

Borderline Health
Scottish Borders Director of Public Health's Annual Report for 2010/11
A Summary

In this my report for 2010/11, I review the implementation of the recommendations in my last report particularly relating to the health of children and young people and the more disadvantaged areas of the Borders. I also comment on what has been done to improve the health of older people, combat unemployment, poverty, and financial exclusion tackling smoking, alcohol and obesity, as well as the implementation of the Borders Joint Health Protection Plan. I have commented on the usefulness of the Strategic Assessment of the Borders as well a basis on which to build more effective community planning.

I am supported by the Joint Health Improvement Team, the Health Protection Team, Scottish Borders Council Regulatory Services and the Borders Alcohol and Drug Partnership. The Health Protection Team works very closely with Scottish Borders Council Regulatory Services to manage, prevent and protect the Borders from communicable disease, and environmental hazards.

I have reviewed the health of what are regarded as the five most disadvantaged communities in the Borders, Bannerfield, Burnfoot in Hawick, Eyemouth, Langlee in Galashiels, and Walkerburn. I benchmark these against Lauder, an affluent town in the Borders with a good health profile. I have used a few measures (defined in detail in my full report) which together give a good picture of the health of these communities. These small numbers must be treated with caution. Across these areas children make up from 14% of the population in Walkerburn to 26% in Burnfoot; the proportion of pensionable age ranges from 15% to 26% in Walkerburn. In Eyemouth, 10% of first-time mothers are teenagers but this is 40% in Burnfoot and none in Lauder. Worryingly, while as few as 21% of pregnant women are smoking at booking in Walkerburn, 50% are in Bannerfield, much worse than the 18% in Lauder. Breastfeeding rates show a similar picture - from 19% in Burnfoot to 50% in Walkerburn and 61% in Lauder. Burnfoot has the lowest MMR uptake at 82% compared with 100% for Lauder. But this figure for Lauder is based on only six children. Educational attainment is much the same. Of the working age population in these communities 4% in Eyemouth claim Jobseekers Allowance ranges from compared with 9% in Langlee and 1% in Lauder. There is a similar picture for income support. Of houses in Burnfoot almost 100% fall into the lowest council tax bands, a proxy measure of housing quality of homes. This contrasts with 34% in Lauder. Eyemouth stands out as particularly remote making opportunities less accessible for that community. The crime rate varies from 191/10,000 in Walkerburn to 881/10,000 in Langlee compared with 124 per 10,000 in Lauder. In these communities hospital episodes related to alcohol use, drug use and emergency admission are much worse than in Lauder which has far better figures than the Scottish Borders as a whole While there is a wide range in these measures between the five communities they are all markedly worse than Lauder. Langlee is the worst. Burnfoot is the worst for hospital admission for accidents, possibly reflecting its younger population. So there are a large number of issues which are common across all five communities but there are a small number of issues in which there is a marked variation. These communities have a similar life experience, with teenage mothers, many mothers smoking in the important early weeks of pregnancy, low rates of breastfeeding and to some extent immunisation uptake coupled with poor educational attainment, and dependence on benefits. However there are important differences between these communities and therefore a variety of responses to their needs driven by the Healthy Living Network.

The Healthy Living Network has been visible and high impact in these areas. In each community a Health Improvement professional has worked with it in collaboration with Community Learning and Development, Social Work and the Voluntary Sector. The coordinator has engaged the community in needs assessment and with them has introduced

initiatives to improve health and well-being. These have included lunch clubs to reduce isolation amongst older people, vegetable growing, linked in three of the communities to allotment projects, one including the novel concept of a "community orchard", food and health sessions for parents and involvement in schools, breakfast clubs, food and health sessions to primary school children. This has taught pupils to understand basic ingredients and create healthy foods. Work on physical activity has ranged from walking groups to programmes of physical activity during class time. In at least one area work goes on to improve literacy and numeracy. One particular project of note is the "Burnfoot Community Futures" which plans to develop a local unused building to provide various facilities in a community centre. Although how interventions are delivered might vary from community to community there is a common core across all five areas. There are also some specific projects pertinent to particular local needs.

In conclusion while these communities have a worse life experience than other parts of the Borders they have enthusiastically embraced initiatives which they see as meeting their needs. Their engagement and collaboration has shown positive changes in terms of lifestyle and individual behaviours and to some extent in environments and the use made of them. I take the view that for a relatively small investment the Healthy Living Network has had a huge impact on many lives in these communities.

However, we cannot afford to be complacent. I recommend that preventative spend should be targeted at these disadvantaged areas, particularly in relation to the health of older people. Work in these areas to prevent the misuse of alcohol and drug should be a priority. Within this context smoking cessation work should target antenatal women, and work to tackle obesity through schools needs to continue. The actions of the Joint Health Protection Plan should continue to ensure that harm from communicable disease and environmental hazards is minimised. Finally I recommend that the partners involved in community planning look at how they work to be more effective in improving health in these disadvantaged areas.



Dr Eric Baijal
08 September 2011

NHS Borders **Borderline Health** **Scottish Borders COUNCIL**
Annual Report of the Scottish Borders Joint Director of Public Health 2010 – 2011

