



**Community Health
Profiles of Greater
Glasgow and Clyde**

KEY FINDINGS

Ten new community health and wellbeing profiles have been compiled by the Glasgow Centre for Population Health (GCPH) for the Greater Glasgow and Clyde NHS Board area¹. They contain a range of public health indicators which reveal important health trends and patterns within communities.

Each of the ten communities (CH(C)P¹ areas) and 176 smaller neighbourhood areas has its own unique health profile. However some observations common to all areas can be made.

At an area level there are strong correlations between socio-economic circumstances and health related behaviours, illness and mortality levels. For example, the areas with the lowest life expectancy, highest mortality and poorest self-assessed health tend to also have the highest levels of income deprivation, worklessness, violence and smoking and the lowest educational attainment. Conversely, the areas with highest life expectancy and best health overall are significantly more affluent, have more people in work, better educational attainment, are far less affected by violence and show healthier behaviours eg less smoking, and higher breastfeeding levels.

A corollary to this is that comparisons across the region demonstrate the stark contrasts in health and life circumstance of people living in different parts of Greater Glasgow and Clyde. Life (and health) in affluent, succeeding communities is very different to the experience of living in a poor and struggling community. Perhaps surprisingly, such contrasting communities can also be close neighbours.

There are many large and sharply defined health and social inequalities across Greater Glasgow and Clyde as the following selected examples show:

- there is a nine year gap in male life expectancy at birth comparing across the CH(C)Ps; the equivalent gap for women is slightly less at around six years
- levels of breastfeeding vary from 20% in East Glasgow to 49% in East Renfrewshire
- rates of income deprivation are approximately half the national average (7.5% vs. 13.9%, nationally) in East Dunbartonshire and East Renfrewshire, but double the Scottish rate in North and East Glasgow
- rates of domestic abuse incidents are four times higher in East Glasgow than in East Renfrewshire and East Dunbartonshire

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¹ Community Health (& Care) Partnerships

Some positive health trends do emerge. Mortality from chronic diseases, such as heart disease, cancer and stroke has been declining in the majority of areas. There have been notable rises in breastfeeding in North Glasgow, West Glasgow and South East Glasgow over the last eight years; and, rates in East Renfrewshire and East Dunbartonshire have been significantly above the Scottish average over the same period. Levels of worklessness, although still high, have dropped in all ten CH(C)P areas. Perhaps a more surprising and positive statistic is that levels of 'non-car' commuting – by foot, bike, bus or train – are more positive in Glasgow and in fact are higher than the national average in all the Glasgow CH(C)Ps.

Preliminary evaluation suggests that the profiles are being used by a wide variety of health professionals and related organisations, and in many areas are influencing planning processes and priorities, particularly in relation to health improvement and efforts to reduce inequalities.

To remain relevant, the profiles will need to be maintained with the most current data available and developed to reflect new issues, and to fill acknowledged gaps. Further work is required to link the indicators used in the profiles with planning priorities for health improvement and reducing inequalities.

INTRODUCTION

Ten new community health and wellbeing profiles have been compiled by the Glasgow Centre for Population Health (GCPH) for the Greater Glasgow and Clyde NHS Board area. Each profile provides indicators for a range of health outcomes (eg life expectancy, mortality, hospitalisation) and health determinants (eg smoking levels, breastfeeding, income, employment, crime, education).

These profiles build on the success of both the 2004 community health and wellbeing profiles² published by NHS Health Scotland (www.scotpho.org.uk/communityprofiles), and of the 'Let Glasgow Flourish' report³ published by GCPH in April 2006 (www.gcph.co.uk/content/view/17/34/). Whilst these sources continue to be useful, there was recognition of the need for more up-to-date health data and for information pertaining to the new Community Health (and Care) Partnership (CH(C)P) structures.

It is worth noting that ISD Scotland plans to publish similar profiles for CH(C)Ps in the rest of Scotland later in 2008.

AIMS AND PURPOSE

The community health and wellbeing profiles were designed to inform service providers, planners, policy makers and the public about public health issues, both locally and at national level. Specifically, it was the aim that each profile would:

- provide organisations and communities with up-to-date and locally-relevant public health intelligence;
- highlight health and social inequalities;
- show trends in key indicators;
- provide local level information to aid priority-setting and the targeting of resources; and
- develop knowledge of the complex nature of health and its determinants.

APPROACH AND METHODS

An initial stage was to consult on the preferred content and format of the profiles. Views were sought from key individuals in CH(C)Ps, other relevant local and national health bodies and some non-health organisations. Comments were invited on the proposed indicators, geographical coverage, the format of data presentation (as maps, graphs and tables) and likely uses of the information.

Thirty-six consultation responses were received from a range of local and national organisations and, while a majority supported the indicators suggested, a number of respondents put forward additional or alternative potential indicators. Most respondents agreed with the small area (neighbourhood) geographies that had been proposed. However in one area, Inverclyde, significant changes to the neighbourhood geographies were requested and these were acted upon.

