	*14*	*<1*
Total	**4002**	**100**

Q24. Scale indicating good or bad health (0 = bad, 100 = good)

Indication of health	Responses	%
0 - 50	323	8
51 - 60	287	7
61 - 70	482	12
71 - 80	816	20
81 - 90	992	25
91 - 100	1086	27
No information provided	*16*	*<1*
Total	**4002**	**100**

Q25a. Have you been a very nervous person?

A very nervous person	Responses	%
All of the time	22	1
Most of the time	46	1
A good bit of the time	83	2
Some of the time	266	7
A little of the time	749	19
None of the time	2826	71
No information provided	*10*	*<1*
Total	**4002**	**100**

Q25b. Have you felt so down in the dumps that nothing could cheer you up?

Felt down in the dumps	Responses	%
All of the time	13	0
Most of the time	36	1
A good bit of the time	86	2
Some of the time	266	7
A little of the time	973	24
None of the time	2618	65
No information provided	*10*	*<1*
Total	**4002**	**100**

Q25c. Have you felt calm and peaceful?

Felt calm and peaceful	Responses	%
All of the time	569	14
Most of the time	1592	40
A good bit of the time	1038	26
Some of the time	508	13
A little of the time	220	5
None of the time	63	2
No information provided	*12*	*<1*
Total	4002	100

Q25d. Have you felt downhearted and low?

Felt downhearted and low	Responses	%
All of the time	22	1
Most of the time	65	2
A good bit of the time	122	3
Some of the time	523	13
A little of the time	1640	41
None of the time	1617	40
No information provided	*13*	*<1*
Total	4002	100

Q25e. Have you been a happy person?

Happy person	Responses	%
All of the time	850	21
Most of the time	1909	48
A good bit of the time	818	20
Some of the time	266	7
A little of the time	106	3
None of the time	41	1
No information provided	*12*	*<1*
Total	4002	100

Q26. Which of these sentences best describes the amount of stress or pressure you experienced in the past 12 months?

Amount of stress or pressure experienced	Responses	%
I have been completely free of stress or pressure	1079	27
I have experienced a small amount of stress or pressure	1489	37
I have experienced a moderate amount of stress or pressure	1010	25
I have experienced a large amount of stress or pressure	407	10
Don't know	14	<1
No information provided	*3*	*<1*
Total	**4002**	**100**

Q27. Which statement do you think best describes your smoking behaviour?

Smoking behaviour	Responses	%
I have never smoked	1179	29
I used to smoke	1068	27
I now smoke occasionally	375	9
I now smoke daily	1377	34
No information provided	*3*	*<1*
Total	**4002**	**100**

Q28a. Please say if you think that any of the following would generally improve people's health

Improving health	Responses	%
More exercise	3084	77
A healthier diet	2804	70

Q29. How often do you include fruit and/or vegetables in the food you eat?

Fruit and/or vegetables	Responses	%
Every day	888	22
Most days	1577	39
Some days	1229	31
Rarely	295	7
Never	7	<1
No information provided	*6*	*<1*
Total	**4002**	**100**

Q30. In general if a person gives up smoking how big an impact is it likely to have on their health?

Smoking on health	Responses	%
Very big effect	2077	52
Fairly big effect	1288	32
Fairly small effect	428	11
Very small effect	86	2
No effect	80	2
No information provided	*43*	*1*
Total	**4002**	**100**

Q31. Generally speaking, do you think that you have a healthy diet?

Healthy diet	Responses	%
Yes	2467	62
No	965	24
Don't know what a healthy diet is	197	5
Don't know if I have a healthy diet	369	9
No information provided	*4*	*<1*
Total	**4002**	**100**

Q32. Qualifications of respondents

Qualifications	Responses	%
Have skills but no formal qualifications	740	18
NVQ4+	538	13
NVQ3 qualifications	467	12
NVQ2 qualifications	704	18
NVQ1 qualifications	287	7
Other	16	<1
None	1237	31
No information provided	*13*	*<1*
Total	**4002**	**100**

Q32. Other qualifications of respondents

Other qualifications	Responses	%
Access Course	2	<1
Butcher	1	<1
C & G C.I.T.B.	1	<1
CSE Grade 1	1	<1
Engineering Skills	1	<1
NNEB	1	<1
Nursing Course	1	<1
Refuse Collector	1	<1
Social Care	1	<1
University	2	<1
Vicar	1	<1
Total	**13**	**<1**

Q33. Employment of respondents

Employment	Responses	%
Working full time (30 hours or more a week)	1442	36
Working part time (up to 30 hours a week)	538	13
Self employed	165	4
On a government training scheme	109	3
Unemployed and looking for a job	285	7
Unable to work because of long term sickness or disability	261	7
At school or in other full time education	109	3
Retired from paid work	593	15
Looking after the home or family	341	9
Voluntary work	93	2
Other	61	2
No information provided	5	*<1*
Total	**4002**	**100**

Q33b. Other types of employment

Other Types of Employment	Responses	%
Caring Duties - Spouse, child, parent, grandchildren	46	1
Community Service	1	<1
Full Time Education & Work Part-time	1	<1
Government Training Scheme	1	<1
Mother	1	<1
Student	3	<1
Voluntary Youth Worker	1	<1
Waiting for Work Permit	1	<1
Working with under privileged children	1	<1
No information provided	*3946*	*99*
Total	**4002**	**100**

Gender of respondents

Gender	Responses	%
Male	2019	50
Female	1983	50
Total	**4002**	**100**

Age of respondents

Age	Responses	%
16-19	256	6
20-24	387	10
25-29	351	9
30-34	414	10
35-39	424	11
40-44	397	10
45-49	375	9
50-54	238	6
55-59	282	7
60-64	196	5
65-69	250	6
70-74	139	3
75+	293	7
Total	**4002**	**100**

