



INSTITUTE *of*
HEALTH EQUITY

AN OVERVIEW OF HEALTH INEQUALITIES IN SCOTLAND: THE COLLABORATION FOR HEALTH EQUITY IN SCOTLAND



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INTRODUCTION

THE COLLABORATION FOR HEALTH EQUITY IN SCOTLAND

The Collaboration for Health Equity in Scotland (CHES) is a two-year partnership (2024-2026) between Public Health Scotland (PHS), the UCL Institute of Health Equity (IHE), led by Professor Sir Michael Marmot, and three places in Scotland [1] [2]. The partnership was established in order to strengthen and accelerate ongoing efforts to improve Scotland's health, promote well-being, and address health inequalities. Despite continuing efforts and policies, health inequalities in Scotland are widening and are steeper than in other countries in Europe.

This CHES will, where possible, strengthen existing analyses of inequalities, particularly at small area level, but the main focus is on addressing challenges in the delivery and implementation of policies. The delivery system has been identified as hampering efforts to reduce inequalities [3]. In order to help understand and address why existing approaches have not had the intended impacts on health and health inequalities, the CHES will work with three places: Aberdeen City, North Ayrshire and South Lanarkshire. The work with the three places is intended to both support and shape action within the three places and inform national stakeholders about ways to strengthen action on health and the social determinants of health. The CHES will build on existing place-based work across Scotland, including the Shaping Places Programme and the Place Standard Tool. The programme will also build on the IHE's work with 'Marmot places' in England and Wales, where places have strengthened the health equity system and the design and delivery of programmes in the social determinants of health to improve health and reduce health inequalities [4][5].

There are two main strands to the CHES programme:

1. Work at a national level to provide new insights into the most effective ways to secure progress on health equity in Scotland through the lens of the Marmot 8 framework [6].
2. Work with three places in Scotland to collaborate on developing and implementing interventions and policies to enhance health equity.

In order to achieve these goals the CHES will:

1. Develop analyses which will provide new insights into the most effective ways to take action in Scotland through the Marmot 8 framework.
2. Show, through practical work with three places in Scotland, how local areas and partnership actions can strengthen action on health equity and improve wellbeing.
3. Develop recommendations for national and local organisations and sectors to strengthen delivery to reduce inequities in health and wellbeing.
4. Provide a catalyst for enhanced action in Scotland and renewed and strengthened partnerships for health equity.

This first, introductory report summarises the initial phase of the work and provides an overview of inequalities in health across Scotland and within the three collaborating places.

Further analysis of inequalities in health and the social determinants will follow over the course of the programme. So far, the CHES has involved the establishment and development of the partnership between IHE and Public Health Scotland and development of the programme with the three places, initial engagement with stakeholders from sectors and places across Scotland and preliminary analysis set out below. Next steps will include an overview of inequalities in the social determinants of health in Scotland and the three places, alongside analysis of resource allocation from national government to local governments in Scotland and how those relate to level of deprivation across Scotland.

Health is shaped by experiences throughout life, in the conditions in which people are born, grow, live, work and age. In subsequent reports we will report on inequalities in the social determinants of health in Scotland, organised by the eight Marmot principles:

- | | |
|---|---|
| 1 | Give every child the best start in life |
| 2 | Enable all children, young people and adults to maximise their capabilities and have control over their lives |
| 3 | Create fair employment and good work for all |
| 4 | Ensure a healthy standard of living for all |
| 5 | Create and develop healthy and sustainable places and communities |
| 6 | Strengthen the role and impact of ill-health prevention |
| 7 | Tackle racism, discrimination and their outcomes |
| 8 | Pursue environmental sustainability and health equity together |

CHAPTER 1

HEALTH INEQUALITIES IN SCOTLAND

The programme focusses on reducing inequalities in health and the social determinants of health. The data presented here is an initial summary of health inequalities across Scotland and within the three CHES places. It is not a complete assessment but is intended to inform the work at the start of the CHES and provide some initial insights. We reaffirm that overall, there are relatively poor levels of health in Scotland and shorter life expectancy compared with comparator countries. There are large and widening health inequalities related to levels of deprivation within and between Council areas.

METHODOLOGY

There are important limitations in the data presented in this report which limit understanding of inequalities in health. IHE, PHS and the three places will work to provide more accurate understandings of inequalities in health and the social determinants, but here we present the data which are available.

Firstly, data from the healthcare system – such as disease registration and hospitalisation rates are based on system activity, rather than actual prevalence. For example, diagnosis or prescriptions for mental health conditions relates to service availability and patterns of referral rather than accurately reflecting poor mental health. Similarly, registrations for diseases rely on those diseases being diagnosed and again reflect access to services and health care diagnoses patterns – these may vary between areas.

Secondly, health data are not routinely available below Intermediate Zone level. Assessing deprivation-related health inequalities at local authority level can be done using the Scottish Index of Multiple Deprivation (SIMD) local share. The local share is an indicator of deprivation for a higher-level geography, such as local authority, as measured by the proportion of Data Zones in a local authority which are among the 20% (or other threshold) most deprived in Scotland. We also developed a ranking of Intermediate Zones within council areas based on levels of deprivation. The methodology is described below. As we show in Section 2 there are wide inequalities within Council areas, which need to be monitored so that they can be reduced through appropriately designed and resourced programmes and approaches.

CALCULATING DEPRIVATION INDICATORS FOR LOCAL AREA

In order to understand inequalities **between** Council areas, we used a modification of the existing SIMD local share indicator for Council areas. In order to look at differences **within** council areas at Intermediate Zone level, we constructed a deprivation indicator based on the population weighted average rank of the Data Zones in each Intermediate Zone [7]. Graphs showing levels of inequality across Scotland in this report are based on other existing measures of inequality (Data Zone quintiles and slope indices of inequality).

Between Council areas: For the Council areas, the existing indicator of deprivation is based on figures for the percent of all Data Zones in the Council area that are among the 20 percent most deprived nationally. This local share, and the ranking of Council areas based on it, is used in this report to assess the relationship between health outcomes and area deprivation. However, Data Zones vary in size, with populations between 375 and 1,125, therefore when we come to looking at the contribution of each Council area to the size of the deprived population in Scotland as a whole, we slightly modified the local share of deprived Data Zones in each Council area to be the percent of the population of the 20 percent most deprived Data Zones nationally that live in each Council area. Using this population-based share results in minor changes in the value of the deprivation indicator and a change in ranking of about a third of areas by between one and three places. However, only one area's ranking changes by three places (Argyll and Bute) and three by two places (Aberdeenshire, Midlothian and Perth and Kinross).

Within Council areas: Currently there is no existing indicator of deprivation for Intermediate Zones, which comprise several contiguous Data Zones and have populations between 2,500 and 6,000 people. However, the lowest geographic level for which much health data are available, and not adversely affected by small number issues, is for Intermediate Zones. Therefore, to quantify the extent of health inequalities within the three CHES places, we derived a deprivation rank for each Intermediate Zone. This was calculated using the population weighted average of the SIMD ranks of the Data Zones that comprise the Intermediate Zones. The weighted average is scaled to the number of Data Zones in Scotland (6,976 in 2020) rather than the number of Intermediate Zones. This average is therefore divided by the total number of Data Zones in Scotland in 2020 and multiplied by 100 to express the figure as a percent of the largest rank possible in Scotland. An Intermediate Zone with a higher weighted average SIMD rank (expressed as a percent), predominantly comprises some of the least deprived Data Zones in Scotland and an Intermediate Zone predominantly made up of deprived Data Zones will have a lower weighted average SIMD rank (expressed as a percent).

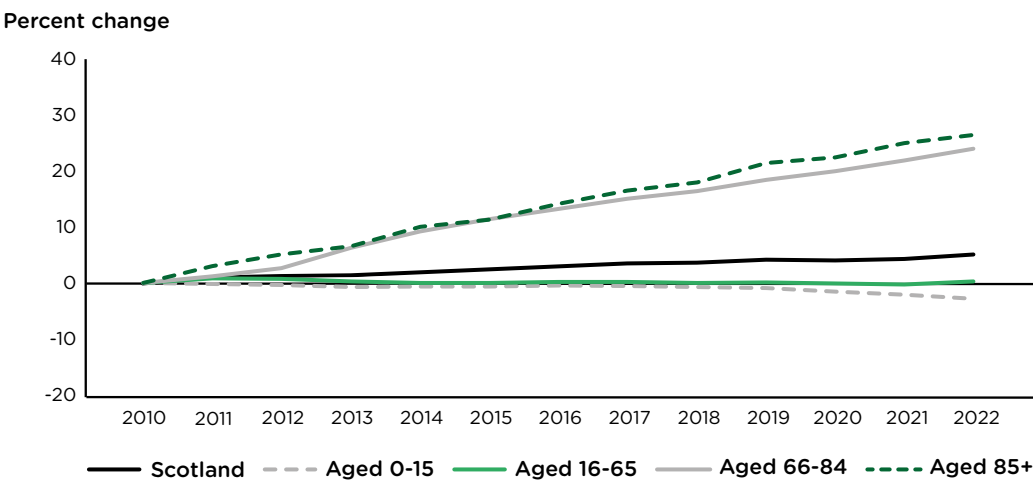
There are other ways of aggregating SIMD to higher geographies, and we will be investigating further whether the methodology for aggregating Data Zones can be improved.

DEMOGRAPHICS

The population of Scotland is approximately five and a half million and is increasing. This increase is mainly accounted for by people moving to Scotland both from other parts of the UK and from abroad, rather than natural change (i.e. not principally a result of reduced death rates or increasing fertility rates) [8].

The population is aging. The rapidly changing age structure impacts on many aspects of social and economic life in Scotland and has important implications for health, health inequalities and the social determinants of health. Figure 1 outlines changes in the age structure of the population since 2010 and while the overall population has grown by approximately 3 percent, the working age population has not increased, the proportion of children has decreased and the proportion of people over 66 and over 85 have increased by 22 and 26 percent respectively.

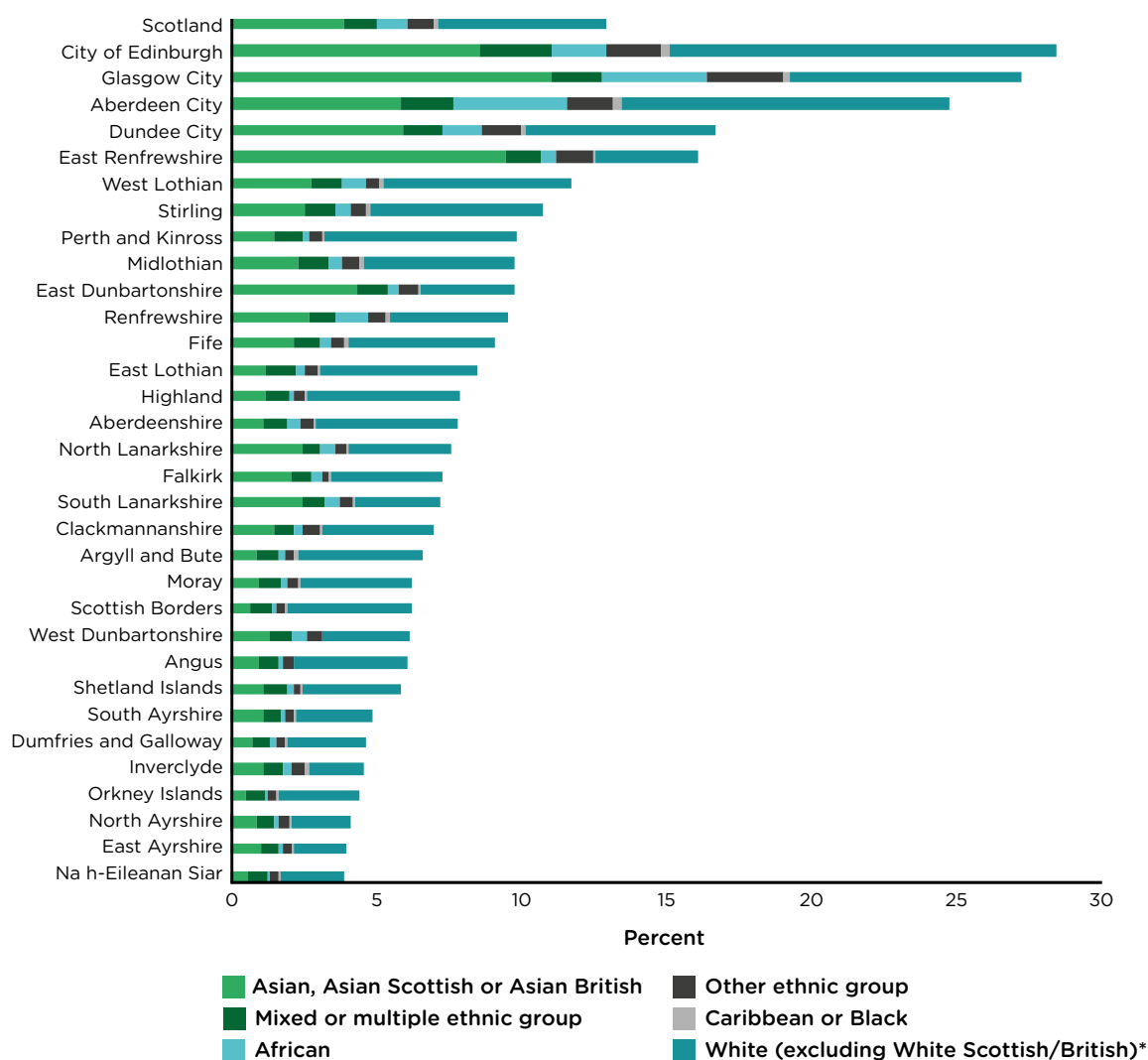
Figure 1: Percent change in the Scottish population by age group, 2010-2022



Source: National Records Scotland (2022) [8]

The Scottish population is nearly 78 percent White Scottish. Of those who are not White Scottish, the next largest group is White British, just over 9 percent. There are large differences in the ethnic composition of different Council areas in Scotland, with Glasgow City, City of Edinburgh and Aberdeen having the largest ethnic minority populations. Figure 2, sets out the major ethnic groups within Council areas, excluding people identifying as White Scottish and White British.

Figure 2: Percent of major ethnic groups excluding White Scottish/British, Scottish Council areas and Scotland, 2022



*White Irish, Gypsy/Traveller, White Polish, and Other White groups combined

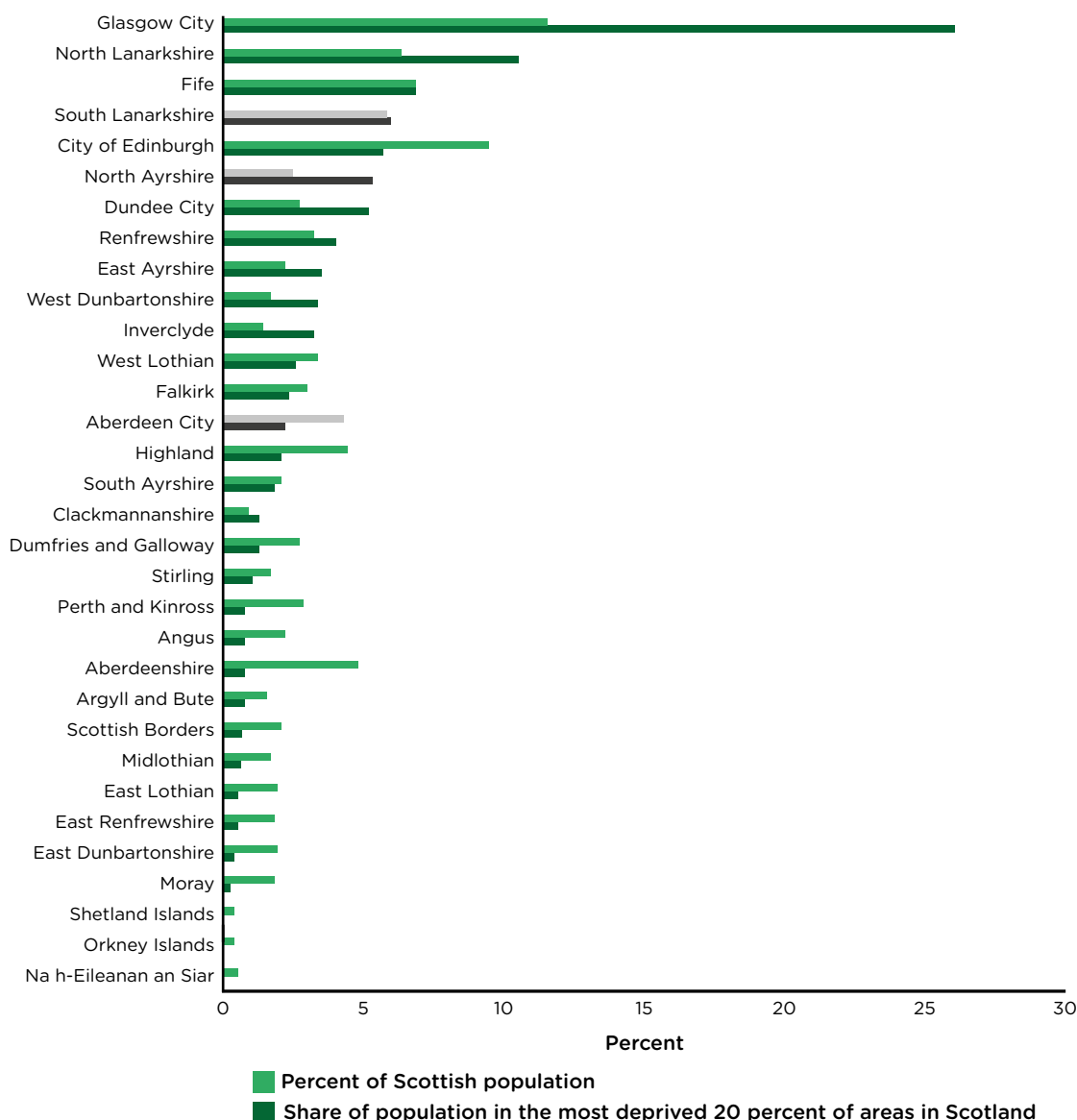
Source: Scotland Census (2022) [9]

Notes: Ordered by percent of group in Scotland.

Our main focus is on inequalities in health and how health relates to level of deprivation of an area and population characteristics, including gender, disability and ethnicity. An important first step in understanding socioeconomic inequalities in health is to establish the proportions of the population in local authority areas who are deprived. This analysis will support work on whether resources, policies and programmes are well allocated and designed to tackle the deprivation which drives poor health.

Social deprivation, as measured by SIMD, is unequally distributed across Scotland [7]. A consequence of this is that much of the population living in deprived areas (namely, the 20 percent of Data Zones with the highest level of deprivation) are concentrated in a relatively small number of Council areas. As Figure 3 shows, the four Council areas with the largest proportion of Scotland's population in deprived Data Zones contain 49 percent of the entire population in deprived areas but contribute only 30 percent of the total Scottish population. 11.45 percent of the Scottish population reside in Glasgow City, but the city has 26 percent of Scotland's most deprived quintile.