Following the consultation, a final set of indicators was selected and the process of gathering and collating these indicators was undertaken. This involved sourcing data from a variety of local organisations (eg Social Work Departments and Strathclyde Police) and from national sources, such as the 2001 Census, the General Register Office of Scotland, ISD Scotland and the Scottish Executive (now the Scottish Government). The indicators required were obtained either directly from internet sites or through specific requests. Many of the health indicators were provided by ISD Scotland, while others, for example the mortality and life expectancy indicators, were calculated by GCPH.

Presentation of the indicators was mainly through a set of excel generated spine and trend charts. These were based on the design used in the 2004 profiles with slight formatting modifications and changes to the indicators used. Multiple charts were generated rapidly using formulae links and visual basic macros.

Sets of maps were included in each profile to identify the overall area covered, neighbourhood boundaries within each CH(C)P and the location of GP practices, social work offices and hospitals. A separate set of maps illustrated fuel poverty, the availability of greenspace and air quality.

All of the above maps and charts were included in the published profiles. Additionally, a brief interpretation of health trends for each area was provided together with a set of background notes on definitions and sources for each indicator.

The profiles were published in February 2008 and have been disseminated in a number of ways:

- as paper copies through direct mailing to key individuals and organisations;
- as pdf and excel (data) files on the GCPH web site;
- through presentations and workshops, coordinated with dissemination of the local Director of Public Health's report, 'A Call to debate, a Call to action'⁴.

It is too early to make a proper evaluation of the impact of the profiles. However we have started to gather feedback from key informants, some of which is included below.

More detail on the indicators in the profiles and the geographies used is provided in the introduction to each profile (www.gcph.co.uk/communityprofiles).

FINDINGS AND CONCLUSIONS

Health and social inequalities

The profiles emphasise the stark differences in health between different communities in Greater Glasgow and Clyde. If we assume life expectancy to be a reasonable proxy for overall health and use this indicator to compare communities, the profile data demonstrate that there is a nine year gap in male life expectancy at birth across CH(C)Ps in the Greater and Clyde region; the equivalent gap for women is slightly less at around six years. At a neighbourhood level, the differences in life expectancy for men and women living in different parts of the region are even more apparent. In areas such as Calton & Bridgeton, Parkhead & Dalmarnock, Greater Gorbals, and Ruchill & Possilpark men live on average for ten years less than the Scottish average of 74 years, while in parts of Milngavie, Bearsden, Lenzie and several East Renfrewshire neighbourhoods male life expectancy is at least 80 years. Women in Ferguslie Park and Ruchill & Possilpark live on average for seven years less than the Scottish average of 79 years, while in parts of East Dunbartonshire and East Renfrewshire women live on average for 84 years or longer.

High levels of long-term concentrated deprivation are known to affect health in the region, particularly in Glasgow itself. However levels of deprivation vary markedly across the region. In East Dunbartonshire and East Renfrewshire rates of income deprivation are approximately half the national average (7.5% vs. 13.9%, nationally), but they are double the Scottish rate in North and East Glasgow, where 27.7% and 29.8% of the population, respectively, are income deprived. The contrasts between smaller areas are much more extreme: in Lower Whitecraigs & South Giffnock less than two people in a hundred are income deprived, while in Parkhead & Dalmarnock one in two people are income deprived.

While there are communities that have more positive health indicators than might be predicted by their socio-economic circumstances, such examples are unusual. In general there are strong correlations between the socio-economic circumstances of areas, health related behaviours and levels of illness and mortality rates. For example, the areas with the lowest life expectancy, highest mortality and poorest self-assessed health tend to also have the highest levels of income deprivation, worklessness, violence and smoking and the lowest educational attainment. Conversely, the areas with highest life expectancy and best health overall are significantly more affluent, have more people in work, better educational attainment, are far less affected by violence and show healthier behaviours eg less smoking, and higher breastfeeding levels.

Health comparisons and trends

There are both improving and worsening health trends across the region. On the positive side, both male and female life expectancy improved in every CH(C)P over the period 1994-98 to 2001-05. However in a significant number of smaller, more deprived, neighbourhoods there has been a reduction or flat trend in life expectancy over the period. This is particularly notable for men.

The profiles show encouraging improvements in relation to chronic diseases. The numbers of patients with heart disease requiring hospital treatment have dropped, as have deaths from heart disease (by at least 30% in the last eight years in every CH(C)P area). Mortality from cancer and stroke has also dropped in the majority of areas.

Levels of breastfeeding vary across Greater Glasgow CH(C)Ps from 20% in East Glasgow to 49% in East Renfrewshire. However there have been notable rises in breastfeeding in North Glasgow, West Glasgow and South East Glasgow over the last eight years; and rates in East Renfrewshire and East Dunbartonshire have been significantly above the Scottish average over the same period.

Levels of worklessness, which include large numbers of people on Incapacity Benefit, are still higher than the Scottish average in all but two of the CH(C)Ps, but the trend in all ten CH(C)P areas has been downward over the last seven years.