Annex II - Comparisons of Questions on the Survey
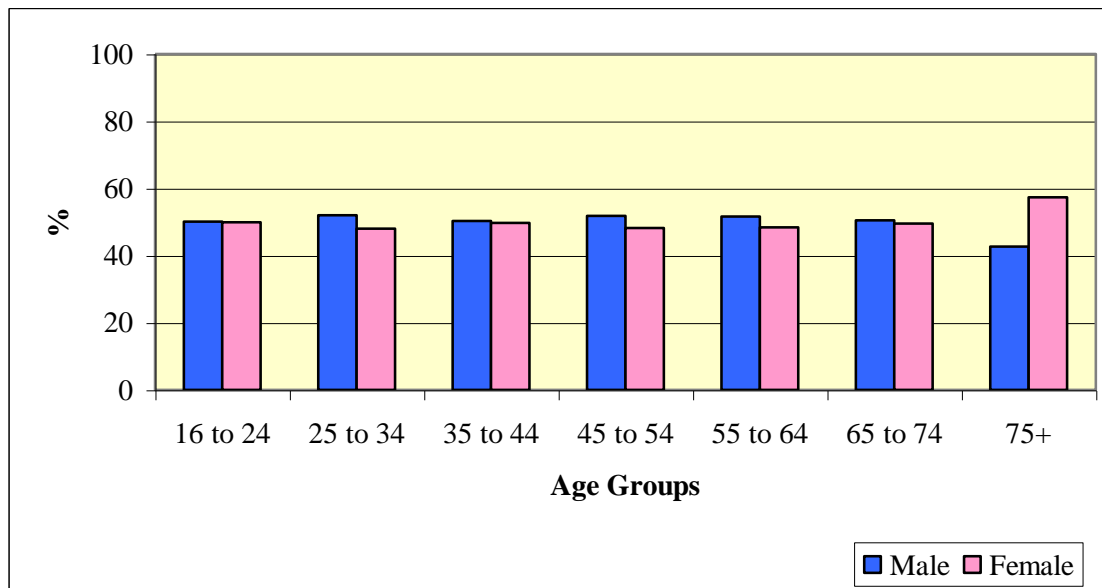
Figure 1: Age groups and gender of respondents
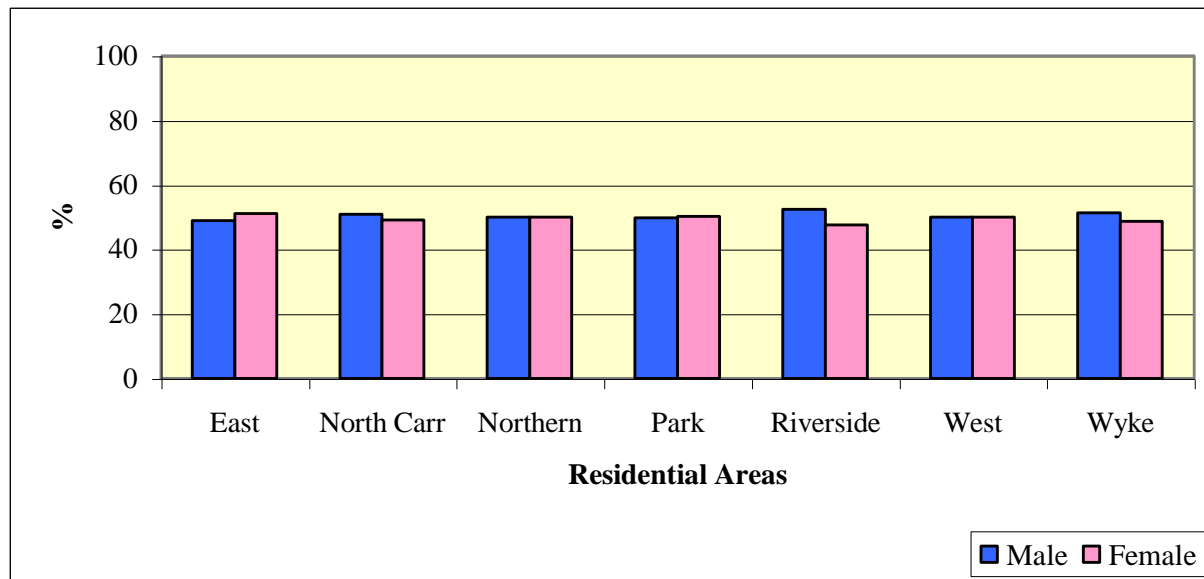
Figure 2: The residential areas and gender of respondents
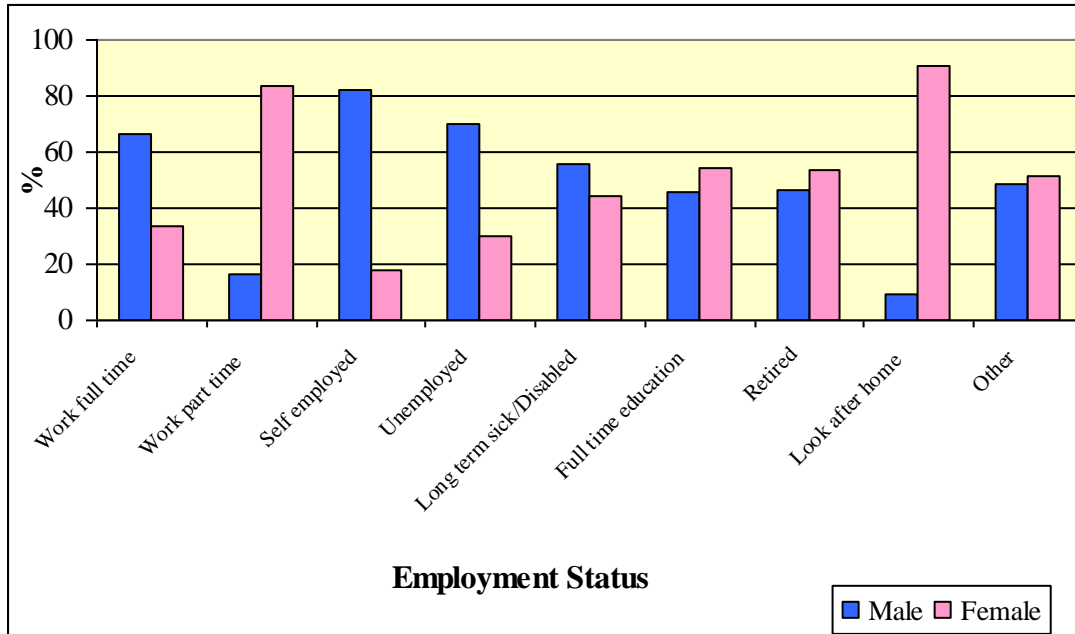
Figure 3: Employment status and gender of respondents
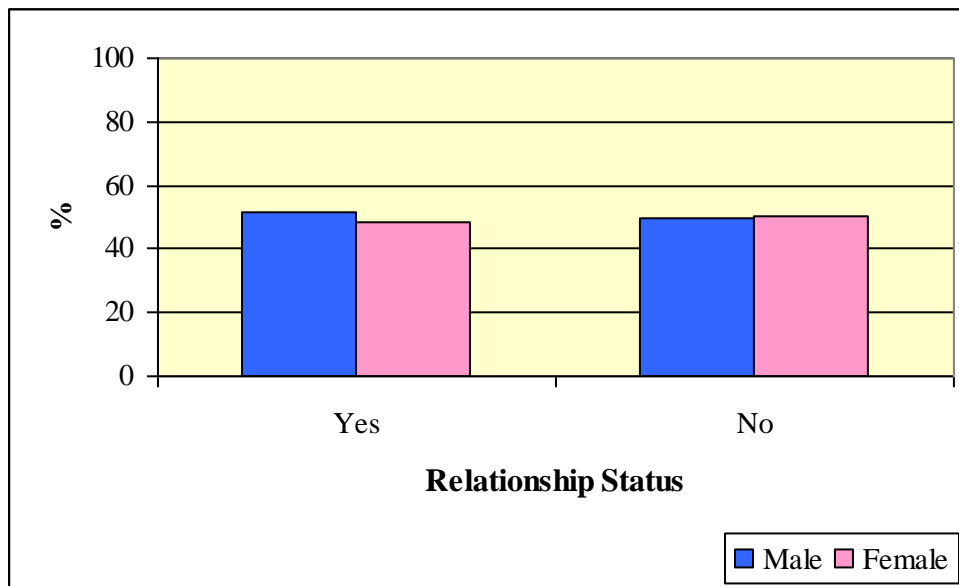
Figure 4: Presence of significant other within gender
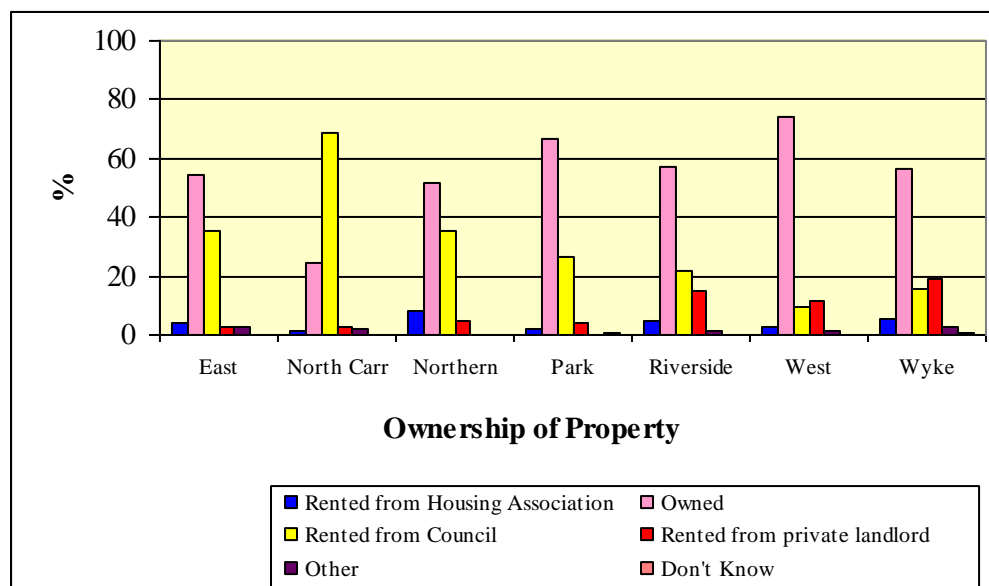
Figure 5: Area of survey by ownership of property