Figure 3: Distribution of (a) total Scottish population (b) population in the 20 percent of most deprived Data Zones in Scotland by Council area, ranked by share of deprived population, 2017

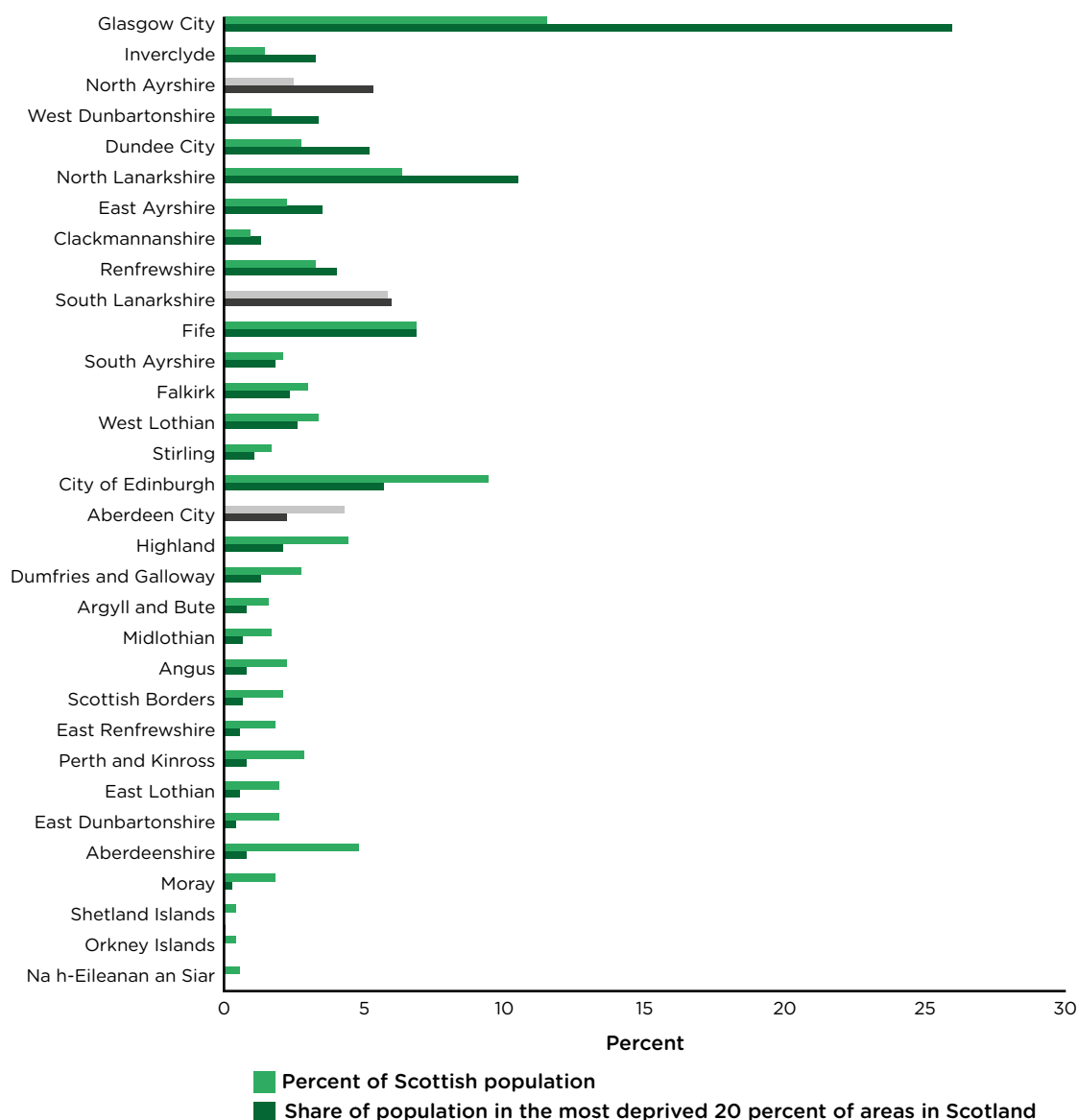


Source: Scottish Index of Multiple Deprivation Website (2020) [7]

Notes: (1) Deprivation is based on the share of national population in the 2020 SIMD quintiles, calculated from the 2017 populations used in SIMD
(2) Council areas are ranked by the percent of population they contribute to the 20 percent of most deprived areas in Scotland

An even more extreme picture is seen by considering the four Council areas with the greatest imbalance between deprivation and overall population - those in which the Council's contribution to Scotland's population in deprived Data Zones is more than twice their contribution to Scotland's overall population, see Figure 4. These four areas - Glasgow City, Inverclyde, North Ayrshire and West Dunbartonshire - alone contribute 38 per cent of the population in deprived Data Zones but only contain 17 per cent of Scotland's population. We note that the Data Zones within the main Islands do not have any of the 20 percent most deprived populations, although there are pockets of individual deprivation in these areas which are not picked up by the Intermediate Zones and therefore remain hidden in these area-based analyses.

Figure 4: Distribution of (a) total Scottish population (b) population in the 20 percent of most deprived Data Zones in Scotland by Council area, ranked by ratio of the share of deprived population to share of total population, 2017



Source: Scottish Index of Multiple Deprivation Website (2020) [7]

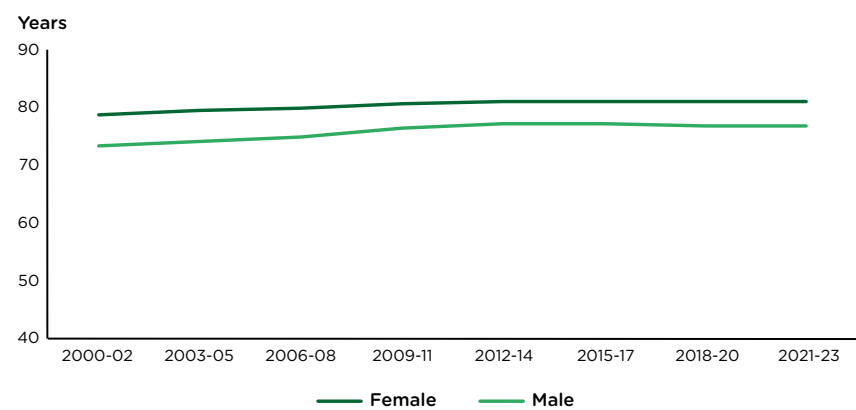
Notes: (1) Deprivation is based on the share of national population in the 2020 SIMD quintiles, calculated from the 2017 populations used in SIMD
 (2) Council areas are ranked by the ratio of percent of population they contribute to the 20 percent of most deprived areas in Scotland to the percent they contribute to the total population of Scotland

The data presented in Figures 3 and 4 have important implications for the discussion of health inequalities which follows.

LIFE EXPECTANCY

Life expectancy in Scotland has stagnated over the last decade and there has been almost no increase for either men or women since 2012-14. This was not a Covid effect as increases in life expectancy began to stall after 2011 – a likely effect of austerity, and deindustrialisation which will be explored further in subsequent analyses. The gap between female and male life expectancy in Scotland closed slightly between 2000-02 to 2012-14, from just under 6 years to 4 years. The gender gap has remained largely constant since 2012-14.

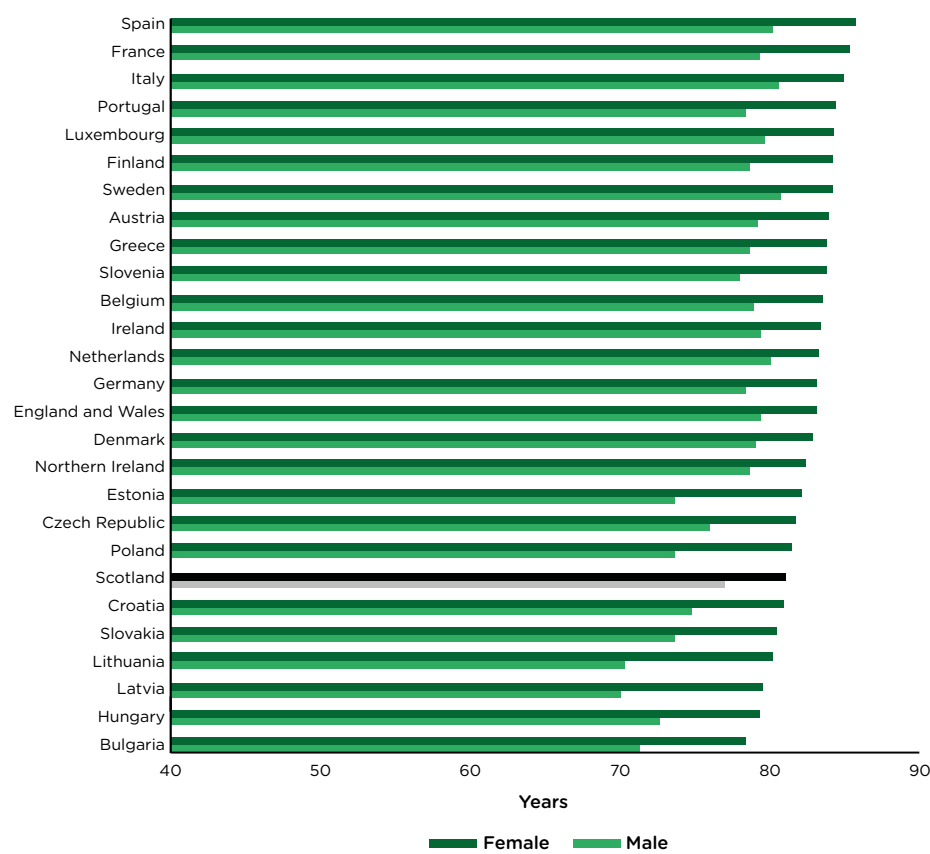
Figure 5: Estimated life expectancy, female and male, Scotland, 2000-02 to 2021-23



Source: National Records of Scotland (2024) [10]

Scotland had relatively low levels of life expectancy, particularly for women, compared with other European countries in 2015-19, see Figure 6.

Figure 6: Life expectancy at birth, male and female, years, EU27 countries*, Scotland, Northern Ireland, England and Wales, 2015-19

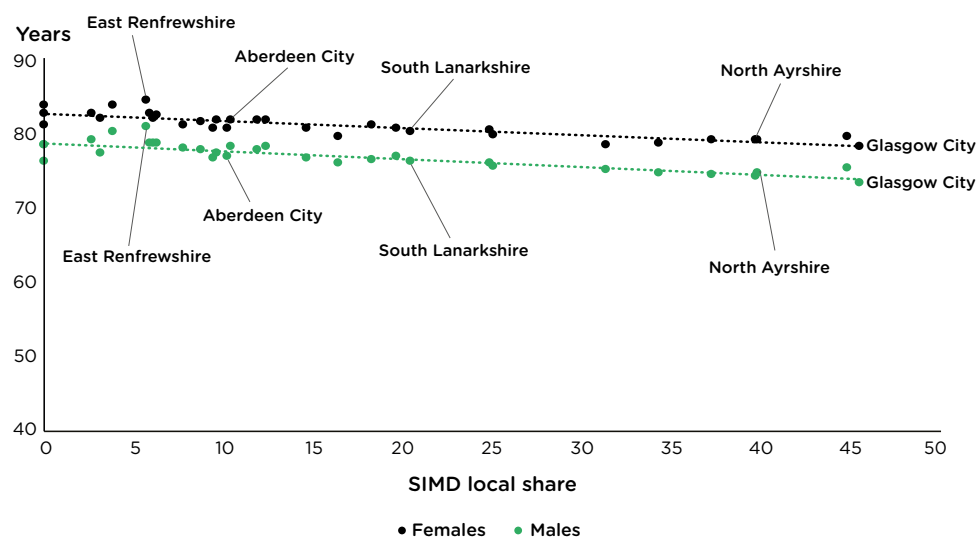


*No data available for Cyprus, Malta, or Romania.

Source: Human Mortality Database (2019) [11]

There is a clear gradient in life expectancy associated with the level of deprivation for Council areas in Scotland in 2021-23, as measured by the SIMD local share, see Figure 7. The gradient by deprivation accounts for nearly 73 percent of the differences in life expectancy by council for both men and women.

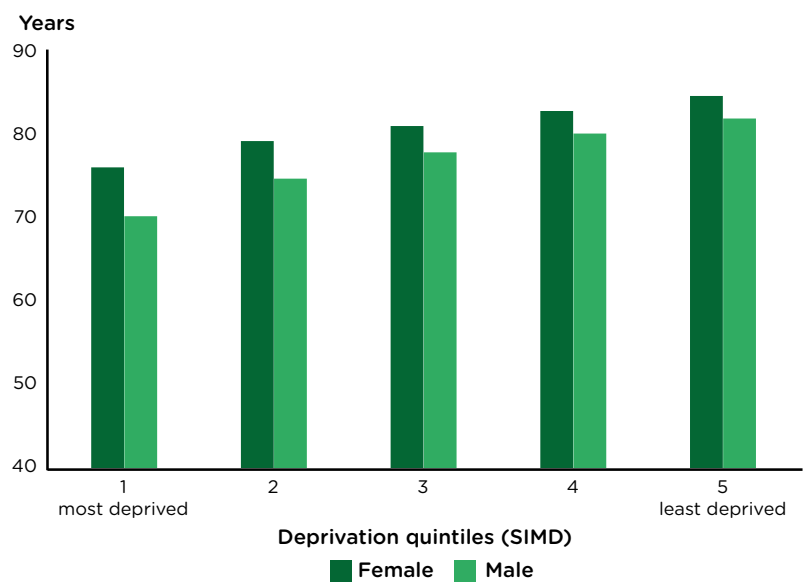
Figure 7: Life expectancy at birth by sex, and deprivation (SIMD local share), Scottish Council areas, 2021-23



Source: National Records of Scotland (2024) [10]
Note: SIMD local share is the percent of all Data Zones in the Council area that are among the 20 percent most deprived nationally.

Figure 8 shows life expectancy by level of deprivation across Scotland. For the 1.06 million people who live in the most deprived 20 percent of areas, life expectancy was 70.5 for men and 76 for women in 2017-21, compared to 82.1 and 85 in the least deprived areas – an 11.6 year gap for men and a 9 year gap for women. Notably the gender gap is wider in the most deprived quintile, 5.5 years, than in the least deprived, where men can expect to live 2.9 years less than women.

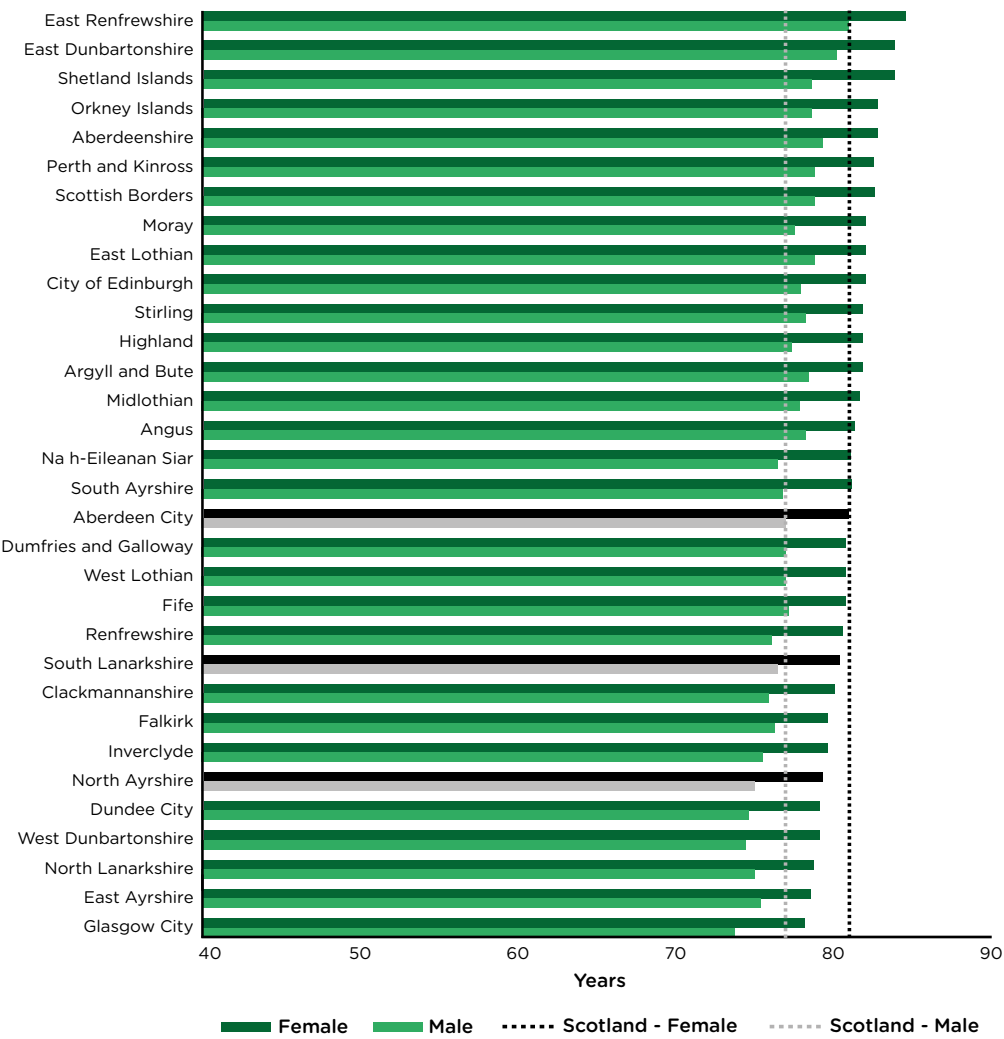
Figure 8: Life expectancy at birth, deprivation quintiles (SIMD), Scotland, 2017-21



Source: ScotPHO profiles, based on data from National Records of Scotland (2022) [12]

There are wide variations in life expectancy by Council area in Scotland, the highest for both men and women in East Renfrewshire, and the lowest for both men and women in neighbouring Glasgow City, which as noted above has the highest proportion of the population in the most deprived 20 percent in Scotland, see Figure 9.