Perhaps a more surprising statistic is that levels of 'non-car' commuting – by foot, bike, bus or train – are more positive in Glasgow and in fact are higher than the national average in all the Glasgow CH(C)Ps, the highest level being 64% in West Glasgow. In several of Glasgow's neighbourhoods this figure exceeds 70%.

There are many less positive trends in health affecting the region (eg in relation to suicide, smoking in pregnancy, alcohol related harm, violence and drug deaths) and even where improvements have occurred Greater Glasgow and Clyde CH(C)Ps tend to have worse health indicators than the Scottish average. The two CH(C)Ps that are exceptions to this generalisation are East Dunbartonshire and East Renfrewshire, which in the main have more positive indicators in comparison to the rest of Greater Glasgow and Clyde and compared to Scotland as a whole.

The trends in alcohol related harm are particularly concerning. In the last eight years deaths from alcohol related causes rose in every CH(C)P and over 13,000 people are now admitted to hospital over the course of a year due to alcohol related or attributable causes across Greater Glasgow and Clyde.

Utility of small area public health data

Finally, it is pertinent to note not only the demand for public health information at a small area level, but its utility. In the profiles the populations of neighbourhoods in Glasgow typically ranged from 3,500-15,000. They ranged from 2,500-6,000 for the smaller areas outside Glasgow. Trends at these geographical levels can often help to highlight the impact of particular projects or activities in local areas.

As an example, the profiles identified improvements in breastfeeding in the South East of Glasgow, which were particularly notable in the Govanhill and Greater Gorbals neighbourhoods. The reasons for improvement are likely to be multi-faceted - a long standing peer support breast-feeding project operating in these areas, population changes and ante-natal services may all have played a part. Further research is planned to understand how mothers have been supported to breastfeed in these areas over the last ten years.

Another compelling neighbourhood statistic is the figure for drug related deaths in Calton and Bridgeton. In an area with a population of 13,000, there were 70 drug deaths in the ten year period, 1997-2006. In comparison, in East Dunbartonshire and East Renfrewshire, which have a combined population of nearly 200,000 (ie 15 times the size of Calton and Bridgeton) there were only 62 drug deaths.

There is often a tendency toward statistical caution leading to suppression of small area data usually for good reasons – for example, to avoid possible disclosure. However, this philosophy can hinder work to identify patterns of inequality and highlight areas where particular problems concentrate. Equally, it is useful to be aware when a particular health issue is not a problem in an area. Taking the example of drug deaths again, we can through neighbourhood profiling note the very many communities within all CH(C)Ps where no drug deaths have occurred in the last ten years.

Use of profile information

The profiles data have been presented at a range of local events either as straightforward presentations or as part of themed workshops. At most of these events, a complementary talk has been given by Dr Linda de Caestecker, the Director of Public Health for NHS Greater Glasgow and Clyde. In her presentations she has moved beyond merely describing of the health data to focus on actions to improve health drawn from her recently published public health report, 'A call to debate: a call to action'⁴.

From our early feedback (quoted below) on three of these events in Inverclyde, South East and South West Glasgow it appears that the presentations and workshops have worked well:

'The presentations linked and flowed well.'

in relation to the workshop format -

'very helpful in getting people from diverse backgrounds to think about health and discuss issues...'

'...format was very useful. We are using the write up to inform local priority setting.'

There was also some evidence that the profiles are already being used in local planning processes.

'The profiles have been discussed in each of the five Health Forums, and are being used to inform the health priorities for the [area] including the allocation of Fairer Scotland Funding.'

'...will be used to set the background and context for the [area] Health Improvement Plan'

'We will also be using the data to focus work on specific issues eg breastfeeding.'

'Have already informed CH(C)P plan and underpinning work of the Alliance's health and wellbeing thematic partnership group.'

'Will inform re-worked version of Single Outcome Agreement'

'Will be used for more detailed analysis and comparative work with other CH(C)Ps'

 **RECOMMENDATIONS**

The health profiles are proving to be a useful resource for supporting a focus on population health issues in Greater Glasgow and Clyde, for highlighting inequality and for showing key trends. In order to remain relevant, the information needs to be maintained and updated to ensure it is as current as possible.

New indicators should be added to illustrate emergent issues and to fill acknowledged gaps. In the latter respect it would be particularly useful to add information on levels of obesity and overweight, physical activity, transport use, dental health of children and low pay, as and when such information becomes available.

Further work is required to link these 'outcome' indicators with indicators of process. While it was not the intention for the profiles to be part of a formal monitoring and evaluation system, clearly it would be beneficial to be able to relate local actions and service priorities in particular areas to population health outcomes such as increased breastfeeding, reduced levels of overweight and obesity, and reduced inequality in heart disease mortality.

The development of comparisons to other UK and European regions is another possible evolutionary direction for the profiles given the increasing availability of information from other countries and regions and the potential that we have to learn from other areas in our efforts to improve health in the communities across Greater Glasgow and Clyde.

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Copies of the ten community health and wellbeing profiles for Greater Glasgow and Clyde can be accessed at: www.gcph.co.uk/communityprofiles