Q6a. Percentages of the rating of social/leisure facilities for people in the residential areas

Rating of Facilities	East	North Carr	Northern	Park	Riverside	West	Wyke
	Residential Areas						
Good	37	46	35	51	50	59	50
Average	29	26	31	29	30	28	29
Poor	31	25	31	16	17	12	19
Don't know	3	3	2	4	4	1	2
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Q6b. Percentages of the rating of facilities for young children in the residential areas

Rating of Facilities	East	North Carr	Northern	Park	Riverside	West	Wyke
	Residential Areas						
Good	32	35	19	45	30	34	26
Average	27	31	27	30	28	31	24
Poor	18	15	27	10	24	18	26
Don't know	23	19	27	14	18	18	25
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Q6c. Percentages of the rating of facilities for teenagers in the residential areas

Rating of Facilities	Residential Areas						
	East	North Carr	Northern	Park	Riverside	West	Wyke
Good	15	33	15	28	20	22	23
Average	27	28	19	28	25	28	22
Poor	38	19	36	30	38	32	31
Don't know	21	20	29	15	17	18	23
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Q6d. Percentages of the rating of rubbish collection in the residential areas

Rating of Rubbish Collection	Residential Areas						
	East	North Carr	Northern	Park	Riverside	West	Wyke
Good	68	83	62	64	67	53	55
Average	26	15	32	33	28	43	37
Poor	2	<1	4	3	4	2	5
Don't know	4	2	2	<1	<1	2	3
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Q6e. Percentages of the rating of local health services in the residential areas

Rating of Health Services	Residential Areas						
	East	North Carr	Northern	Park	Riverside	West	Wyke
Good	68	79	58	65	64	58	52
Average	21	18	32	27	28	37	38
Poor	7	1	7	5	6	4	7
Don't know	4	2	3	3	1	1	4
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Q6f. Percentages of the rating of local public transport in the residential areas

Rating of Transport	Residential Areas						
	East	North Carr	Northern	Park	Riverside	West	Wyke
Good	74	78	61	71	65	52	49
Average	20	15	33	22	23	44	41
Poor	2	3	3	3	4	2	7
Don't know	4	4	4	4	7	3	4
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Q6g. Percentages of the rating of the local schools, colleges and adult education in the residential areas

Rating of Local Schools	East	North Carr	Northern	Park	Riverside	West	Wyke
			Residential Areas				
Good	50	64	43	52	54	44	40
Average	32	20	29	32	29	43	36
Poor	4	5	13	7	4	2	8
Don't know	14	12	16	10	13	11	15
Total	100	100	100	100	100	100	100

Q6h. Percentages of the rating of the local police services in the residential areas

Rating of Police Services	East	North Carr	Northern	Park	Riverside	West	Wyke
			Residential Areas				
Good	34	35	32	36	29	27	23
Average	37	43	39	39	39	53	48
Poor	23	18	23	19	25	12	20
Don't know	6	5	7	6	7	9	9
Total	100	100	100	100	100	100	100

Q11a. Percentages of the rating of the speed or volume of road traffic in the residential areas

Rating of Speed/Volume of Traffic	East	North Carr	Northern	Park	Riverside	West	Wyke
			Residential Areas				
Very big problem	6	2	2	6	13	1	7
Fairly big problem	13	6	8	12	22	8	12
Minor problem	25	28	26	22	25	19	28
Not a problem	54	63	63	60	39	72	52
Don't know	1	2	1	<1	1	0	1
Total	100	100	100	100	100	100	100

Q11b. Percentages of the rating of the parking on the streets in the residential areas

Rating of Parking	East	North Carr	Northern	Park	Riverside	West	Wyke
			Residential Areas				
Very big problem	8	1	1	8	10	1	8
Fairly big problem	18	10	15	14	19	6	14
Minor problem	23	21	21	21	26	21	23
Not a problem	47	65	61	57	42	72	54
Don't know	3	2	2	<1	2	<1	2
Total	100	100	100	100	100	100	100

Q11c. Percentages of the rating of the car crime (e.g. damage, theft and joy riding) in the residential areas