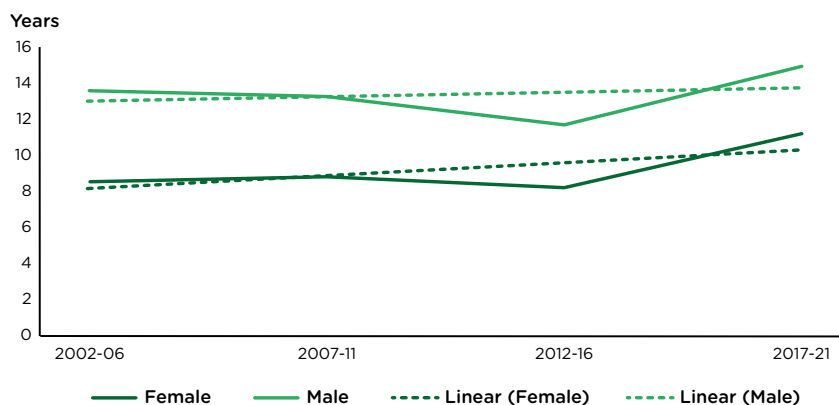
Figure 9: Life expectancy at birth by sex, Scottish Council areas and Scotland, 2021-23



Source: National Records of Scotland (2024) [10]

Looking only at differences in life expectancy between Council areas does not give an indication of inequalities between smaller areas, such as Data Zones across Scotland. The slope index of inequality (SII) in life expectancy, however, shows the gradient in inequality in life expectancy. Inequalities between these small areas (measured by the SII) had been decreasing in Scotland before 2012-16 prior to the effects of austerity programmes [6,13]. Rapid increases in inequality subsequently mean that between 2002-06 and 2017-21 there has been an overall increase in inequality in life expectancy from 8.3 to 11.1 years for women and 13.4 to 14.9 year difference among men, see Figure 10. While inequalities in life expectancy are particularly wide for men the inequalities among women increased slightly faster and may be related to additional burdens on women as a result of austerity.

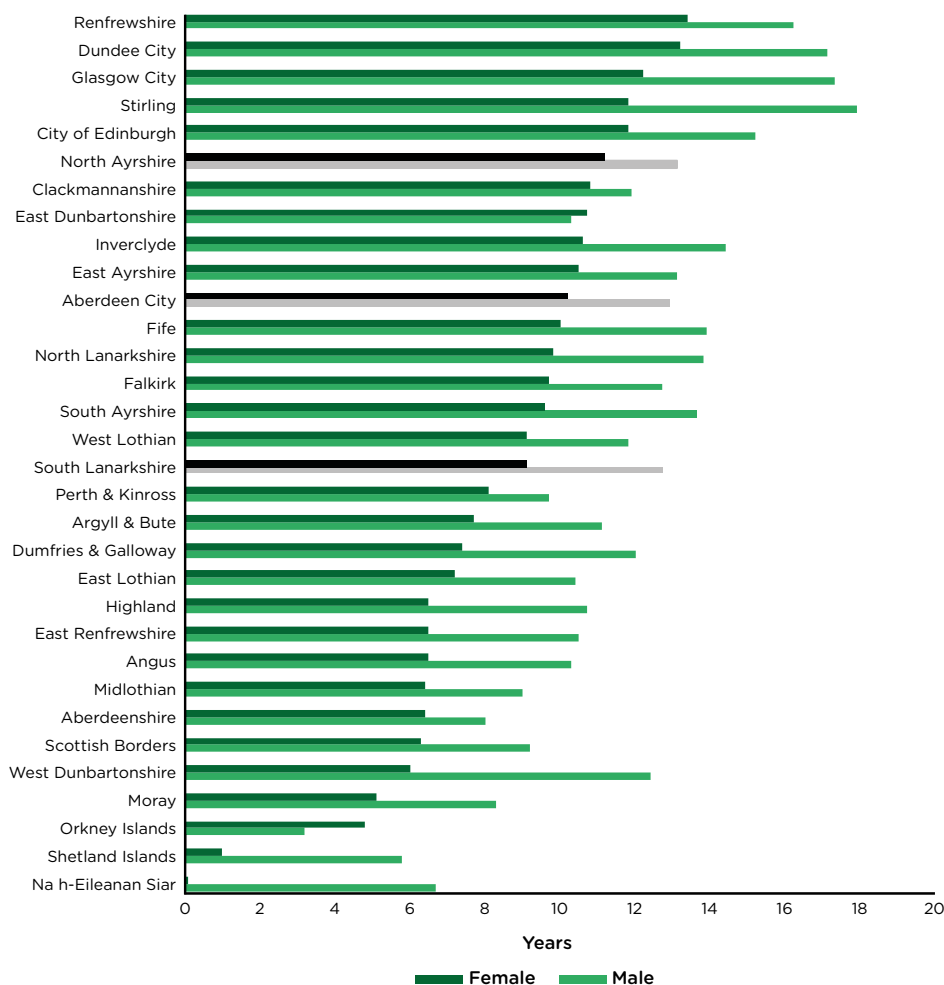
Figure 10: Inequality in life expectancy (SII), Scotland, 2002-06 to 2017-21



Source: ScotPHO profiles, based on data from National Records of Scotland (2022) [12]

The slope index of inequality can also be used to measure the gradient within Council areas. Renfrewshire had the largest within-area inequality in 2017-21 for females – a difference of 13.4 years, while Stirling has the highest level of inequality in life expectancy for males – 17.9 years. The Islands have the lowest within-area inequalities in life expectancy in Scotland for both men and women, although as noted, current Data Zone measures may be unable to pick up small area inequalities within Islands and in rural areas, see Figure 11.

Figure 11: Slope index of inequality in life expectancy (SII) by sex, Scottish Council areas, 2017-21



Source: ScotPHO profiles, based on data from National Records of Scotland (2022) [12]

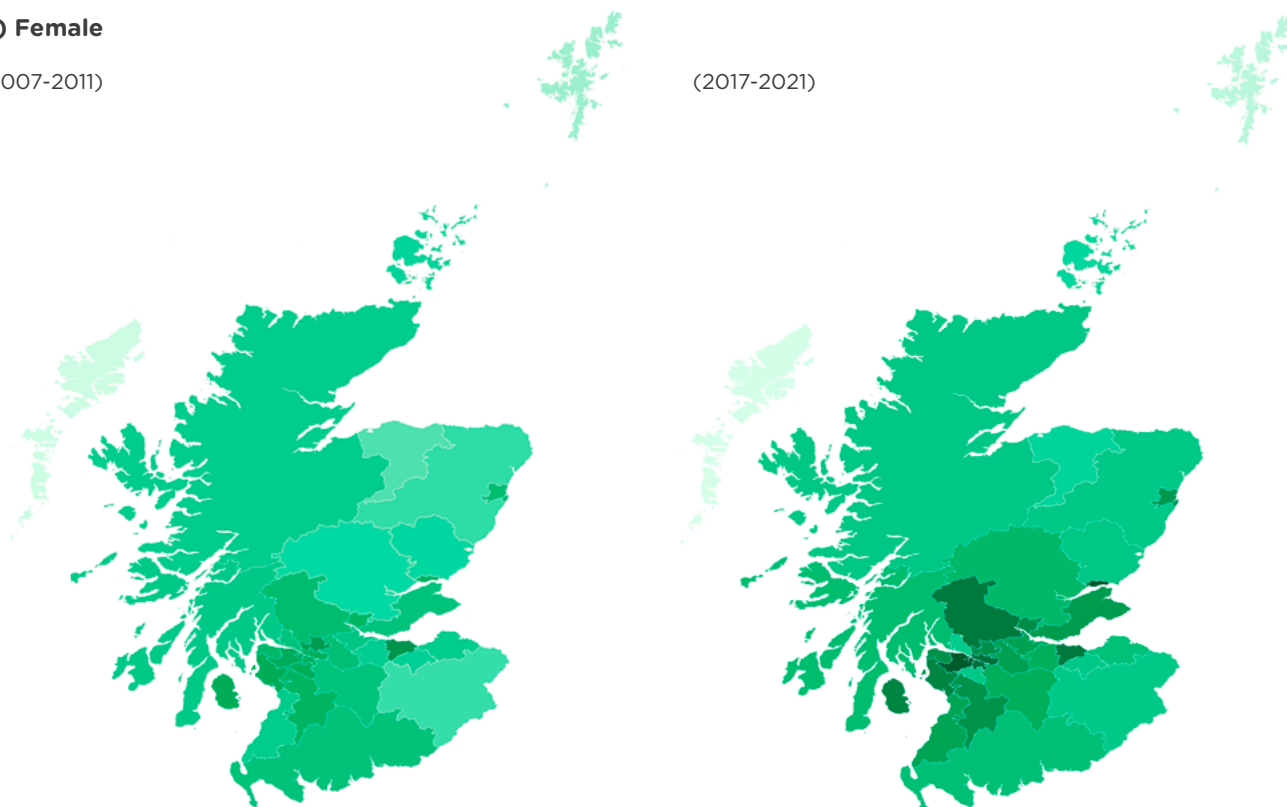
The maps in Figure 12 below clearly show the increasing life expectancy inequality gradient within places (Council areas) for both men and women since 2007-11.

Figure 12: Slope index of inequality in life expectancy (SII) by sex, Scottish Council areas, 2007-11 and 2017-21

A) Female

(2007-2011)

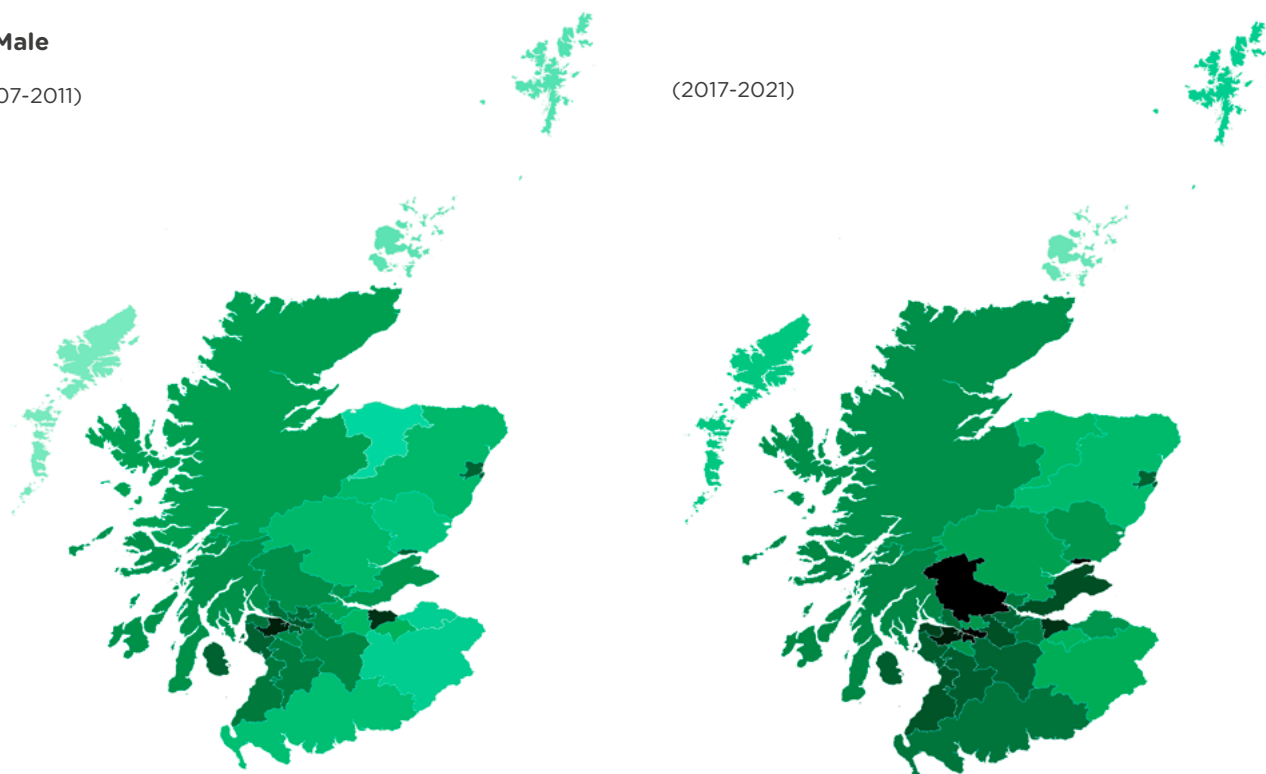
(2017-2021)



B) Male

(2007-2011)

(2017-2021)



YEARS



Created using Flourish

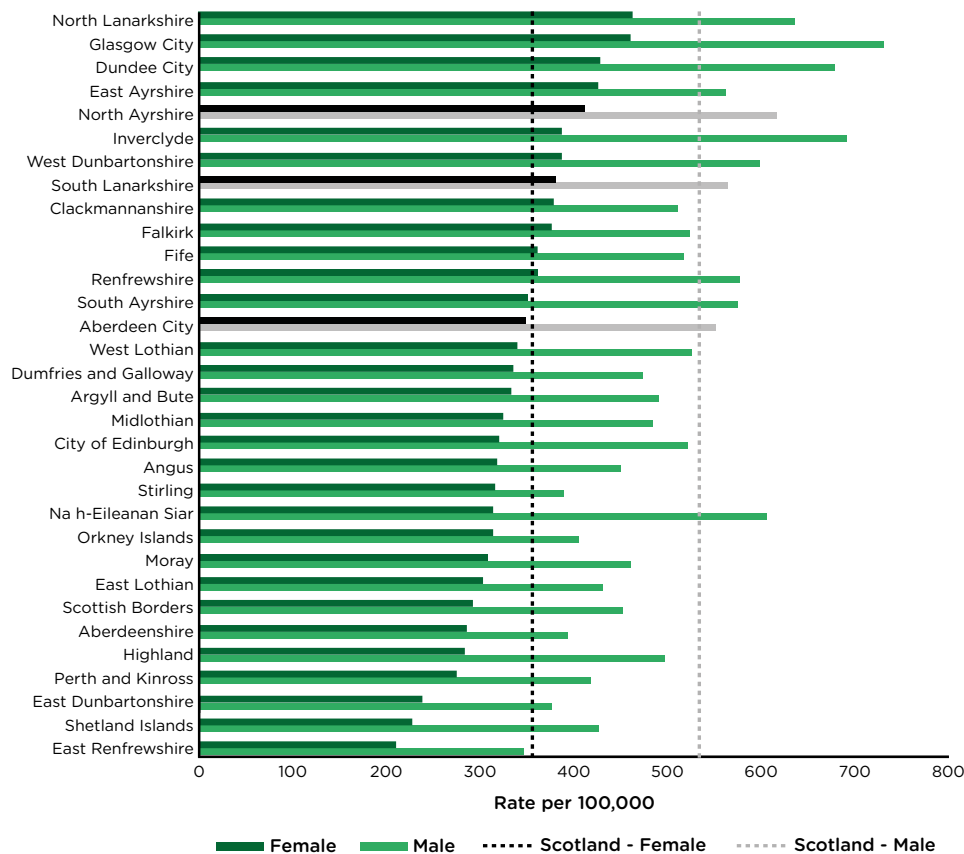
Source: ScotPHO profiles, based on data from National Records of Scotland (2022) [12]

Further in the report we explore inequalities in life expectancy and other health indicators within Aberdeen City, North Ayrshire and South Lanarkshire.

UNDER 75 MORTALITY

Males have high rates of mortality under 75, deaths which are often considered to be preventable. There are also wide differences in rates of mortality under 75 between Council areas; Glasgow City has the highest rates among men and North Lanarkshire the highest among women, see Figure 13.

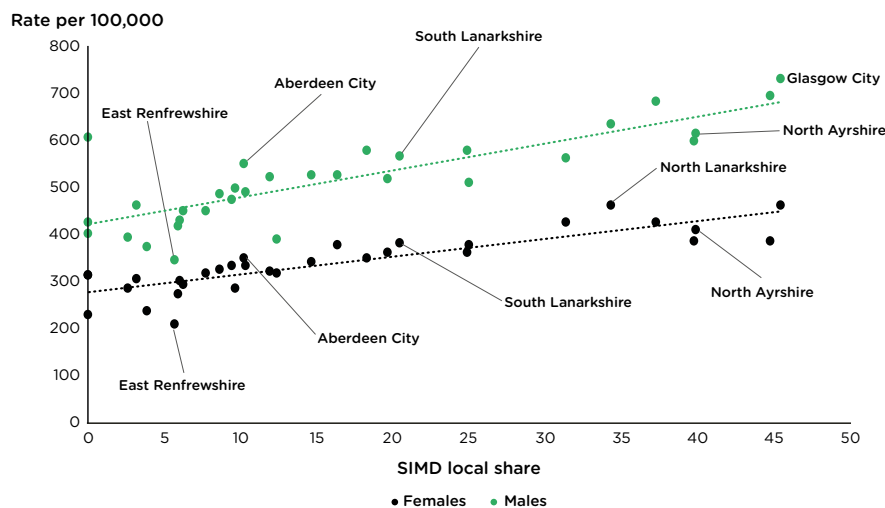
Figure 13: Age standardised rates of mortality under 75, by sex and per 100,000, Scottish Council areas and Scotland, 2023



Source: National Records of Scotland (2024) [10]

There are clear gradients in rates of under 75 mortality among Council areas, related to level of deprivation of the Council, with a steeper gradient among men than women, see Figure 14.

Figure 14: Deaths under 75, age standardised by sex, per 100,000, and deprivation (SIMD local share), Scottish Council areas and Scotland, 2023



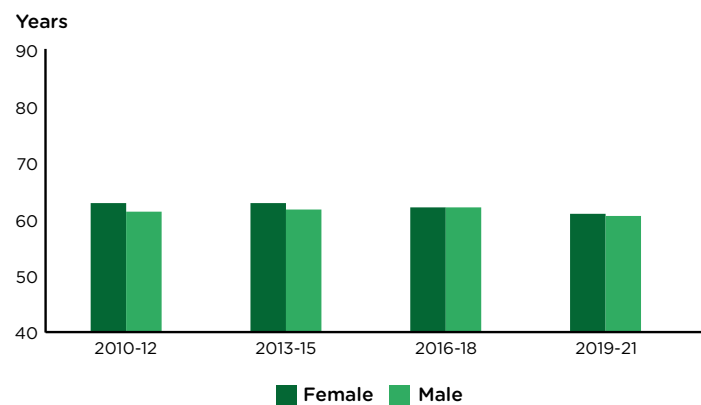
Source: Scottish Government Statistics (2023) [14]

Note: SIMD local share is the percent of all Data Zones in the Council area that are among the 20 percent most deprived nationally

HEALTHY LIFE EXPECTANCY

In 2019-21, healthy life expectancy, how long you can expect to live in good health in Scotland, was 61 years for women and 60 years for men. Healthy life expectancy in Scotland has deteriorated for both men and women since 2010-12, particularly for women. For men, healthy life expectancy did increase between 2010-12 and 2016-18 but has since fallen – the impacts of Covid need to be taken into account, see Figure 15. Notably the gender difference in healthy life expectancy has been closing and, as in most countries, is much less than the gender difference in life expectancy.