Rating of Car Crime	Residential Areas						
	East	North Carr	Northern	Park	Riverside	West	Wyke
Very big problem	12	6	7	8	17	1	6
Fairly big problem	17	18	17	16	19	8	12
Minor problem	30	35	23	29	34	27	24
Not a problem	30	35	42	42	24	57	48
Don't know	11	7	11	6	6	7	10
Total	100	100	100	100	100	100	100

Q11d. Percentages of the rating of the rubbish and litter lying around in the residential areas

Rating of Rubbish	Residential Areas						
	East	North Carr	Northern	Park	Riverside	West	Wyke
Very big problem	5	2	1	4	11	1	4
Fairly big problem	7	4	7	7	15	3	11
Minor problem	24	30	26	19	27	13	25
Not a problem	63	63	66	69	46	81	57
Don't know	2	1	1	1	1	3	3
Total	100	100	100	100	100	100	100

Q11e. Percentages of the rating of the dog mess in the residential areas

Rating of Mess	Residential Areas						
	East	North Carr	Northern	Park	Riverside	West	Wyke
Very big problem	4	2	1	3	11	2	5
Fairly big problem	12	9	9	9	16	4	9
Minor problem	32	38	25	28	34	22	22
Not a problem	50	50	65	57	38	68	60
Don't know	3	2	1	2	2	3	4
Total	100	100	100	100	100	100	100

Q11f. Percentages of the rating of the graffiti or vandalism in the residential areas

Rating of Vandalism	Residential Areas						
	East	North Carr	Northern	Park	Riverside	West	Wyke
Very big problem	6	3	5	4	8	1	2
Fairly big problem	15	3	10	14	17	4	7
Minor problem	27	20	26	24	23	15	26
Not a problem	49	65	56	53	46	71	58
Don't know	4	9	3	5	5	9	7
Total	100	100	100	100	100	100	100

Q11g. Percentages of the rating of the level of noise in the residential areas

Rating of Noise	Residential Areas						
	East	North Carr	Northern	Park	Riverside	West	Wyke
Very big problem	3	<1	2	3	4	1	2
Fairly big problem	5	3	9	5	10	4	8
Minor problem	16	23	19	16	26	14	24
Not a problem	74	70	69	76	58	80	64
Don't know	1	3	<1	1	1	1	2
Total	100	100	100	100	100	100	100

Q11h. Percentages of the rating of the alcohol or drug use in the residential areas

Rating of Drugs	Residential Areas						
	East	North Carr	Northern	Park	Riverside	West	Wyke
Very big problem	8	4	11	5	13	2	5
Fairly big problem	14	19	15	14	21	6	14
Minor problem	25	36	16	18	26	21	18
Not a problem	32	25	52	49	30	55	51
Don't know	22	16	6	13	10	16	13
Total	100	100	100	100	100	100	100

Q12. Percentages of the types of crimes experienced in the residential areas

Types of Crime	East	North Carr	Northern	Park	Riverside	West	Wyke	Total	n
Theft/break-in to house or flat	15	20	11	15	21	9	9	**100**	**240**
Theft/break-in to car	19	13	15	12	19	10	12	**100**	**233**
Personal experience of theft/mugging	15	6	20	12	22	8	17	**100**	**65**
Physical attack	25	12	7	7	22	5	23	**100**	**60**
Racist attack	8	4	4	17	29	0	38	**100**	**24**
Other	11	8	10	14	17	11	29	**100**	**63**

NB. n = Number of responses to the question

Q13. Percentages of the types of actions taken to resolve problems in the residential areas

Types of Action	East	North Carr	Northern	Park	Riverside	West	Wyke	Total	n
Written to local newspaper	22	6	8	19	20	15	10	**100**	**206**
Contacted appropriate organisation	22	21	17	12	19	2	8	**100**	**441**
Contacted a local councillor or MP	19	9	17	7	27	7	15	**100**	**153**
Attended protest meeting/joined action group	29	6	12	12	19	8	14	**100**	**253**
Thought about it/did nothing	18	5	11	19	16	18	12	**100**	**694**
None of these	11	9	14	17	17	16	16	**100**	**2411**
Other	11	2	4	7	40	18	18	**100**	**55**

NB. n = Number of responses to the question

Q13. Percentages of the types of actions taken to resolve problems between men and women

Types of Action	Male	Female	Total	n
Written to local newspaper	65	35	**100**	**206**
Contacted appropriate organisation	48	52	**100**	**441**
Contacted a local councillor or MP	54	46	**100**	**153**
Attended protest meeting/joined action group	47	53	**100**	**253**
Thought about it/did nothing	53	47	**100**	**694**
None of these	50	50	**100**	**2411**
Other	64	36	**100**	**55**

NB. n = Number of responses to the question

Percentages comparing the level of trust (Q14) with support in neighbourhood (Q15)

Level of Trust	Look out for each other		
	Yes	No	Don't know
Most of the people in your neighbourhood	30	4	5
Many of the people in your neighbourhood	30	5	12
A few of the people in your neighbourhood	39	42	73
You do not trust people in your neighbourhood	1	50	10
Total	**100**	**100**	**100**

Q19. Percentages of the numbers of close relatives or friends within residential areas

Relatives/Friends	Residential Areas						
	East	North Carr	Northern	Park	Riverside	West	Wyke
One or two	30	35	39	35	39	40	35
Three or four	35	27	27	37	27	33	28
Five or more	19	17	15	18	20	16	24
None	16	21	19	10	14	11	13
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Q19. Percentages of the numbers of close relatives or friends between men and women

Relatives/Friends	Gender	
	Male	Female
One or two	38	34
Three or four	29	33
Five or more	17	20
None	16	13
Total	**100**	**100**

Q21. Percentages of available persons to assist when ill within the residential areas

Person to Assist	Residential Areas								
	East	North Carr	Northern	Park	Riverside	West	Wyke	Total	*n*
Husband/wife/partner	14	10	15	17	16	16	12	**100**	**2212**
Other household member	18	8	14	18	15	18	9	**100**	**1381**
Relative (outside the house)	17	8	14	19	17	15	10	**100**	**2535**
Friend	18	6	12	20	17	16	11	**100**	**1895**
Neighbour	22	5	10	22	16	15	10	**100**	**1131**
Community, voluntary or other organisation	34	5	3	14	25	11	7	**100**	**175**
Would prefer not to ask for help	9	1	23	10	10	19	28	**100**	**69**

NB. n = Number of responses to the question

Q23a. Percentages of long standing ill health within the residential areas

Ill-Health	Residential Areas						
	East	North Carr	Northern	Park	Riverside	West	Wyke
Yes	23	16	13	16	28	17	13
No	77	84	87	84	72	83	87
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Q23a. Percentages of long standing ill health within the age groups

Ill-Health	Age group						
	16 to 24	25 to 34	35 to 44	45 to 54	55 to 64	65 to 74	75+
Yes	3	7	9	15	36	40	58
No	97	93	91	85	64	60	42
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Q28ab. Percentages of opinions of lifestyles by gender

Lifestyle	Gender			
	Male	Female	Total	*n*
More Exercise	50	50	**100**	**3084**
A Healthier Diet	48	52	**100**	**2804**

NB. n = Number of responses to the question

Q28ab. Percentages of opinions of lifestyles by age groups

Lifestyle	Age Groups								
	16 to 24	25 to 34	35 to 44	45 to 54	55 to 64	65 to 74	75+	Total	*n*
More Exercise	17	19	21	15	12	9	7	**100**	**3084**
A Healthier Diet	16	19	21	15	11	10	8	**100**	**2804**

NB. n = Number of responses to the question

Q29. Percentages of inclusion of fruit and/or vegetables in food choices by gender

Food Choices	Gender	
	Male	Female
Every day	19	26
Most days	36	43
Some days	36	26
Rarely	9	5
Never	<1	<1
Total	**100**	**100**

Q29. Percentages of inclusion of fruit and/or vegetables in food choices by age groups

Food Choices	Age Groups						
	16 to 24	25 to 34	35 to 44	45 to 54	55 to 64	65 to 74	75+
Every day	13	22	25	21	24	30	25
Most days	29	44	43	38	37	39	47
Some days	39	26	28	35	34	25	24
Rarely	19	7	4	5	5	5	4
Never	<1	<1	<1	0	<1	<1	0
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Q32. Percentages of qualifications by residential areas

Qualifications	Residential Areas						
	East	North Carr	Northern	Park	Riverside	West	Wyke
Skills no formal qualifications	21	16	17	20	22	16	15
NVQ4+	8	9	10	10	15	14	27
NVQ3	9	16	15	12	13	10	11
NVQ2	20	18	15	18	19	18	15
NVQ1	8	9	7	9	7	7	4
Other	<1	0	<1	<1	1	<1	1
None	34	33	36	30	23	35	27
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Q33. Percentages of types of employment of by residential areas

Employment	East	North Carr	Northern	Park	Riverside	West	Wyke
			Residential Areas				
Working full time	35	36	29	34	35	39	44
Working part time	15	17	12	14	11	15	12
Self employed	4	3	3	4	4	6	5
Government training	1	3	8	2	3	2	1
Unemployed/Job searching	5	9	10	9	6	4	7
Long term sickness/Disability	9	3	7	7	8	6	3
School/Full time education	2	2	3	2	3	2	6
Retired	15	15	14	14	18	16	11
Looking after the home/family	8	10	9	9	8	7	11
Voluntary work	4	1	3	3	2	2	<1
Other	2	<1	2	2	2	1	<1
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Annex III - Additional Analyses From Section 2

Additional figures and information are presented from Section 2.

The majority of analyses conducted on age, categorise the age groups into a smaller number of categories for ease of presentation, and the **Figure A1** illustrates distribution of these categories.

Figure A1: Distribution of age groups for all study responders
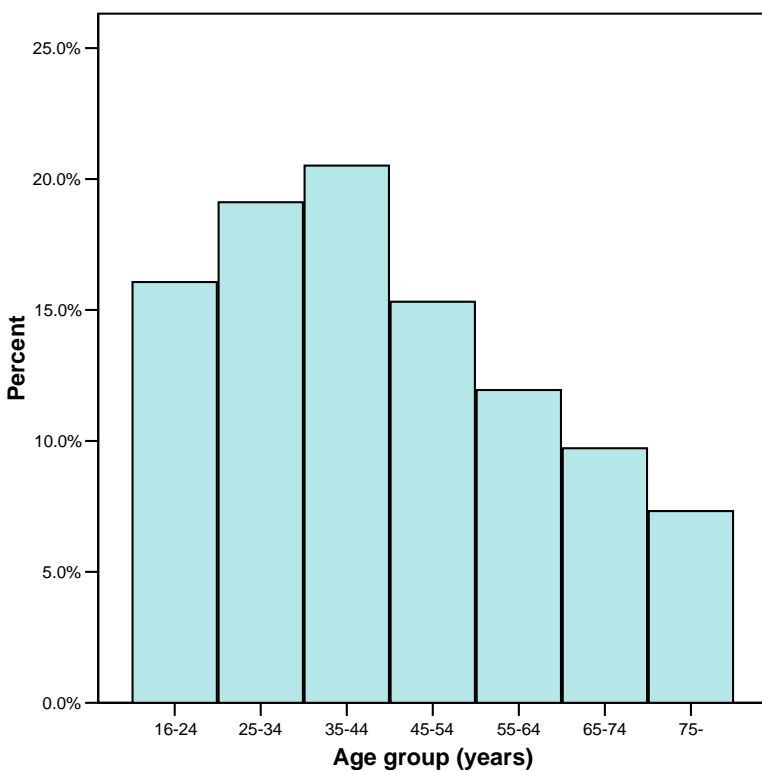
Certain social capital characteristics and health are related to age. Therefore, when comparing social capital and health among the area committees, it is useful to know how age is distributed within each area.

Figures A2 to A8 show the age distribution for each of the seven area committees. The figures are all produced on the same scale so that they can be compared directly.

Figure A2: Distribution of age for the East area committee

Area committee: East
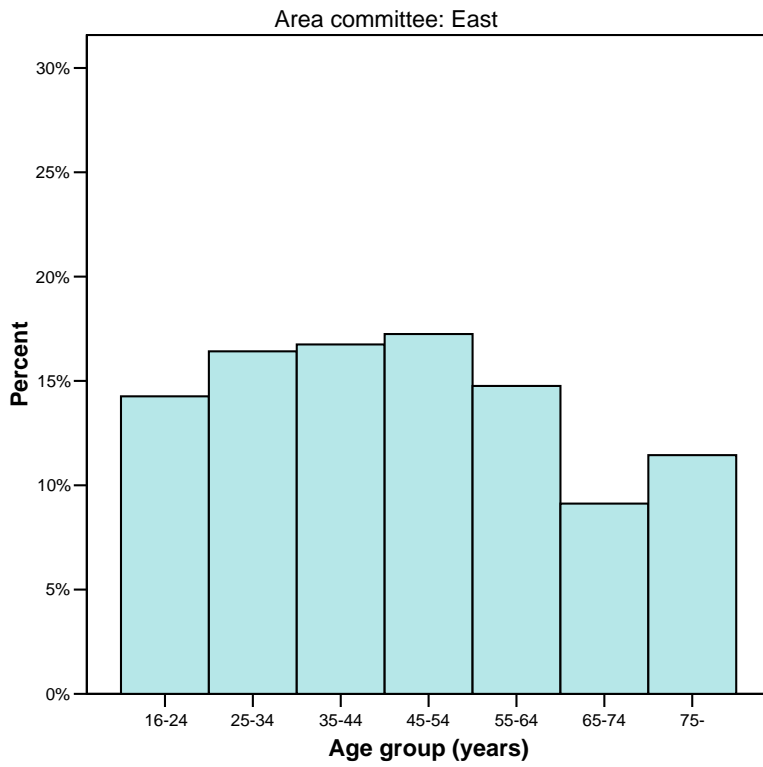
Figure A3: Distribution of age for the North Carr area committee