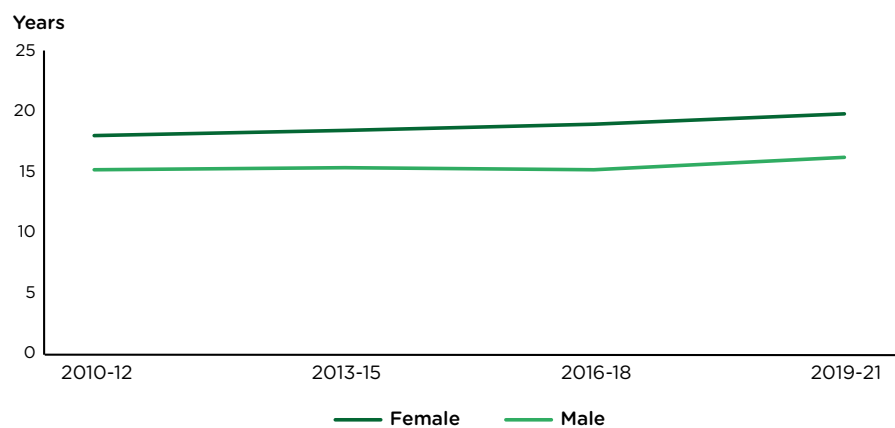
Figure 15: Estimated healthy life expectancy, female and male, years, Scotland, 2010-12 to 2019-21



Source: National Records of Scotland (2022) [15]

The differences between the gender gaps for life expectancy and healthy life expectancy can be summarised as: women tend to live longer than men but spend more time in ill health, this is shown in Figure 16. By 2019-21 women could expect to live nearly 20 years in poor health, men just over 16 years.

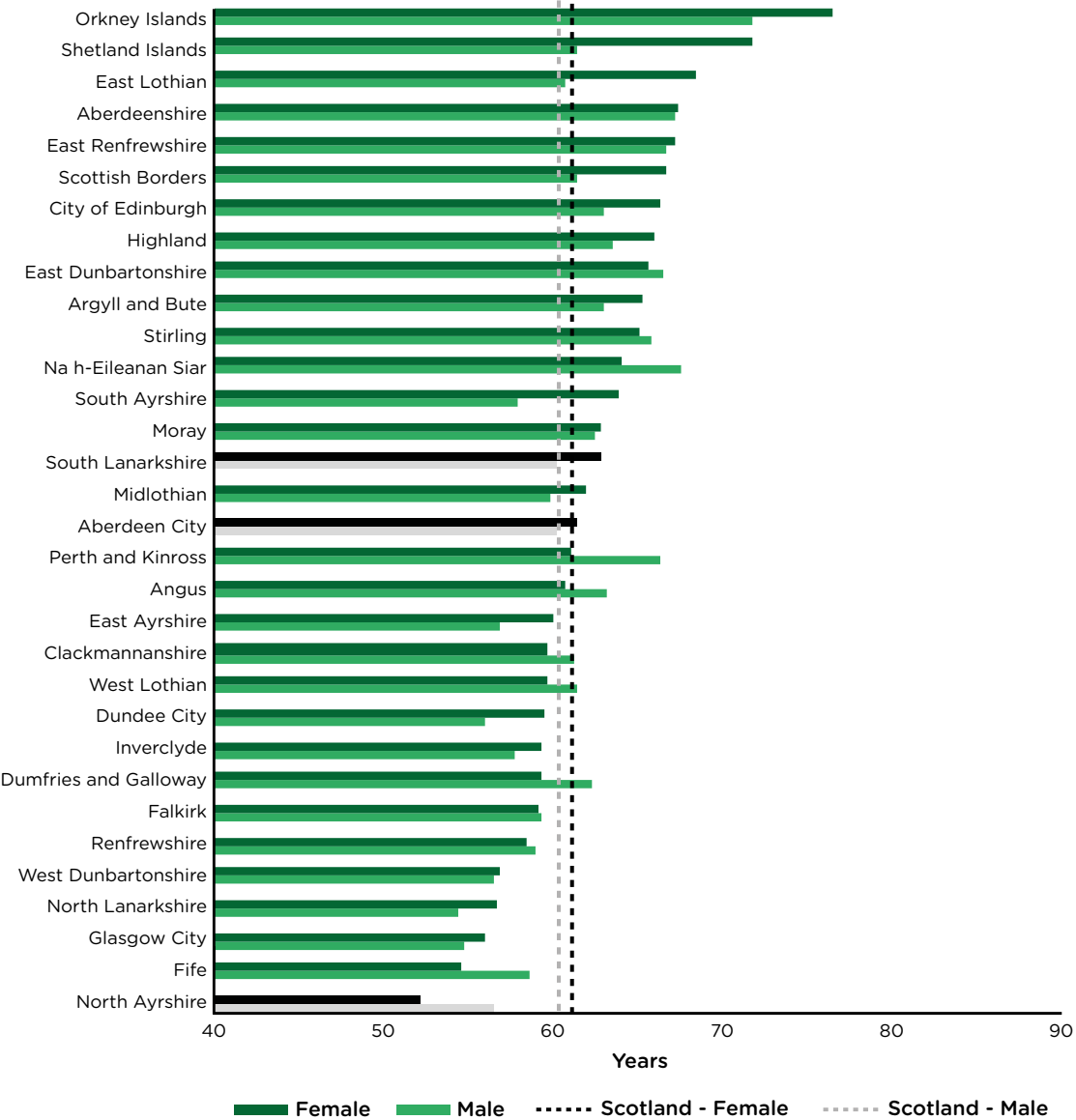
Figure 16: Estimated years spent in poor health, female and male, Scotland, 2010-12 to 2019-21



Source: Author's calculations using data from National Records of Scotland accessed via Scot PHO (2022) [15]

In the Orkney Islands men can expect to live in good health until around age 72, while in North Lanarkshire they can only expect to live in good health until aged 54. For women the lowest healthy life expectancy is 52 in North Ayrshire compared with 76 years in the Orkney Islands, see Figure 17.

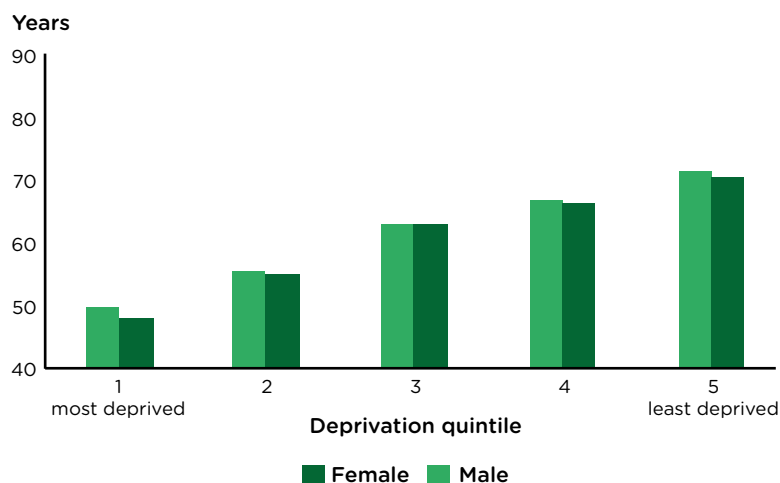
Figure 17. Healthy life expectancy at birth by sex, Scottish Council areas and Scotland, 2019-21



Source: National Records of Scotland (2022) [15]

Looking at healthy life expectancy by levels of deprivation across Scotland shows a particularly stark picture with low healthy life expectancy for much of the population. In 2019-21 the 20 percent (quintile) of the population in the most deprived small areas, nearly 1.06 million, had a healthy life expectancy below 50 years – 49.6 years for women and 47.7 years for men, a 20 year difference compared with the over 1.12 million people in the least deprived areas, see Figure 18. The gender gap is wider among those living in the most deprived 20 percent.

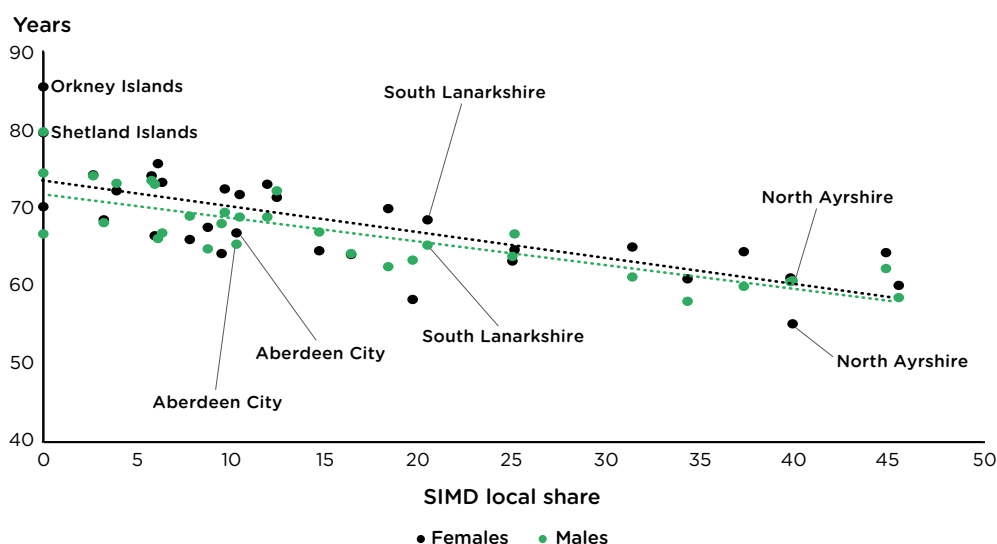
Figure 18. Healthy life expectancy at birth, by sex and deprivation quintile, years, Scotland, 2019-21



Source: ScotPHO profiles, based on data from National Records of Scotland (2022) [12]

As with life expectancy there is a clear association between healthy life expectancy and average level of deprivation of Council areas in Scotland in 2019-20, see Figure 19.

Figure 19: Healthy life expectancy at birth, by sex and deprivation (SIMD local share), Scottish Council areas, 2019-21



Source: National Records of Scotland (2022) [15]

Note: SIMD local share is the percent of all Data Zones in the Council area that are among the 20 percent most deprived nationally

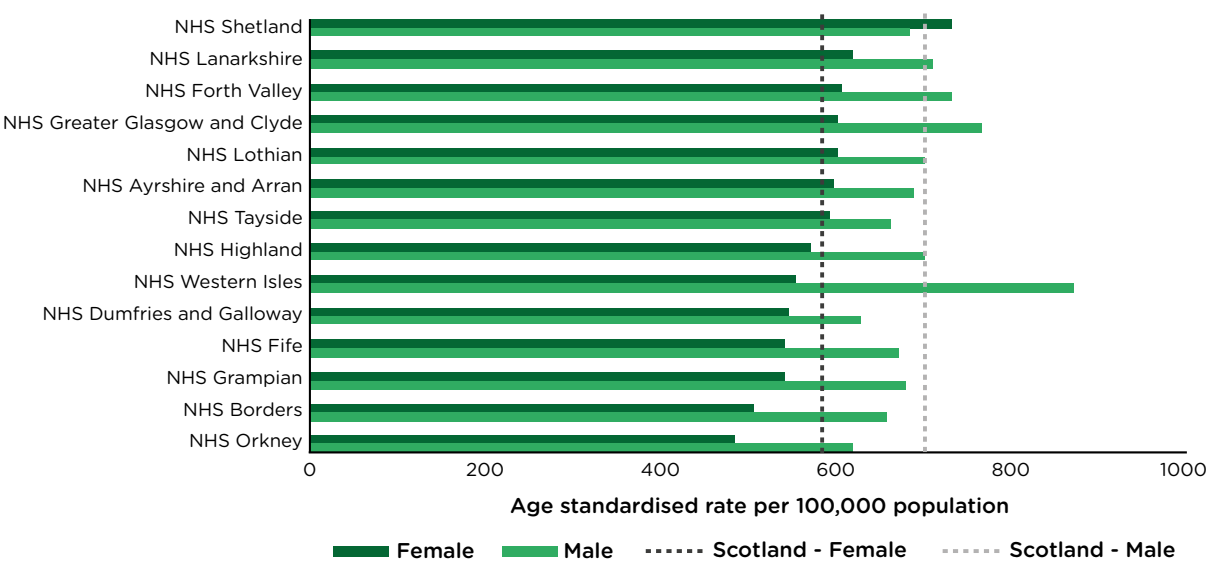
MAJOR DISEASES

Here we overview major diseases by Council area and level of deprivation and sex. The data is based on recording within the health system, and there may well be cases which are not recorded or are only recorded at a late stage (thereby distorting the age of occurrence). For these reasons, the figures do not necessarily represent an accurate picture of prevalence or incidence. This caveat notwithstanding, there are socioeconomic inequalities seen across the available proxy measures of incidence and prevalence of many of the major diseases in Scotland.

CANCER

Data for cancer registration rates are available by health board area in Scotland. Overall rates are higher for men than women, with the highest rates for men in the area covered by the NHS Western Isles and the highest rates for women in the area covered by NHS Shetland, see Figure 20. Lowest rates for females and males are in NHS Orkney. It is important to recognise, as highlighted earlier, that registration rates may not reflect prevalence.

Figure 20: Age standardised cancer registration rates per 100,000 by sex, Scottish Health Boards and Scotland, 2022

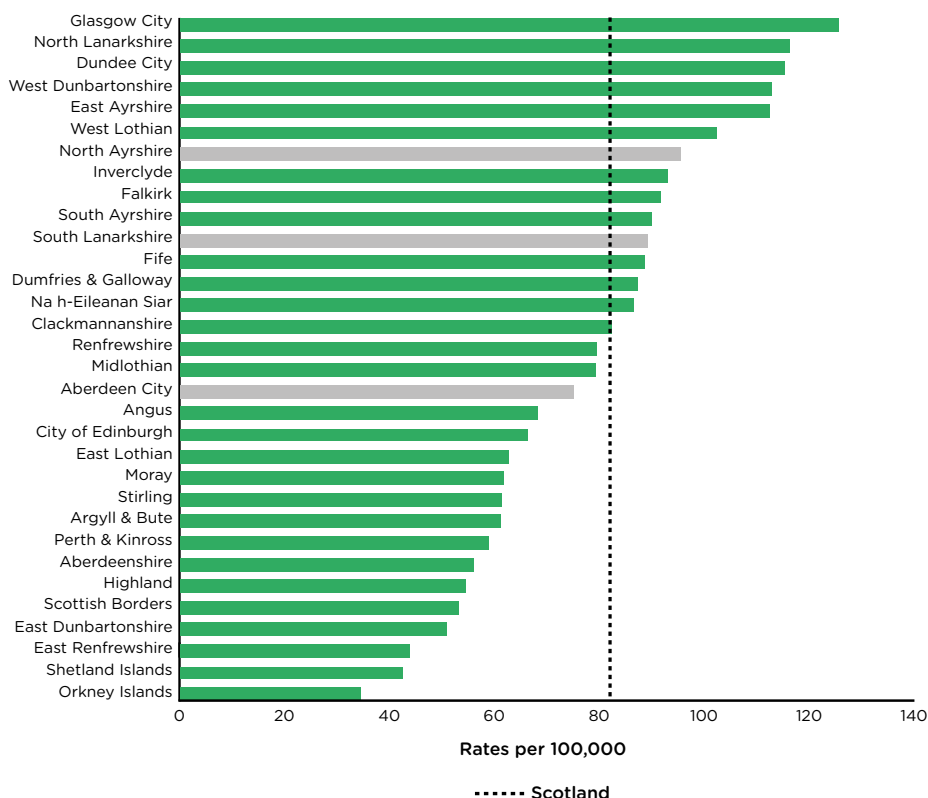


Source: Public Health Scotland (2022) [16]

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

The incidence of chronic obstructive pulmonary disease (COPD) differs markedly by Council area in Scotland, see Figure 21. Glasgow City has the highest rate and the Orkney Islands the lowest. COPD is closely related to lifetime smoking, which as highlighted in Figure 36, is currently higher in more deprived areas, although rates have declined over time.

Figure 21: Age-sex standardised rate of chronic obstructive pulmonary disease (COPD) incidence¹, per 100,000 population, Scottish Council areas and Scotland, financial years 2020/21-2022/23

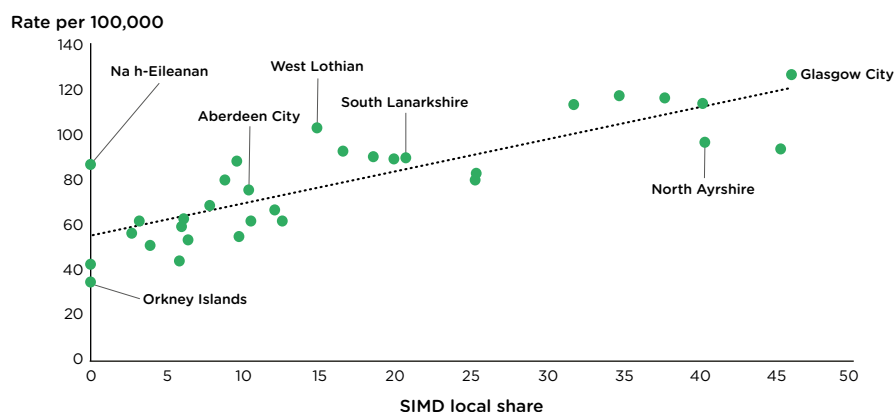


Source: ScotPHO profiles, based on data from Public Health Scotland (2024) [17]

Note: ¹ This is a proxy measure of incidence: the number of patients discharged from hospital with COPD recorded in the 6 diagnosis fields during that hospital stay, who had not had a COPD hospital stay in the 5 years prior to the stay of interest. Patient is selected only once per year, based on their first COPD-related admission to hospital that year. Patient's demographic data (age, gender, location of residence) are extracted from the first valid information within that stay

There is a close association between COPD incidence and level of deprivation of Council areas in Scotland and particularly steep inequalities, see Figure 22.

Figure 22: Age-sex standardised rate of chronic obstructive pulmonary disease incidence¹, per 100,000 population, Scottish Council areas and deprivation (SIMD local share)² financial years 2020/21-2022/23



Source: ScotPHO profiles, based on data from Public Health Scotland (2024) [17]

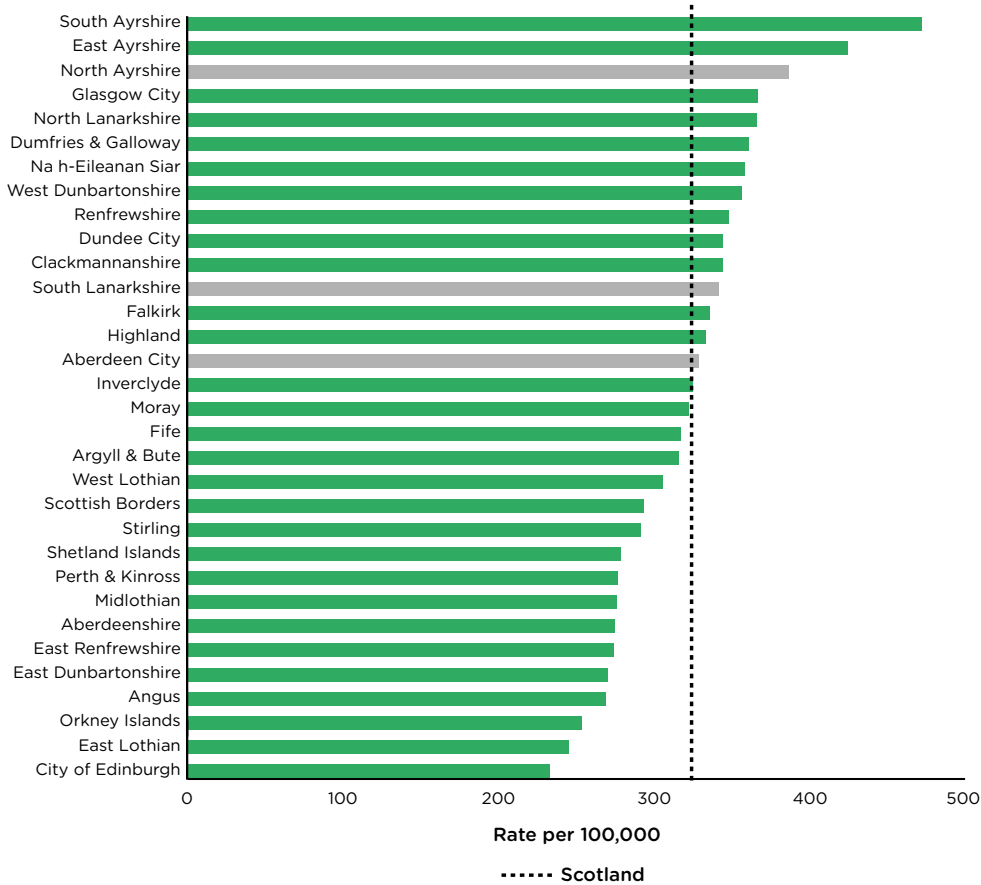
Notes: ¹ This is a proxy measure of incidence: the number of patients discharged from hospital with COPD recorded in the 6 diagnosis fields during that hospital stay, who had not had a COPD hospital stay in the 5 years prior to the stay of interest. Patient is selected only once per year, based on their first COPD related admission to hospital that year. Patient's demographic data (age, gender, location of residence) are extracted from the first valid information within that stay.