Area committee: North Carr
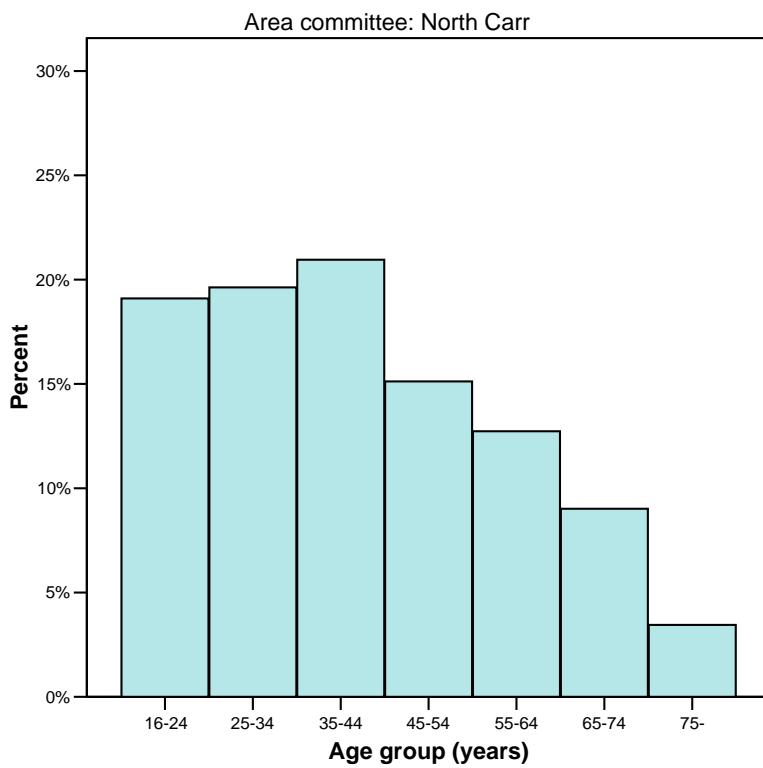
Figure A4: Distribution of age for the Northern area committee

Area committee: Northern
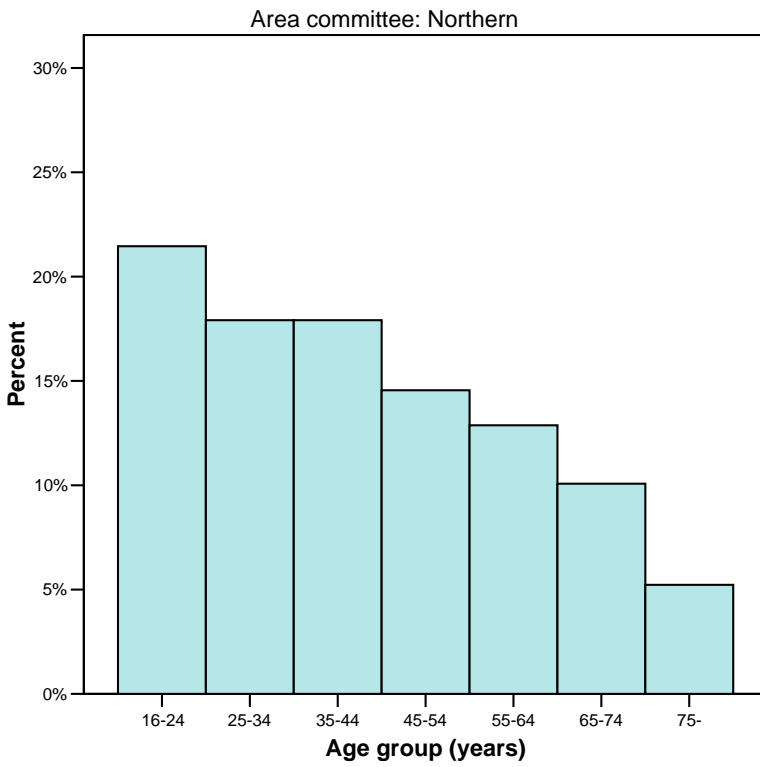
Figure A5: Distribution of age for the Park area committee

Area committee: Park
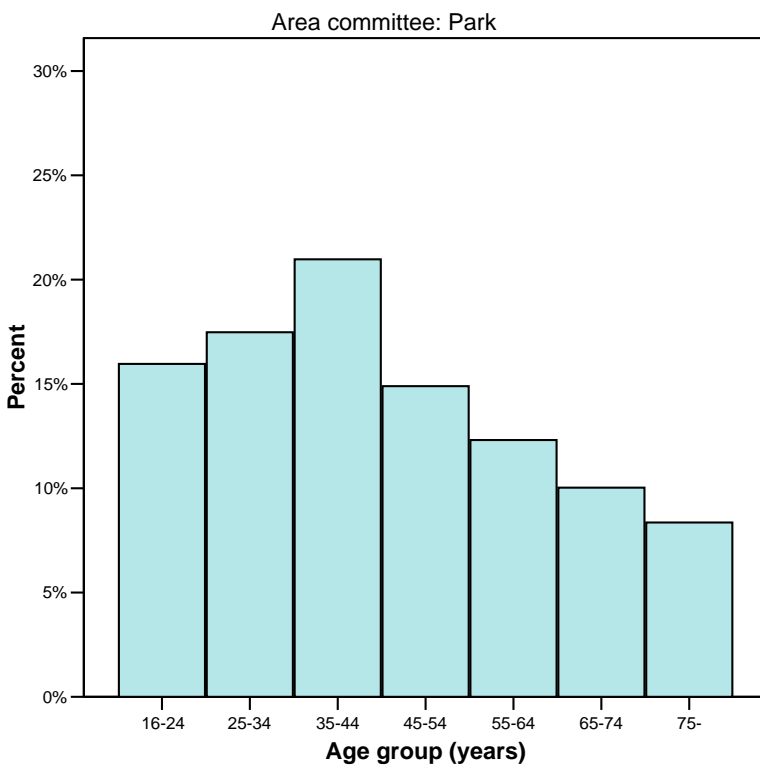
Figure A6: Distribution of age for the Riverside area committee

Area committee: Riverside
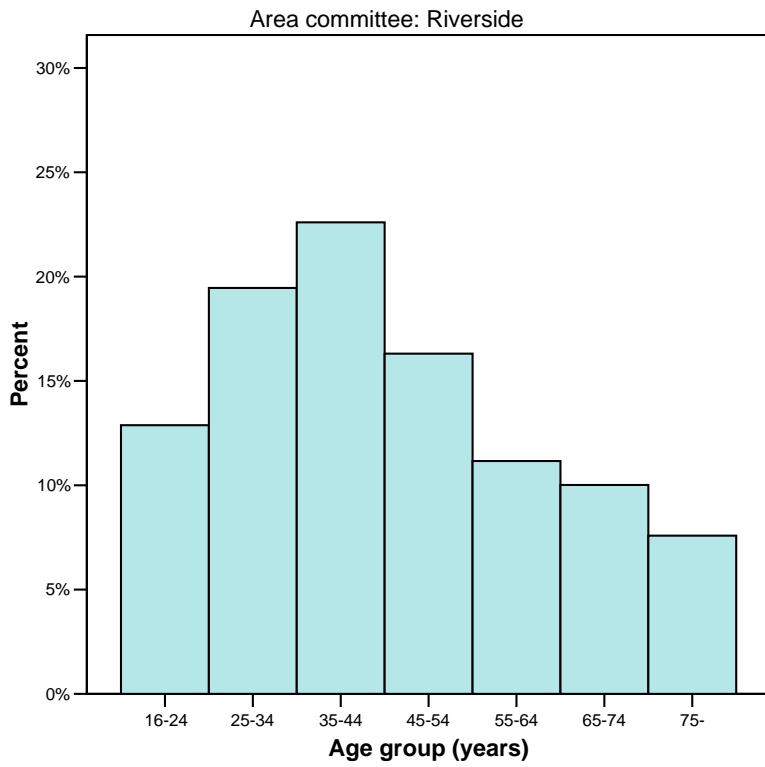
Figure A7: Distribution of age for the West area committee

Area committee: West
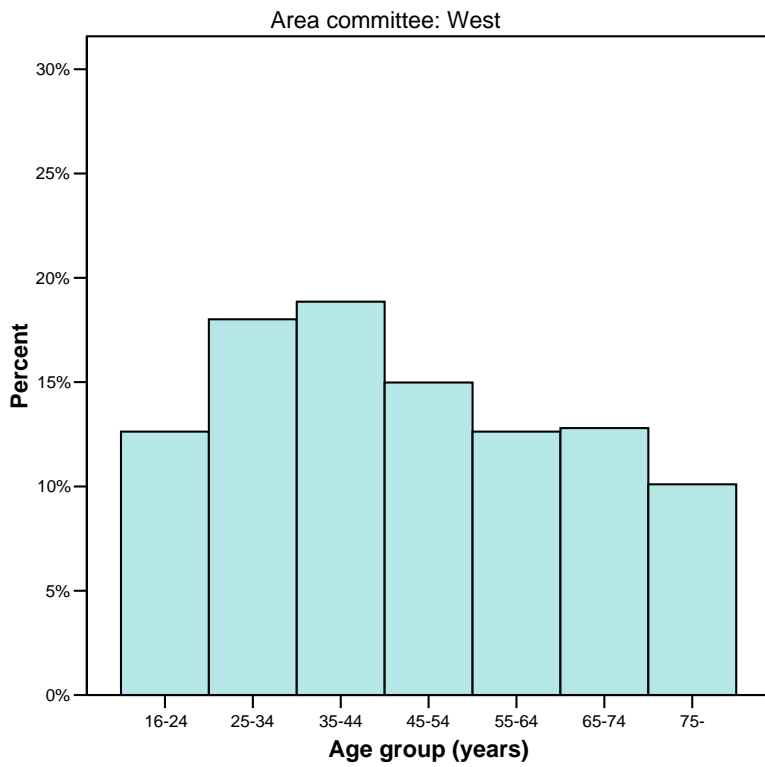
Figure A8: Distribution of age for the Wyke area committee

Area committee: Wyke
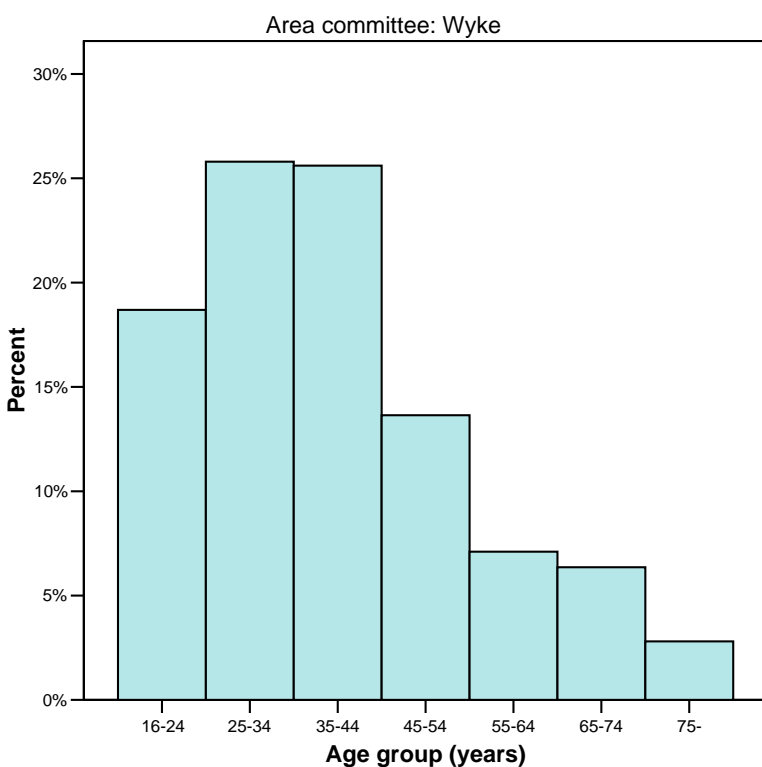
Tables A1 to A4 illustrate the rating of facilities for young children and teenagers, rubbish collection and public transport for each of the seven area committees.