² SIMD local share is the percent of all Data Zones in the Council area that are among the 20 percent most deprived nationally

CORONARY HEART DISEASE

There are wide differences in rates of coronary heart disease (CHD) hospitalisation between Council areas in Scotland with the Ayrshires having the highest rates and the City of Edinburgh the lowest. South Ayrshire has particularly high rates, well above the Scottish average, see Figure 23.

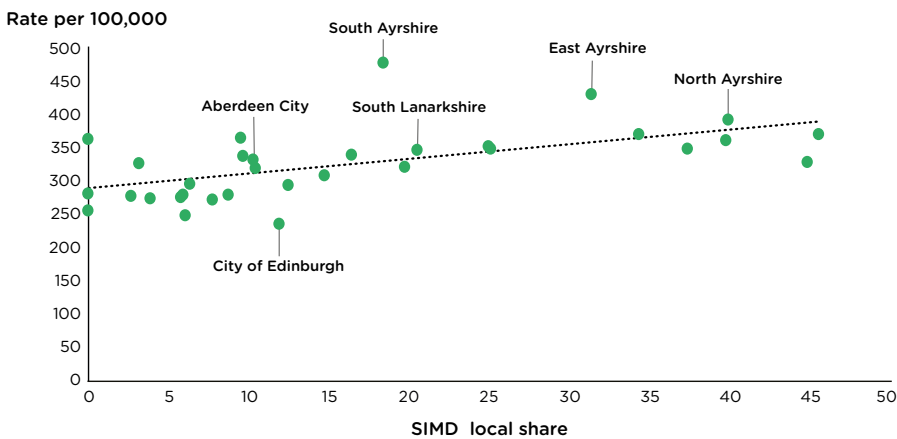
Figure 23: Age-sex standardised rate of coronary heart disease hospitalisations, per 100,000 population, Scottish Council areas and Scotland, financial years 2020/21-2022/23



Source: ScotPHO profiles, based on data from Public Health Scotland (2024) [17]

There is a close association between hospitalisation for CHD and Council deprivation area in Scotland, there are some exceptions, including South and East Ayrshire which have higher rates than expected for their level of deprivation, see Figure 24.

Figure 24: Age-sex standardised rate of coronary heart disease patient hospitalisations, per 100,000 population, by area deprivation (SIMD local share), Scottish Council areas, 2020/21-2022/23 financial years



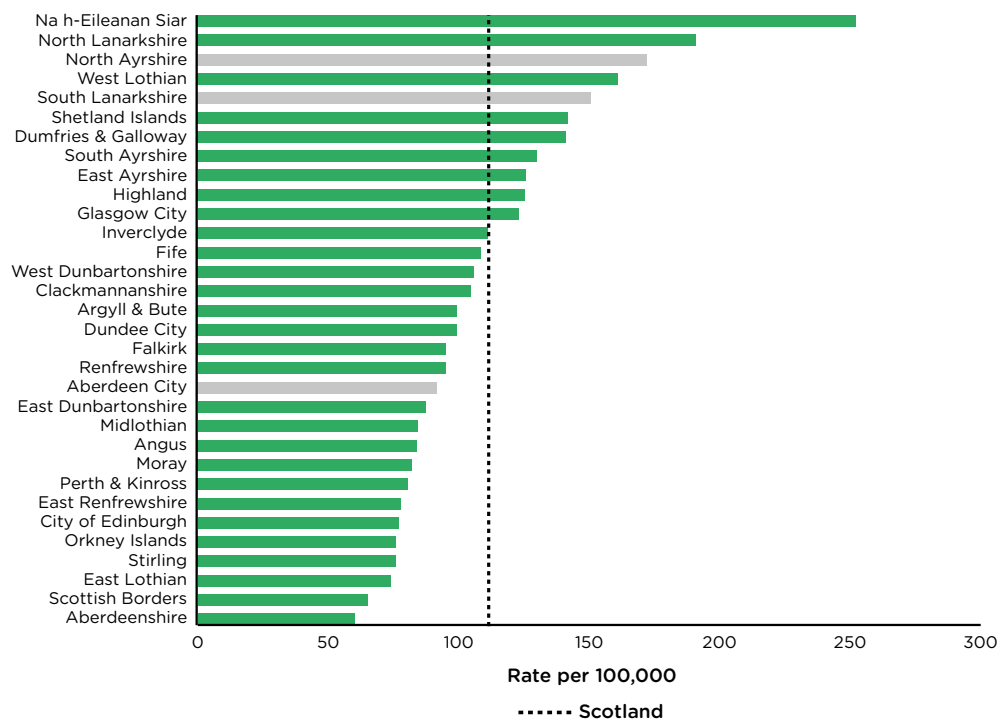
Source: ScotPHO profiles, based on data from Public Health Scotland (2024) [17]

Note: SIMD local share is the percent of all Data Zones in the Council area that are among the 20 percent most deprived nationally

ASTHMA

Prevalence of asthma relates to levels of air pollution and to housing quality, clearly both are modifiable through policies and programmes which will be explored further in subsequent reports [18]. For young children across Scotland there are large differences in rates of hospitalisation due to asthma by Council area, see Figure 25.

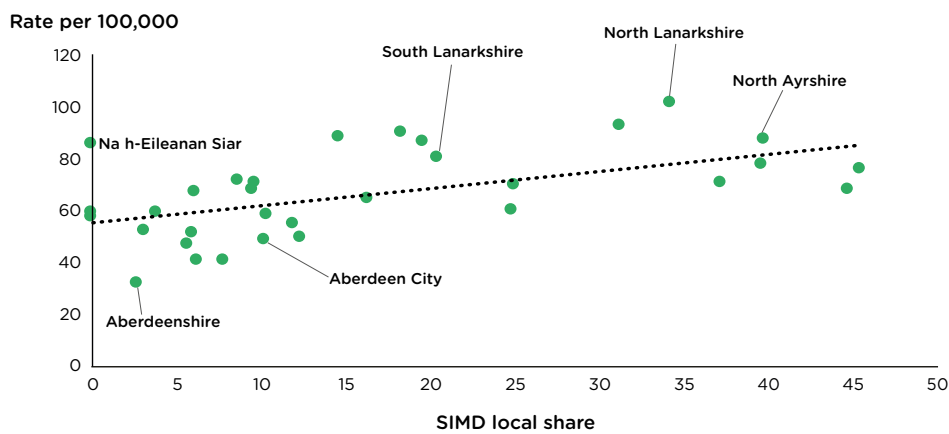
Figure 25: Age-sex standardised rate of hospitalisation due to asthma per 100,000 children aged under 16 years, Scottish Council areas and Scotland, financial years 2019/20-2021/22



Source: ScotPHO profiles, based on data from Public Health Scotland (2024) [17]

There is an association between deprivation and rates of asthma patient hospitalisation (among all age groups), with higher rates tending to be in more deprived areas, although there is quite wide variation.

Figure 26: Asthma patient hospitalisations, age-sex standardised rate per 100,000, and deprivation (SIMD local share), Scottish Council areas, 2019/20-2021/22 financial years



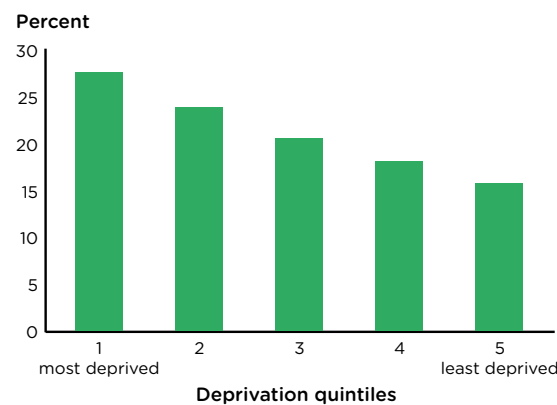
Source: ScotPHO profiles, based on data from Public Health Scotland (2024) [17]

Note: SIMD local share is the percent of all Data Zones in the Council area that are among the 20 percent most deprived nationally

MENTAL HEALTH

Across Scotland there are differences in prescription of drugs for common and severe mental illness; the most deprived 20 percent having higher rates (nearly double) that of the least deprived 20 percent, Figure 27. This reflects the mental health impacts associated with living in more deprived areas, having lower incomes and living in poverty; to be overviewed further in subsequent reports. The prescription rates may also reflect differences in health care access and practice between areas in Scotland.

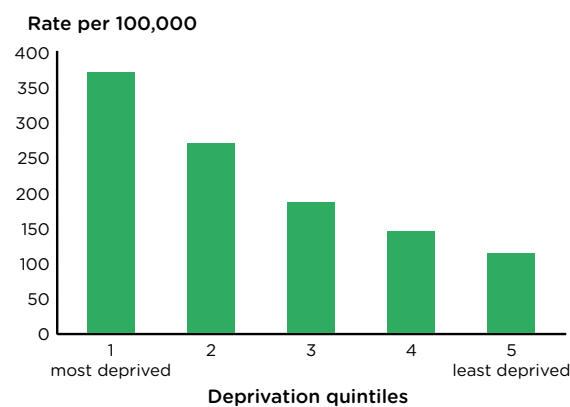
Figure 27: Population prescribed drugs for anxiety/ depression/ psychosis, by deprivation quintile, percent, Scotland, 2023/24 financial year



Source: ScotPHO profiles, based on data from Public Health Scotland (2024) [17]

There are also higher rates of hospitalisation for psychiatric disorders related to level of deprivation in Scotland, with people in the most deprived 20 percent of Data Zone areas having hospitalisation rates nearly three times that of the least deprived 20 percent of Data Zone areas, see Figure 28.

Figure 28: Psychiatric patient hospitalisations, by deprivation quintile, age-sex standardised rate per 100,000, Scotland, 2021/22-2023/24 financial years



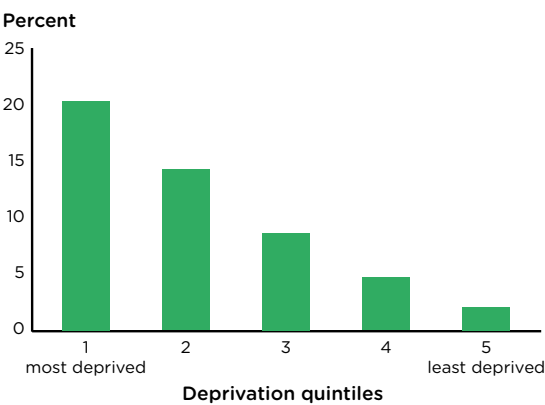
Source: ScotPHO profiles, based on data from Public Health Scotland (2024) [17]

There are wide differences between Councils in deaths from suicide in Scotland, with the highest rates in the Orkney Islands for both young adults and adults [19]. There is not a particularly close association between deaths from suicide and level of deprivation of Council areas.

INFANT HEALTH

While smoking rates have declined in Scotland overall, there are clear differences in rates of women smoking during pregnancy by level of deprivation across Scotland. Smoking during pregnancy has impacts on the health of infants and long term health impacts for mother and child. Those in the most deprived 20 percent of areas are nearly ten times more likely to smoke during pregnancy than those in the least deprived quintile in Scotland, see Figure 29.

Figure 29: Women smoking during pregnancy, by deprivation quintile, Scotland, 2021-23 calendar years

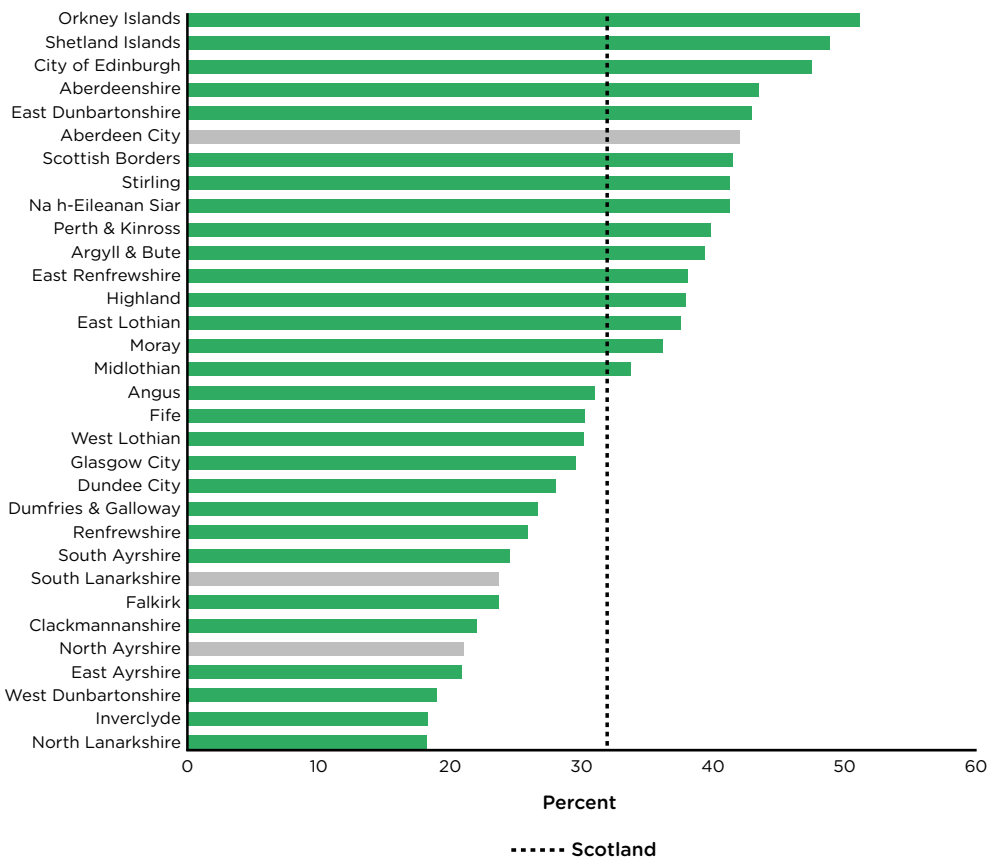


Source: ScotPHO profiles, based on data from Public Health Scotland (2023) [19]

BREASTFEEDING

Breastfeeding for at least 6-8 weeks is associated with a range of health benefits for the infant and longer term health of the baby. There are large differences in breastfeeding rates between Councils and in North Lanarkshire and Inverclyde only around 18 percent of babies are exclusively breast fed for the first 6-8 weeks, compared with more than half in the Orkney Islands, see Figure 30.

Figure 30: Percent of babies exclusively breastfed at 6-8 weeks, Scottish Council areas and Scotland, financial years 2020/21-2022/23



Source: ScotPHO profiles, based on data from Child Health Systems Programme Pre-school (CHSP-PS) (2024) [17]

There is a clear relationship between level of deprivation of Council areas and breastfeeding rates, set out in Figure 31.

Figure 31: Babies exclusively breastfed at 6-8 weeks, percent, and deprivation (SIMD local share), Scottish Council areas, 2020/21-2022/23 financial years



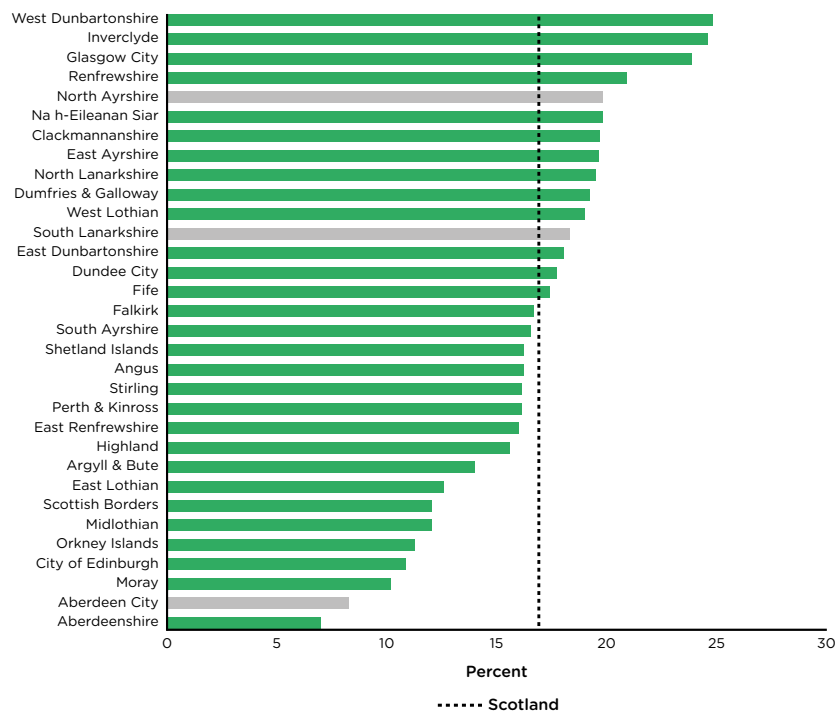
Source: ScotPHO profiles, based on data from Child Health Systems Programme Pre-school (CHSP-PS) (2024) [17]
Note: SIMD local share is the percent of all Data Zones in the Council area that are among the 20 percent most deprived nationally

DEVELOPMENTAL CONCERNS

Good development among young children is an important bedrock for future health and positive outcomes throughout life. Inequalities in development can, without intervention, lead to significant inequalities in health and the social determinants of health. The 27-30 month review, introduced in 2013, is a universal assessment offered to every child reaching the appropriate age in Scotland. The Review captures the outcome of developmental assessment in the following 9 domains: social; emotional; behavioural; attention; speech language & communication; gross motor; fine motor; vision and hearing. The analysis looks at the responses for all 9 domains to establish the presence of one (or more) concerns. All percentages are based on the total number of reviews provided.