Table A1: Rating of facilities for young children up to the age of 12 years for each area committee

Rating for facilities for young children	Percentages of responders for each area committee							
	East	**North Carr**	**Northern**	**Park**	**Riverside**	**West**	**Wyke**	**Hull**
Very good/Good	32	35	19	45	30	34	26	**26**
Average	27	31	27	30	28	31	24	**24**
Poor/Very poor	18	15	27	10	24	18	26	**26**
Don't know	23	19	27	14	18	18	25	**25**
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Table A2: Rating of facilities for teenagers for each area committee

Rating for facilities for teenagers	Percentages of responders for each area committee							
	East	**North Carr**	**Northern**	**Park**	**Riverside**	**West**	**Wyke**	**Hull**
Very good/Good	15	33	15	28	20	22	22	**22**
Average	27	28	19	28	25	28	28	**25**
Poor/Very poor	38	19	36	30	38	32	31	**33**
Don't know	21	20	29	15	17	18	23	**20**
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Table A3: Rating of rubbish collection for each area committee

Rating of rubbish collection	Percentages of responders for each area committee							
	East	**North Carr**	**Northern**	**Park**	**Riverside**	**West**	**Wyke**	**Hull**
Very good/Good	68	83	62	64	67	53	55	**64**
Average	26	15	32	33	28	43	37	**31**
Poor/Very poor	2	<1	4	3	4	2	5	**5**
Don't know	4	2	2	<1	<1	2	3	**3**
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Table A4: Rating of local public transport for each area committee

Rating of local pubic transport	Percentages of responders for each area committee							
	East	**North Carr**	**Northern**	**Park**	**Riverside**	**West**	**Wyke**	**Hull**
Very good/Good	74	78	61	71	65	52	49	**64**
Average	20	15	33	22	23	44	41	**28**
Poor/Very poor	2	3	3	3	4	2	7	**7**
Don't know	4	4	4	4	7	3	4	**4**
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Tables A5 to A12 illustrate the problem perceived by residents of each area committee for the volume or speed of road traffic, parking in residential streets, car crime, rubbish and litter lying around, dog mess, graffiti or vandalism, level of noise, and alcohol or drug use.

Table A5: Problem of speed or volume of road traffic in area for each area committee

Problem of road traffic in area	Percentages of responders for each area committee							
	East	North Carr	Northern	Park	Riverside	West	Wyke	Hull
Very big problem	6	2	2	6	13	1	7	**6**
Fairly big problem	13	7	8	12	22	8	12	**12**
Minor problem	25	28	26	22	25	19	28	**28**
Not a problem	54	63	63	60	39	72	52	**52**
Don't know	1	2	1	<1	1	0	1	**1**
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Table A6: Problem of parking in residential streets for each area committee

Problem of street parking in area	Percentages of responders for each area committee							
	East	North Carr	Northern	Park	Riverside	West	Wyke	Hull
Very big problem	8	1	1	8	10	1	8	**6**
Fairly big problem	18	10	15	14	19	6	14	**14**
Minor problem	23	21	21	21	26	21	22	**22**
Not a problem	47	65	61	57	42	72	54	**56**
Don't know	3	2	2	<1	2	<1	2	**2**
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Table A7: Problem of car crime in area for each area committee

Problem of car crime in area	Percentages of responders for each area committee							
	East	North Carr	Northern	Park	Riverside	West	Wyke	Hull
Very big problem	12	6	7	8	17	<1	6	**8**
Fairly big problem	17	18	17	16	19	8	12	**15**
Minor problem	30	35	23	29	34	27	24	**29**
Not a problem	30	35	42	42	24	57	48	**39**
Don't know	11	7	11	11	6	7	10	**8**
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Table A8: Problem of rubbish and litter lying around in area for each area committee

Problem of litter in area	Percentages of responders for each area committee							
	East	**North Carr**	**Northern**	**Park**	**Riverside**	**West**	**Wyke**	**Hull**
Very big problem	5	2	1	4	11	1	4	**4**
Fairly big problem	7	4	7	7	15	3	11	**8**
Minor problem	24	30	26	19	27	13	14	**23**
Not a problem	63	63	66	69	46	81	57	**63**
Don't know	2	1	1	1	1	3	3	**2**
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Table A9: Problem of dog mess in area for each area committee

Problem of dog mess in area	Percentages of responders for each area committee							
	East	**North Carr**	**Northern**	**Park**	**Riverside**	**West**	**Wyke**	**Hull**
Very big problem	4	2	1	3	11	2	5	**4**
Fairly big problem	12	9	9	9	16	4	9	**10**
Minor problem	32	38	25	28	34	22	22	**28**
Not a problem	50	50	65	57	38	68	60	**55**
Don't know	3	2	1	2	2	3	4	**2**
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Table A10: Problem of graffiti or vandalism in area for each area committee

Problem of graffiti or vandalism in area	Percentages of responders for each area committee							
	East	**North Carr**	**Northern**	**Park**	**Riverside**	**West**	**Wyke**	**Hull**
Very big problem	6	3	5	4	8	1	2	**5**
Fairly big problem	15	3	10	14	17	4	7	**11**
Minor problem	27	20	26	24	23	15	26	**23**
Not a problem	49	65	56	53	47	71	58	**56**
Don't know	4	9	3	5	5	9	7	**6**
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Table A11: Problem of level of noise in area for each area committee

Problem of noise in area	Percentages of responders for each area committee							
	East	North Carr	Northern	Park	Riverside	West	Wyke	Hull
Very big problem	3	<1	2	3	4	1	2	**2**
Fairly big problem	5	3	9	5	10	4	8	**7**
Minor problem	16	23	19	16	26	14	24	**20**
Not a problem	74	70	69	76	58	80	64	**70**
Don't know	1	3	<1	1	1	1	2	**1**
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Table A12: Problem of alcohol or drug use in area for each area committee

Problem of alcohol or drug use in area	Percentages of responders for each area committee							
	East	North Carr	Northern	Park	Riverside	West	Wyke	Hull
Very big problem	8	4	11	5	13	2	5	**7**
Fairly big problem	14	19	15	14	21	6	14	**15**
Minor problem	25	36	16	18	26	21	18	**22**
Not a problem	32	25	52	49	30	55	51	**42**
Don't know	22	16	6	13	10	16	13	**13**
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Table A13 illustrates the percentage of residents within each age group within each area who have perfect and very poor quality of life as measured by the EuroQoL score.

Table A13: Percentage with perfect to very poor quality of life as measured by the EuroQoL for three different age groups for each area committee

Age group (years)	Area	N	Percentage of residents with EuroQoL (measure of quality of life) within stated range			
			Zero or less	0.001 to 0.499	0.500 to 0.999	1
			very poor	poor	not perfect	perfect
16-54	East	386	1	3	21	75
	North Carr	281	1	2	14	84
	Northern	379	1	1	14	84
	Park	451	1	2	15	82
	Riverside	495	2	4	22	72
	West	377	1	2	12	85
	Wyke	466	<1	2	15	83
55-74	East	143	5	3	38	54
	North Carr	82	2	1	50	46
	Northern	121	3	5	25	67
	Park	145	2	4	31	63
	Riverside	147	5	10	44	41
	West	149	3	2	29	66
	Wyke	72	1	4	33	61
75 and over	East	69	6	9	39	46
	North Carr	13	0	15	46	39
	Northern	27	4	4	30	63
	Park	55	5	13	20	62
	Riverside	53	6	13	40	42
	West	59	7	8	29	56
	Wyke	14	7	7	57	29