In West Dunbartonshire, Inverclyde and Glasgow City nearly a quarter of all young children (aged 27-30) months were identified as having developmental concerns in 2020/21 and 2022/23, see Figure 32.

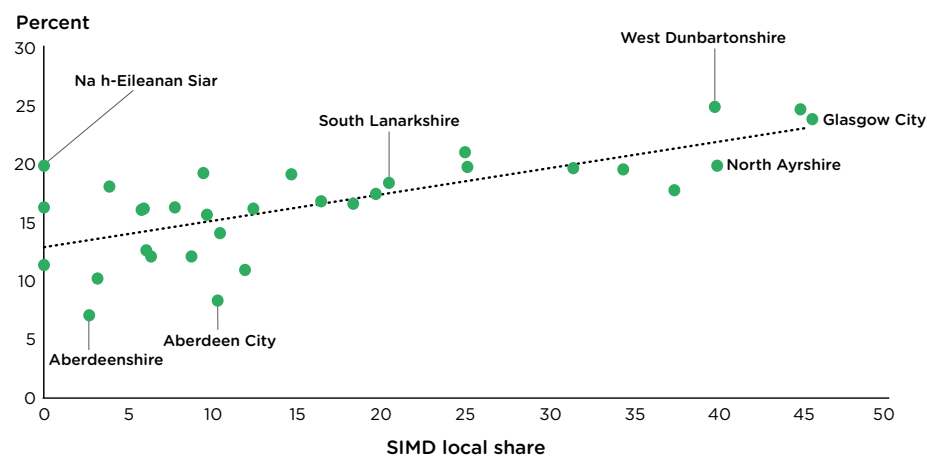
Figure 32: Developmental concerns at 27-30 months, percent, Scottish Council areas and Scotland, 2020/21-2022/23 financial years



Source: ScotPHO profiles, based on data from Public Health Scotland (2024) [17]
Notes: 1. Figures for Orkney Islands, Moray, Aberdeen City and Aberdeenshire may be biased due to under-reporting in 2022/23 [20]
Note: The 27-30 month review is a universal assessment offered to every child reaching the appropriate age. It was introduced in Scotland in April 2013. The 27-30 month review records capture the outcome of developmental assessment for the following 9 domains: social; emotional; behavioural; attention; speech language & communication; gross motor; fine motor; vision and hearing. The analysis looks at the responses for all 9 domains to establish the presence of one (or more) concern. All percentages are based on the total number of reviews provided.

Figure 33 shows the relationship between developmental concerns at ages 27-30 months and Councils' level of deprivation. There is a relatively close association although with some notable outliers (high rates in Na h-Eileanan Siar and low rates in Aberdeenshire). In subsequent sections we explore the inequalities within the three areas.

Figure 33: Developmental concerns at 27-30 months¹, percent, and deprivation (SIMD local share²), Scottish Council areas, 2020/21-2022/23 financial years



Source: ScotPHO profiles, based on data from Public Health Scotland (2024) [17]

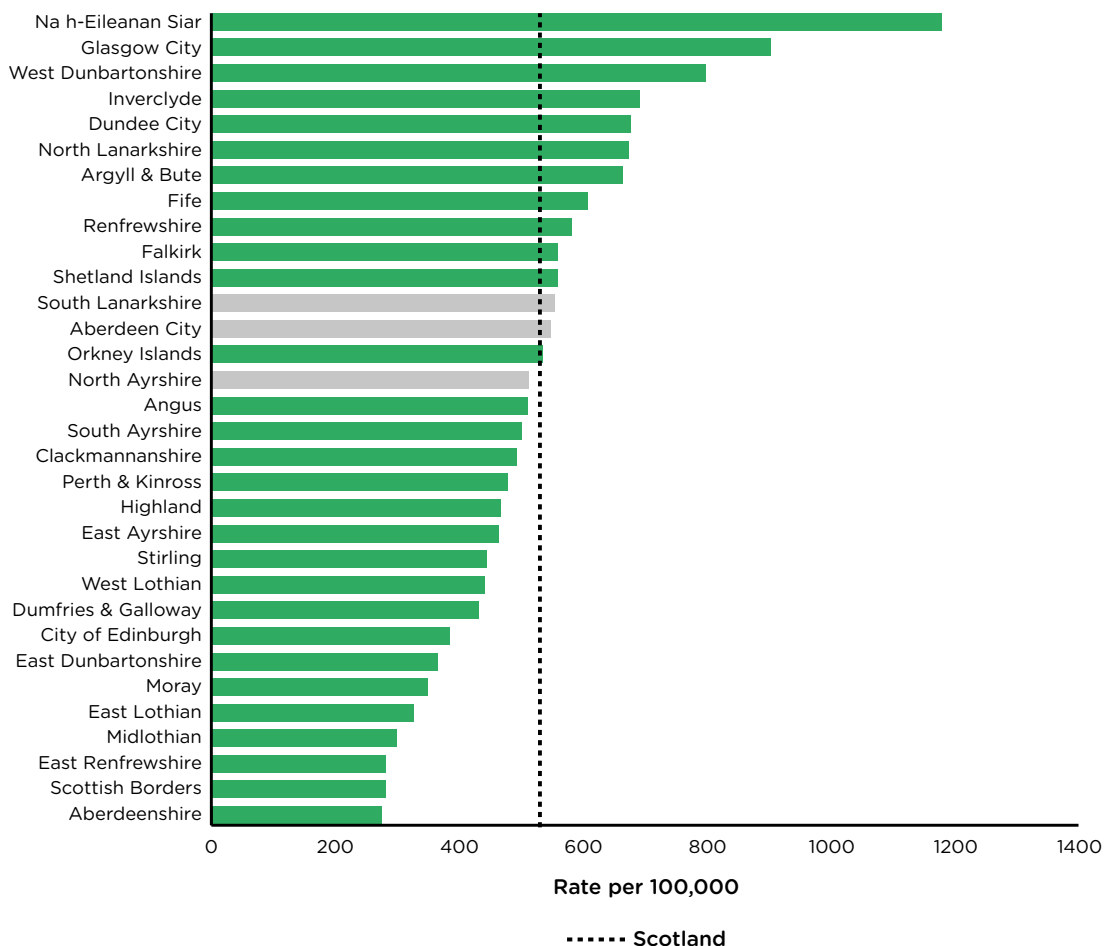
Note: ¹The 27-30 month review is a universal assessment offered to every child reaching the appropriate age. It was introduced in Scotland in April 2013. The 27-30 month review records capture the outcome of developmental assessment for the following 9 domains: social; emotional; behavioural; attention; speech language & communication; gross motor; fine motor; vision and hearing. The analysis looks at the responses for all 9 domains to establish the presence of one (or more) concern. All percentages are based on the total number of reviews provided.

²SIMD local share is the percent of all Data Zones in the Council area that are among the 20 percent most deprived nationally

ALCOHOL

Across Scotland, on average there are relatively high rates of hospital admissions for alcohol related ill health – an average of 532 admissions per 100,000 people annually. There are wide differences, however, between Councils with Na h-Eileanan Siar having a rate of 1,175 per 100,000 population compared with 273 in Aberdeenshire, see Figure 34.

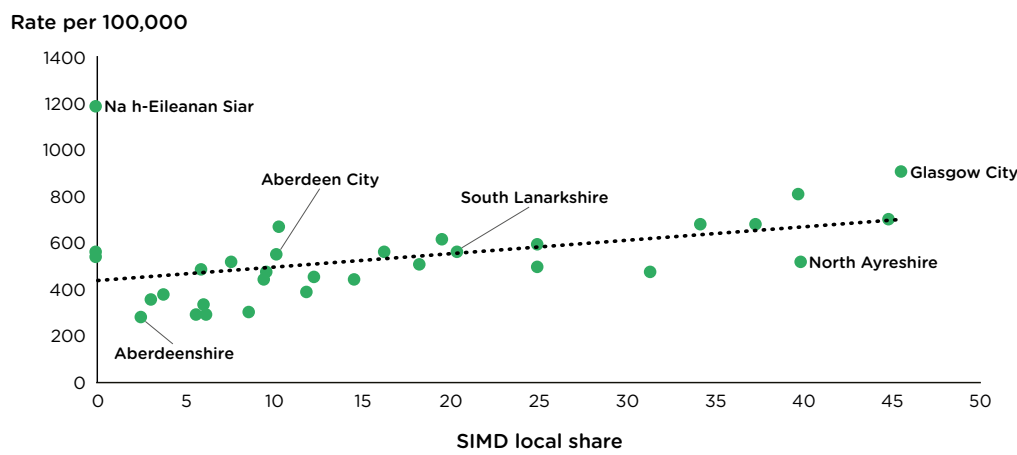
Figure 34: Age-sex standardised rate of alcohol-related hospital admissions per 100,000 population, Scottish Council areas and Scotland, 2022/23 financial year



Source: ScotPHO profiles, based on data from Public Health Scotland (2023) [19]

There is a reasonably close association between alcohol related hospital admissions in Councils and their level of deprivation, see Figure 35, although some of the islands have particularly high rates and much higher than expected for their relatively low levels of deprivation.

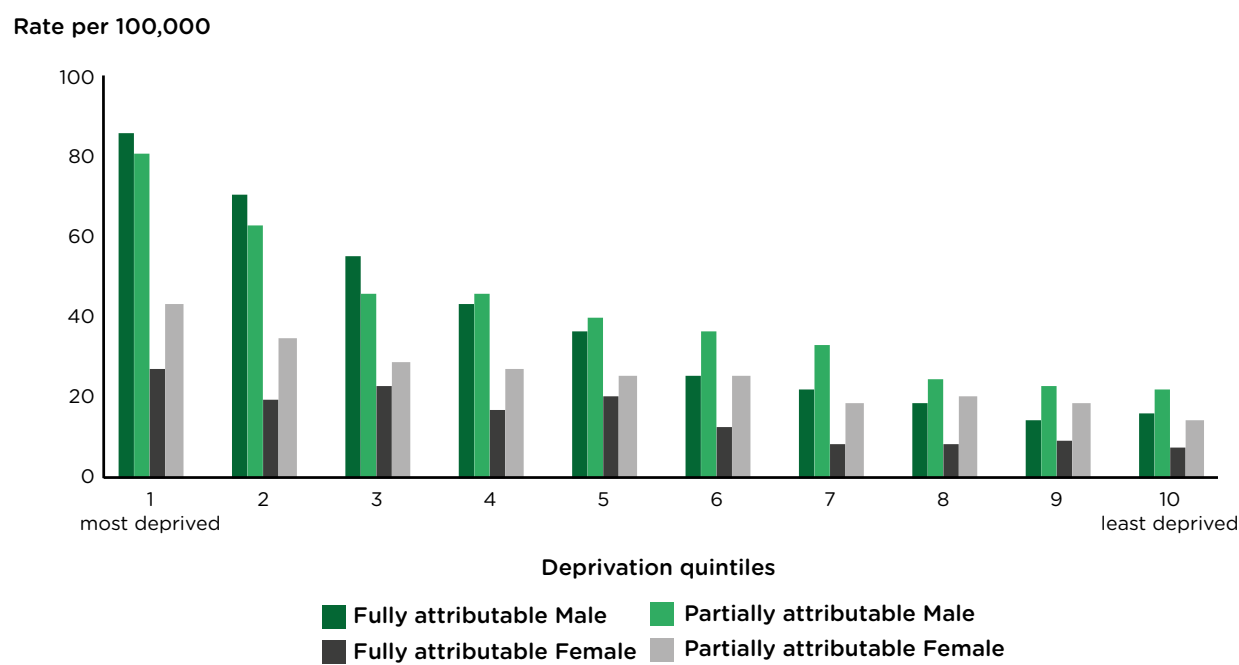
Figure 35: Alcohol-related hospital admissions, age-sex standardised rate per 100,000, and deprivation (SIMD local share), Scottish Council areas, 2022/23 financial year



Source: ScotPHO profiles, based on data from Public Health Scotland (2023) [19]
Note: SIMD local share is the percent of all Data Zones in the Council area that are among the 20 percent most deprived nationally

Figure 36 shows the much higher rates of death which are attributable to alcohol by sex and area deprivation. There are much higher rates in more deprived deciles for both men and women and a clear gradient related to level of deprivation.

Figure 36: Age-sex standardised rate of death fully or partially attributable to alcohol, by sex and deprivation decile (SIMD), Scotland, 2020

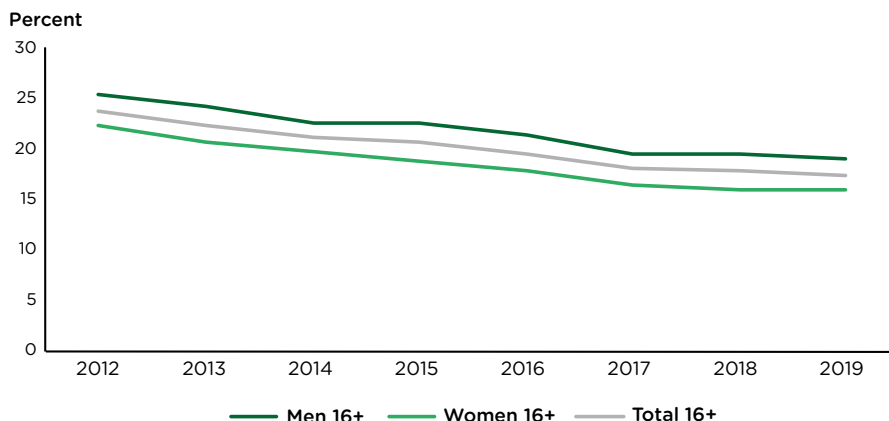


Source: Source: Public Health Scotland (2020) [21]

SMOKING

Smoking rates in Scotland fell rapidly between 2012 and 2019. In 2012 rates were 25 percent of the male population and 22 percent of the female population. By 2019 these rates had fallen to 19 and 16 percent respectively, see Figure 37.

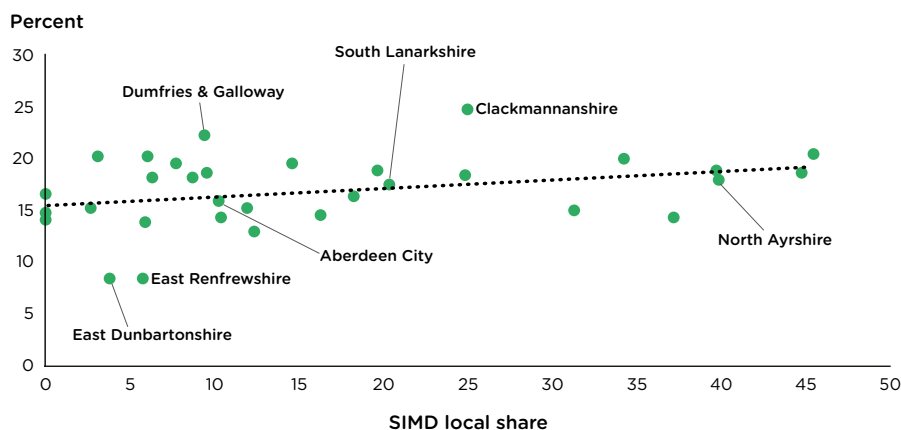
Figure 37: Smoking prevalence by sex, Scotland, 2012-19



Source: ScotPHO (2020) [22]

There are wide differences in smoking rates between Council areas in Scotland, shown in Figure 38 and these are weakly related to levels of deprivation of Council areas.

Figure 38: Smoking prevalence, aged 16 years and over, percent, and deprivation (SIMD local share), Scottish Council areas, 2019



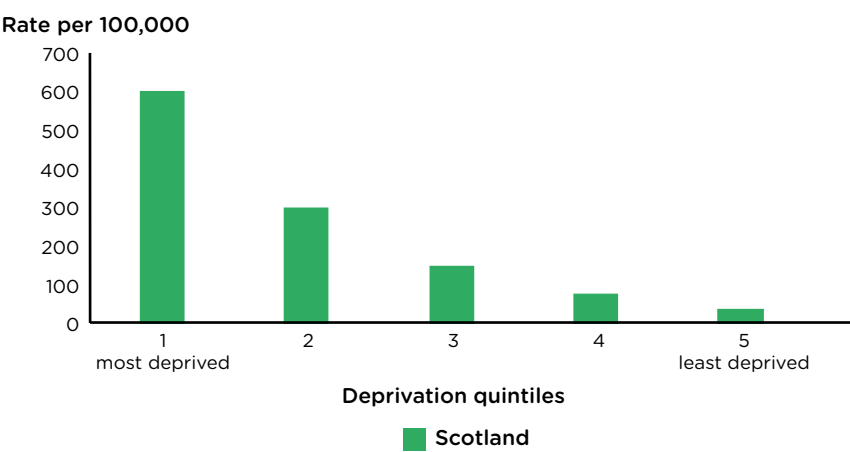
Source: ScotPHO (2020) [22]

Note: SIMD local share is the percent of all Data Zones in the Council area that are among the 20 percent most deprived nationally

DRUG USE

There are clear inequalities in the rates of hospital admissions related to drugs, with the rate 10 times higher in the most deprived than least deprived quintiles of Data Zone areas, see Figure 39.

Figure 39: Drug related hospital admissions, by deprivation quintile, Age-sex standardised rate per 100,000, Scotland, 2018/19-2020/21 financial years



Source: ScotPHO profiles, based on data from National Records of Scotland (2022) [12]

CHAPTER 2

PLACE BASED COLLABORATIONS

As noted, the CHES involves collaborations with Aberdeen City, North Ayrshire and South Lanarkshire and covers 4 main strands. This overview report is an initial summary of these strands of the programmes.

1

Analysis of health, the social determinants of health and resources

The data analysis will support making the case and prioritisation of specific issues, places and population groups in conjunction with discussions with stakeholders.

- Analysis of data nationally and locally identifying inequities in health and the social determinants of health - the Marmot 8 principles. This will build on and enhance local work already in place.
- Development of data packs for a range of sectors, helping make the case for action on health equity.
- Potentially, an assessment of available resources and resource allocations nationally and locally and the nature of the funding, such as duration, organisation specific funding.

2

Understanding enablers and barriers to action

Working with stakeholders across the 'health equity' system within the place to assess opportunities and barriers to action.

- Identifying where barriers require national action and ensuring this information influences the priorities of national leaders.
- Where needed, support for systems leadership and organisational and workforce capacity and capability to support action.
- Assessing the opportunities for strengthening commissioning for social and equity impacts and shifting resource allocations to strengthen equitable impacts.
- Working with the health equity system to identify, develop and implement ways forward for a long-lasting improvement in equity.

3

Development of recommendations for action and prioritised implementation plan

- Refine and build on existing plans and develop recommendations to support local and national actions for health equity.
- Development of an implementation plan.
- Development of indicators to capture impacts on the social determinants.

4

Working with other places and the national system in Scotland

- Development of a national learning system for all local areas across Scotland with a focus on shared learning from the work of the three places.
- Development of relevant networks for local places and connecting with other programmes across Scotland.

HEALTH INEQUALITIES IN THREE PARTNER PLACES

This section explores health inequalities within the three collaborating places and the analysis serves as a starting point for work with these three places.

Further analysis will follow and to note the analysis can be made available for other Council areas in Scotland. Much of what we set out is well known by places, although there are some useful insights from the exploration of health by Intermediate Zone (IZ) deprivation scores (see Methodology above) within each place. Next steps will be a fuller analysis of the data which is available locally, an overview of social determinants of health and ongoing discussions with stakeholders, including the public, third and private sectors and Councils to support understanding of the opportunities for further action on inequalities within the places including from nationally.

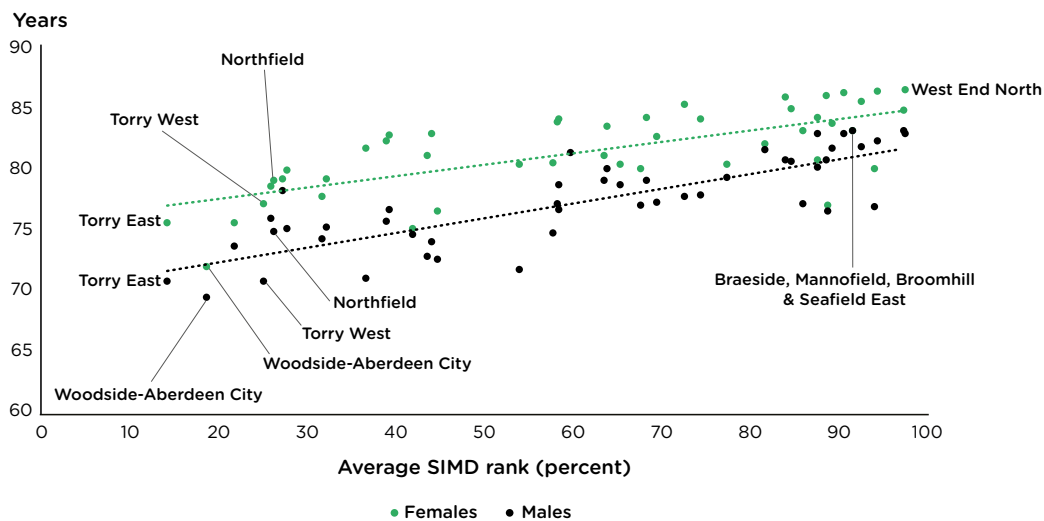
INEQUALITIES IN LIFE EXPECTANCY

Within each place there are clear gradients in life expectancy, related to level of deprivation of Intermediate Zone (IZ) in each area (calculated using the approach set out in the Methodology section).

Aberdeen City has an average life expectancy of 81 years for women and 77 for men, aligned with the overall average life expectancy in Scotland. However, there are wide differences within the City ranging from 69 years for men in Woodside, the lowest, to 83 years in Braeside, Mannofield, Broomhill and Seafield East, the area with the highest male life expectancy– a difference of 14 years. For women equivalent figures are life expectancy of 86 years in West End North to 72 years in Woodside, again a difference of 14 years, see Figure 40 a).

Figure 40: Life expectancy at birth, Intermediate Zones (IZ) within the three intervention areas by sex and average SIMD rank of each IZ, 2017-21

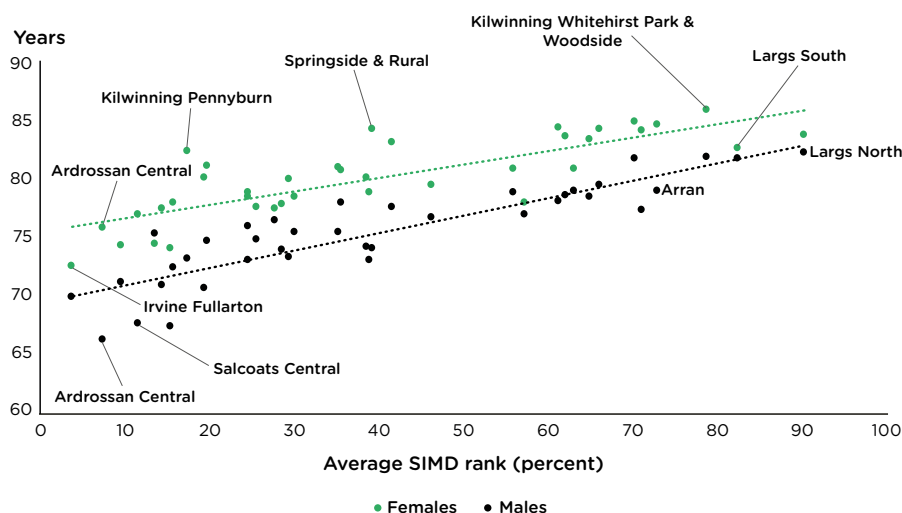
a) Aberdeen City



Note: Data has been suppressed for males in Froghall, Powis & Sunnybank, Hanover North and City Centre East, and females in City Centre East.
Source: National Records of Scotland (2024) [10]

North Ayrshire has relatively low life expectancy for both men and women, compared with other places in Scotland – 75 years for men and 79 years for females in 2021-23. There are large differences in life expectancy within the Council from life expectancy for men of only 66 years in Adrossan Central to 82 years in Largs North - a difference of 16 years. For women equivalent figures are 73 years in Irving Fullarton to 86 years in Kilwinning Whitehirst Park & Woodside - a difference of 13 years.

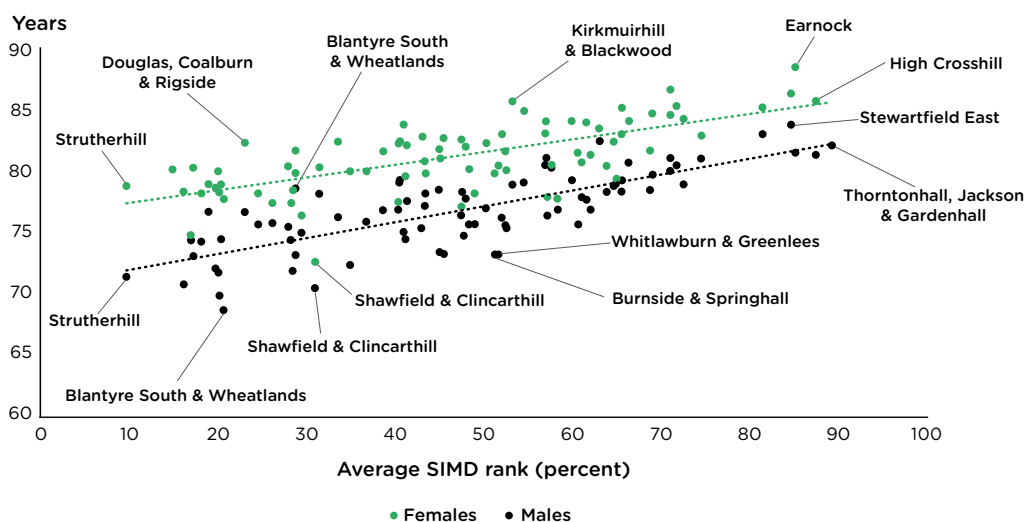
b) North Ayrshire



Source: National Records of Scotland (2024) [10]

South Lanarkshire has an average life expectancy of 80 for women and 76 for men and there are significant differences within the area related to deprivation. The lowest life expectancy for men is 69 in Blantyre South and Wheatlands and the highest, 84 years, in Stewartfield East, a difference of 15 years. For women life expectancy is lowest in Shawfield and Clincarthill at 72.5 years and highest in Earnock at 88 years, a difference of nearly 16 years

c) South Lanarkshire



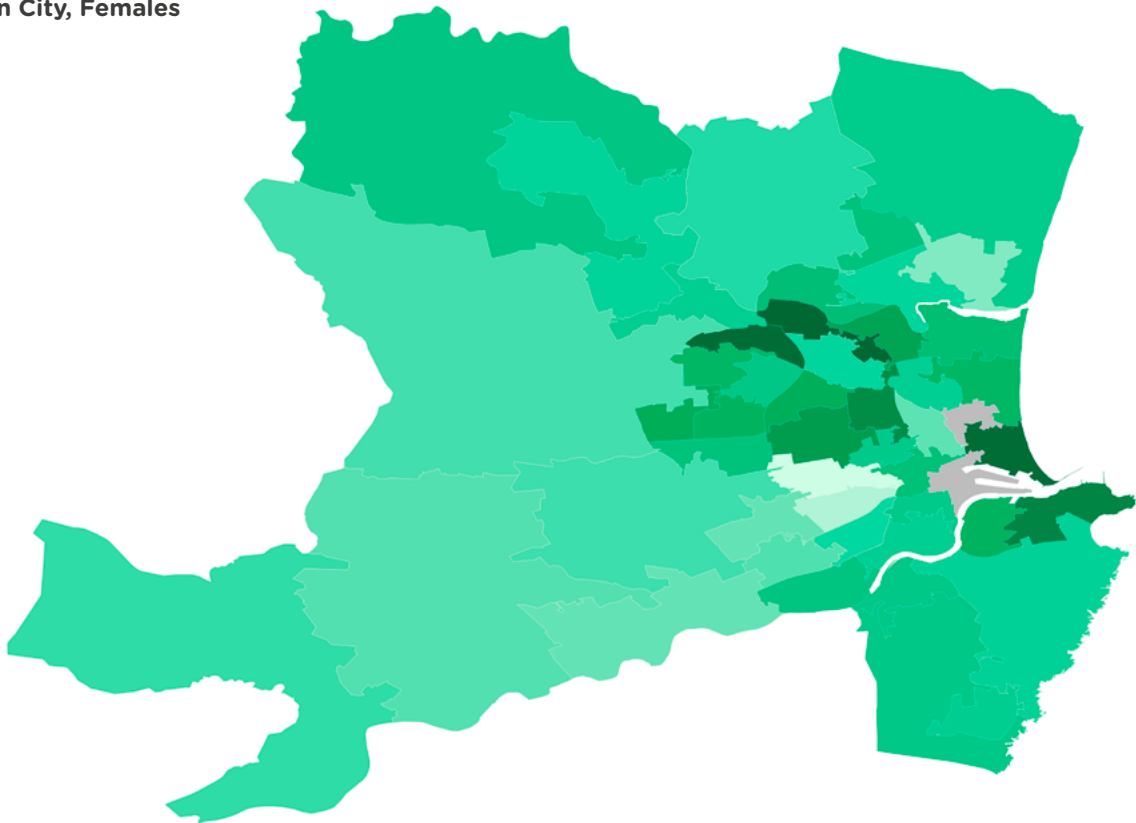
Note: Data has been suppressed for males in Fairhill, and females in Clydesdale South and Thorntonhall, Jackton & Gardenhall.

Source: National Records of Scotland (2024) [10]

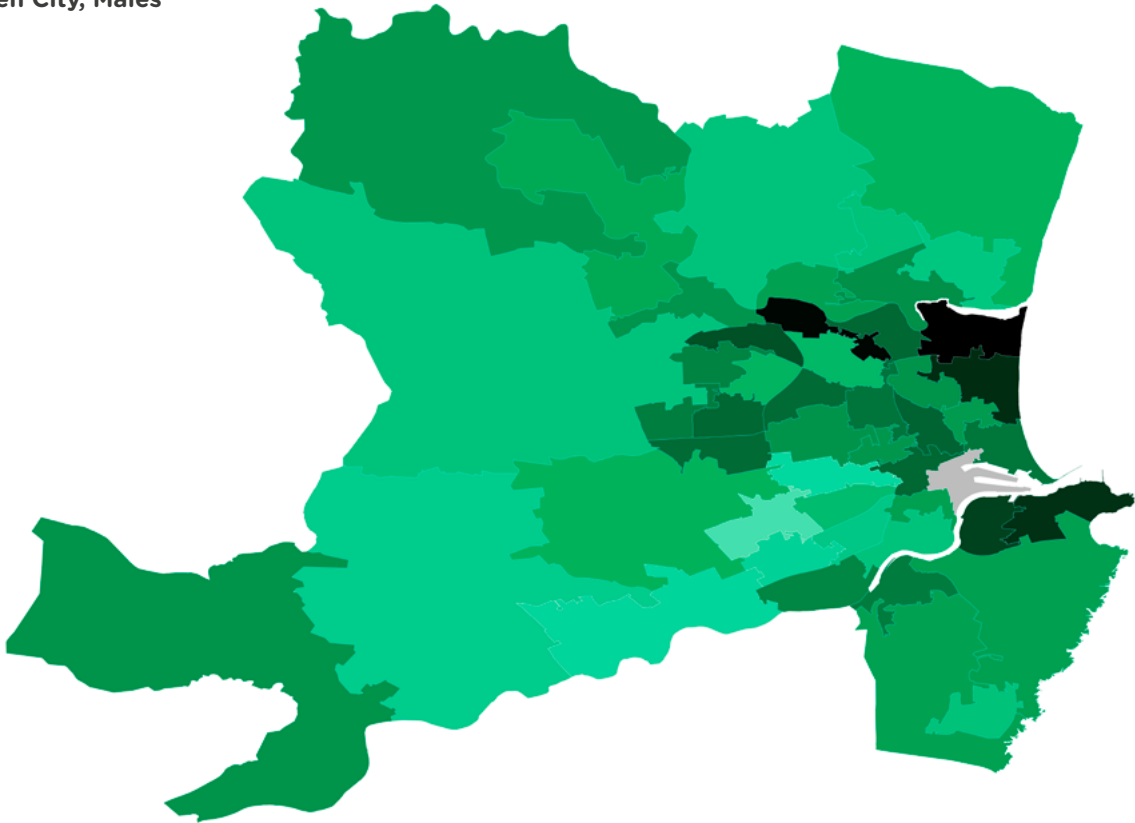
Life expectancy by Data Zone in the three areas is presented in a map of each region for male and females see Figure 41.

Figure 41: Life expectancy, male and female, years, Intermediate Zones, 2019-23

a) Aberdeen City, Females



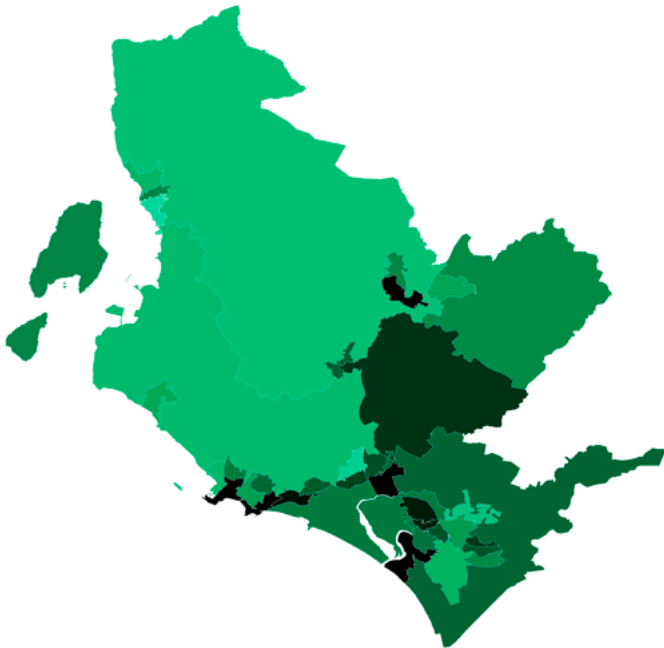
b) Aberdeen City, Males



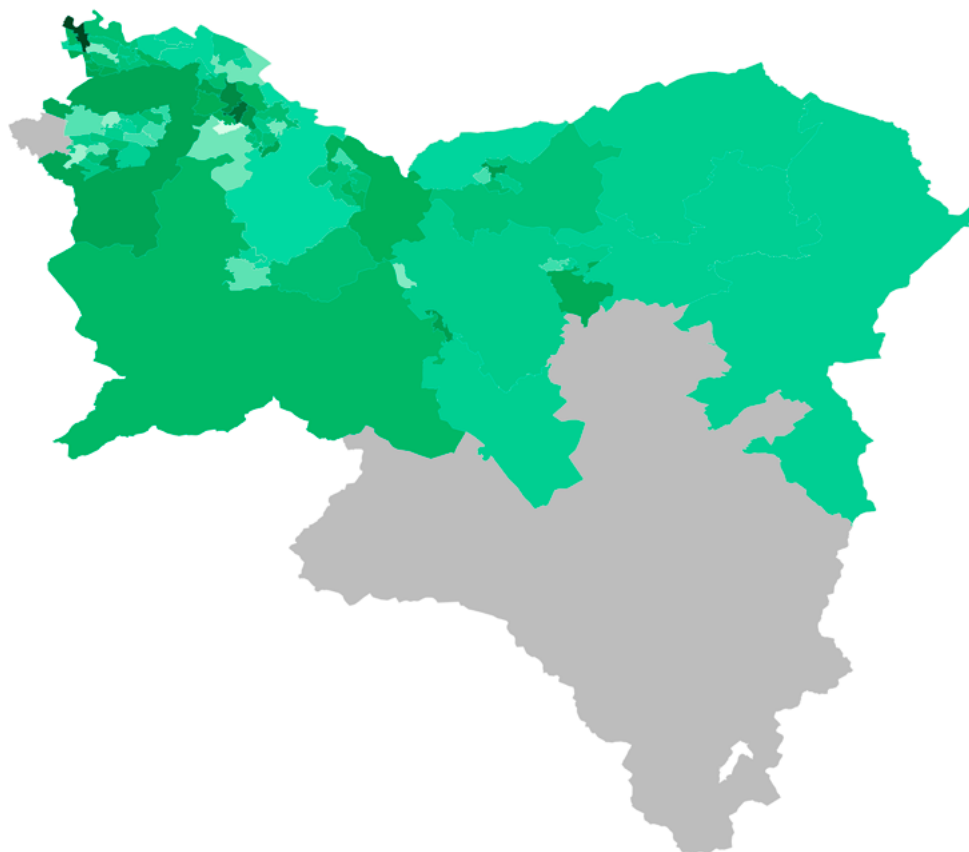
c) North Ayrshire, Females



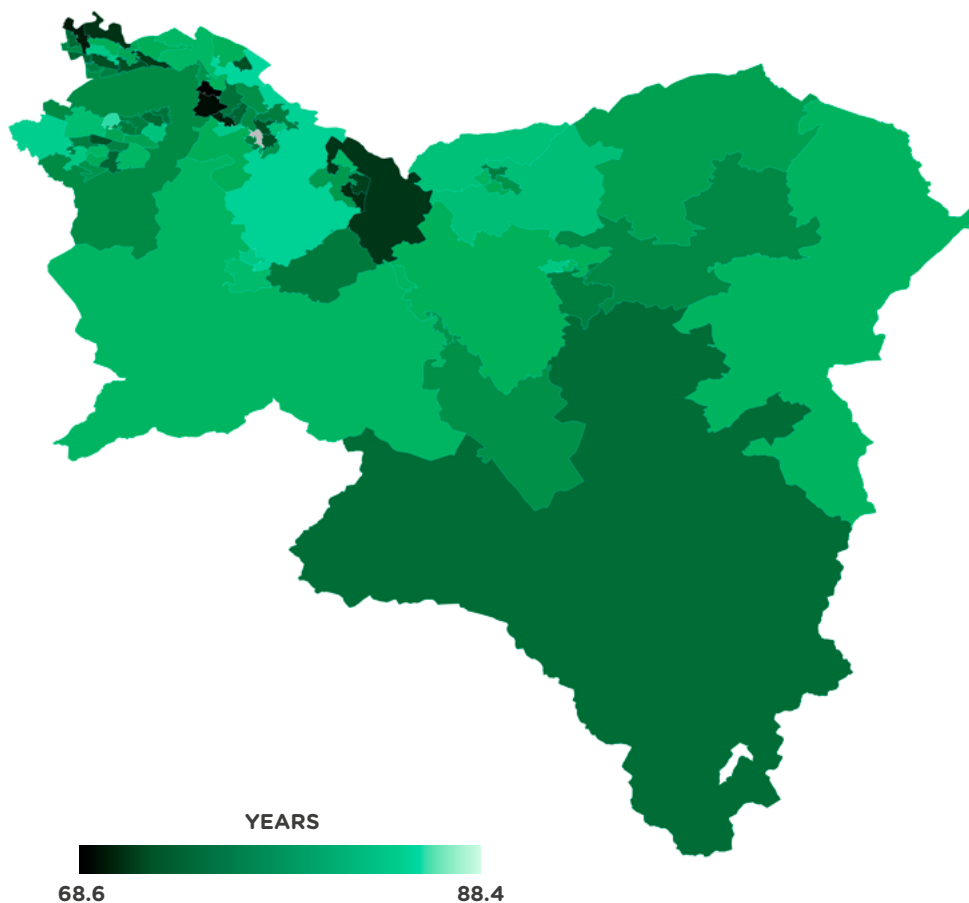
d) North Ayrshire, Males



e) South Lanarkshire, Females



f) South Lanarkshire, Males



Note: Data is unavailable for areas in gray

Healthy life expectancy is not available at Intermediate Zone level so it is not possible to explore inequalities in healthy life expectancy within Council areas. As reported in Figure 7, earlier in this report, North Ayrshire has the lowest healthy life expectancy in Scotland – 52 years for women and 56.5 for men. South Lanarkshire and Aberdeen City have healthy life expectancy which is more in line with the average for Scotland (61 for males and 60 years for females).

UNDER 75 MORTALITY

There are inequalities in rates of under 75 mortality between Council areas in Scotland. Looking at trends in under 75 mortality among the three places since 2010, it is clear that rates in South Lanarkshire and North Ayrshire have increased and the differences between these places and Scotland have widened, see Figure 42

Figure 42: Age standardised mortality under 75, by sex, per 100,000, Marmot local Council areas, and Scotland, 2010-23



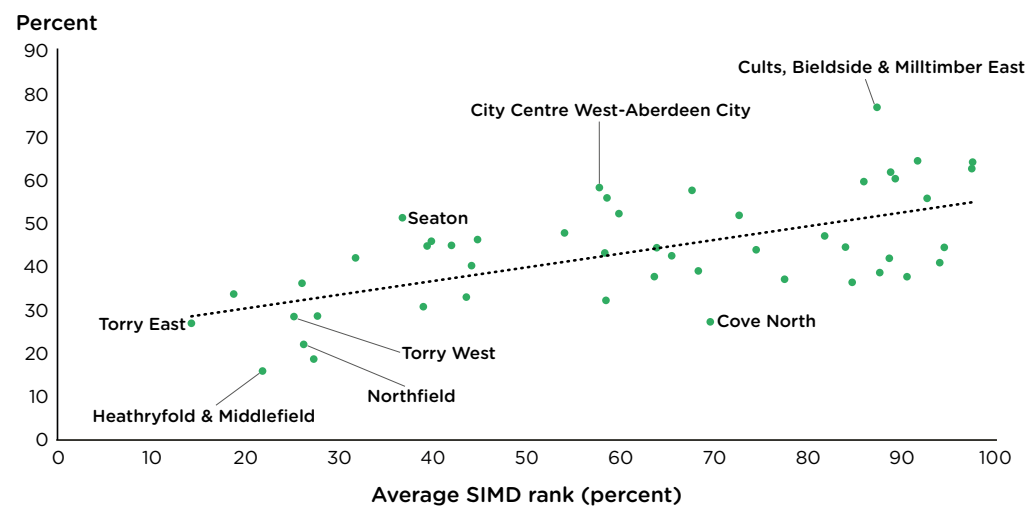
Source: National Records of Scotland (2024) [10]

INFANT HEALTH

As indicated in the previous section, exclusive breastfeeding for the first 6-8 weeks has short- and long-term health benefits for babies. There are wide differences in each area related to levels of deprivation. Rates are particularly low in North Ayrshire and South Lanarkshire and lower than 10 percent in some of the more deprived areas, see Figure 43.

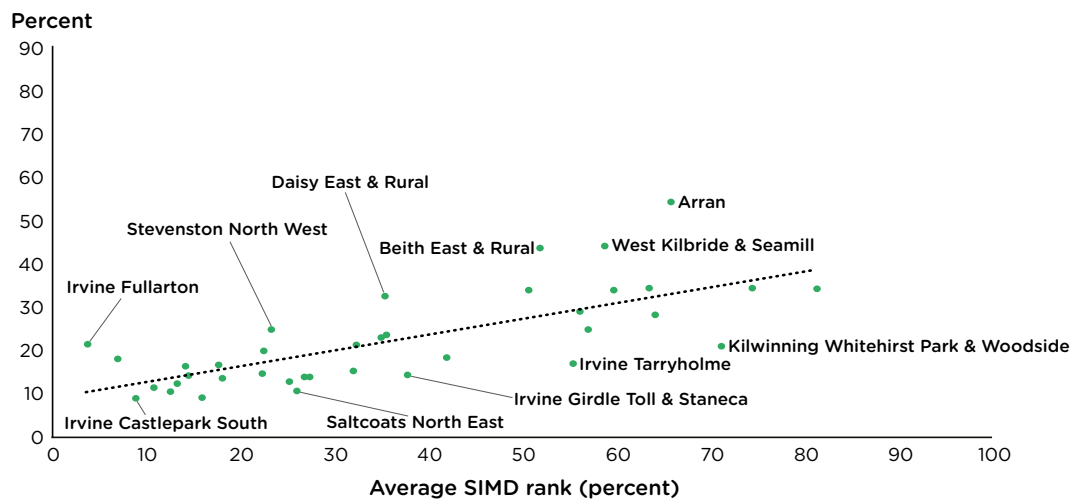
Figure 43: Percent of babies exclusively breastfed at 6-8 weeks, Intermediate Zones (IZ) within the three intervention areas by average SIMD rank of each IZ, financial years 2020/21-2022/23

a) Aberdeen City



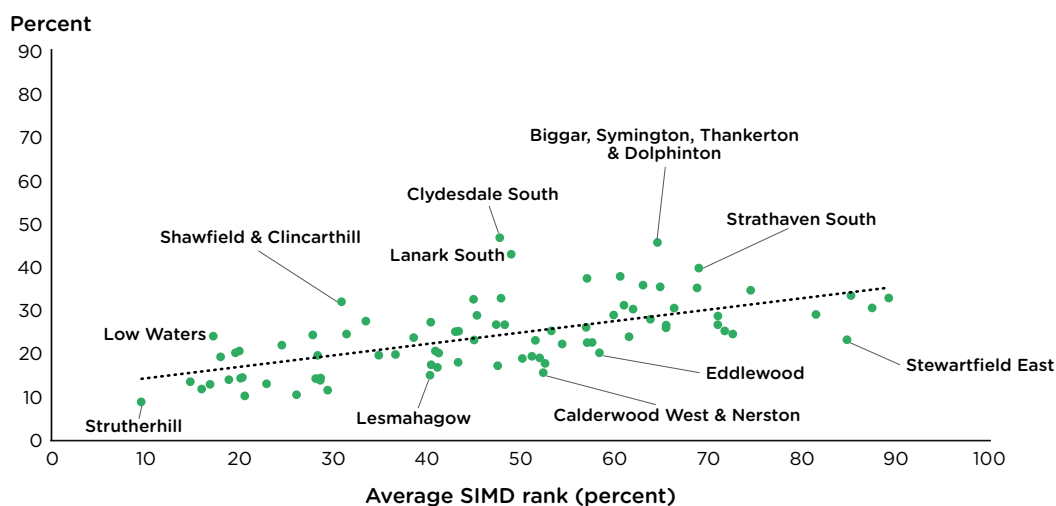
Source: ScotPHO profiles, based on data from Child Health Systems Programme Pre-school (CHSP-PS) (2024) [17]

b) North Ayrshire



Source: ScotPHO profiles, based on data from Child Health Systems Programme Pre-school (CHSP-PS) (2024) [17]

c) South Lanarkshire



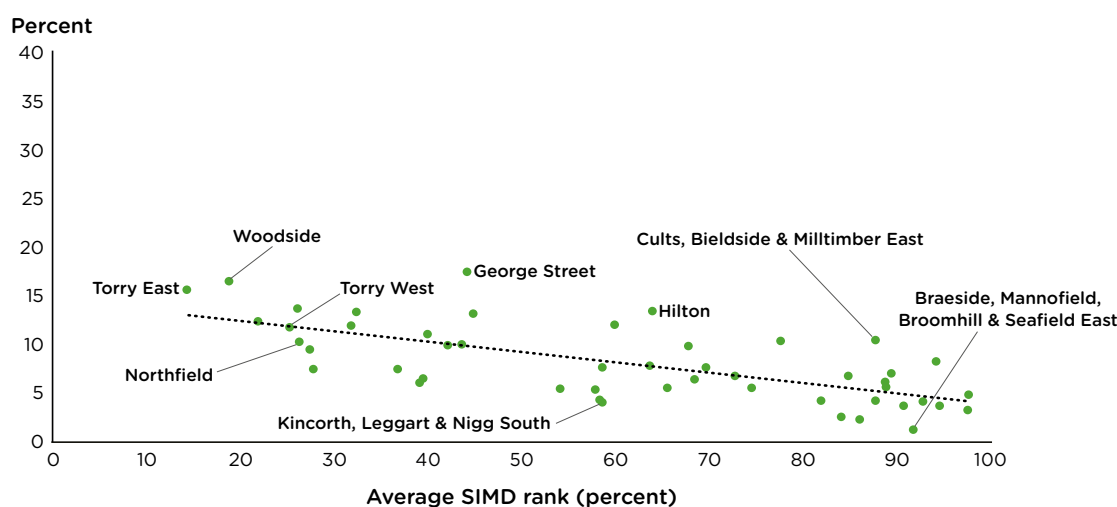
Source: ScotPHO profiles, based on data from Child Health Systems Programme Pre-school (CHSP-PS) (2024) [17]

DEVELOPMENTAL CONCERNS

As noted in the previous section, good levels of development in the early years contribute to good health and positive outcomes in the social determinants of health. Developmental concerns, on the other hand, indicate for poor health and low outcomes in other domains, such as employment and income throughout life. Levels of development among babies and young children are closely related to levels of deprivation. In Figure 44 we showed that there are relatively low levels of children with developmental concerns in Aberdeen City, well below what might be expected given its overall level of deprivation and the second lowest level of concerns about development in Scotland. It is important to note that there are wide confidence intervals in the data so the data for individual Intermediate Zones need to be explored further. Nonetheless it is apparent that in each Council area here there are clear relationships between levels of concerns about early childhood development and levels of deprivation. Values for particular Intermediate Zones should be interpreted with caution.

Figure 44: Developmental concerns at 27-30 months, Intermediate Zones (IZ) within the three intervention areas by average SIMD rank of each IZ, 2020/21-2022/23 financial years

a) Aberdeen City

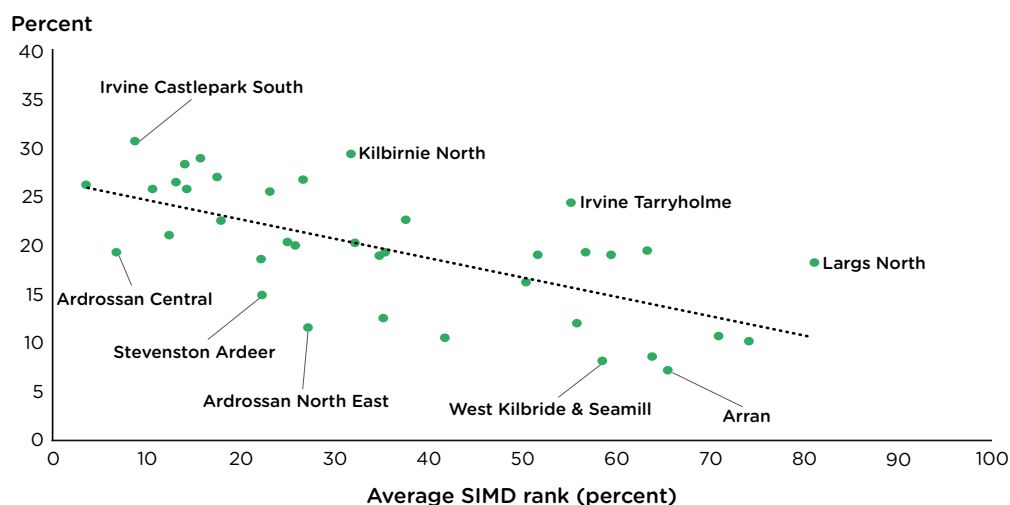


Source: ScotPHO profiles, based on data from Public Health Scotland (2024) [17]

Note: The 27-30 month review is a universal assessment offered to every child reaching the appropriate age. It was introduced in Scotland in April 2013. The 27-30 month review records capture the outcome of developmental assessment for the following 9 domains: social; emotional; behavioural; attention; speech language & communication; gross motor; fine motor; vision and hearing. The analysis looks at the responses for all 9 domains to establish the presence of one (or more) concern. All percentages are based on the total number of reviews provided.

In North Ayrshire, rates of developmental concern at the 27-30 month are higher and the fifth highest in Scotland. There are, however, large differences within North Ayrshire from nearly 30 percent of young children having developmental concerns in Irvine Castlepark South to around 7 percent in Arran. The differences are related to level of deprivation of the area with some scatter around the line.

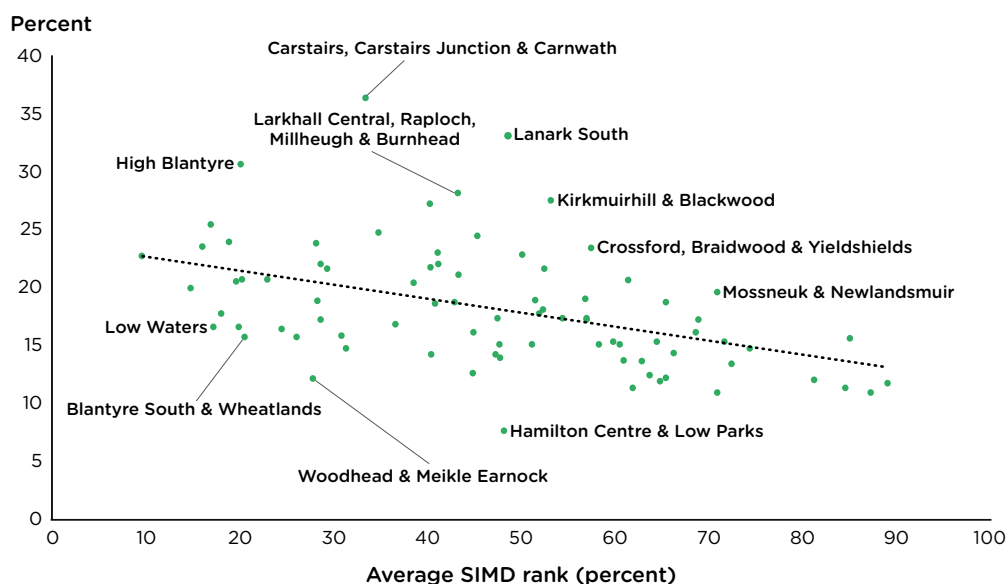
b) North Ayrshire



Source: ScotPHO profiles, based on data from Public Health Scotland (2024) [17]

South Lanarkshire has only slightly higher levels of children with developmental concerns than the Scottish average, but again there is systematic variation within the Council, with the estimated gradient line indicating an eight percentage point difference between the least and most deprived IZs. Moreover, South Lanarkshire have highlighted to us that within IZs there are pockets of deep deprivation, which mean that the average levels of deprivation of an IZ can mask wide inequalities.

c) South Lanarkshire



Source: ScotPHO profiles, based on data from Public Health Scotland (2024) [17]

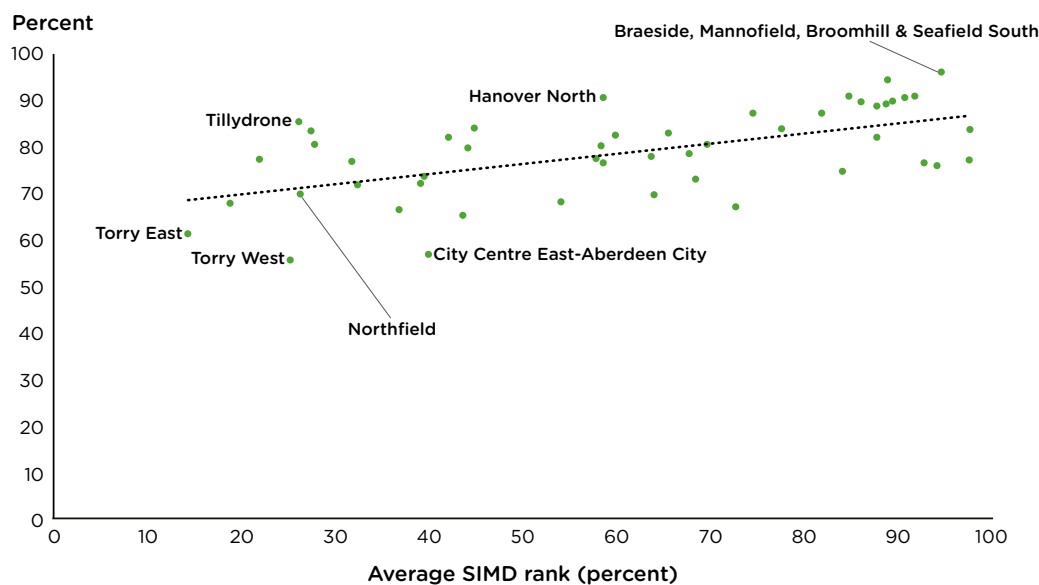
Note: The 27-30 month review is a universal assessment offered to every child reaching the appropriate age. It was introduced in Scotland in April 2013. The 27-30 month review records capture the outcome of developmental assessment for the following 9 domains: social; emotional; behavioural; attention; speech language & communication; gross motor; fine motor; vision and hearing. The analysis looks at the responses for all 9 domains to establish the presence of one (or more) concern. All percentages are based on the total number of reviews provided.

CHILD DENTAL HEALTH

Across Scotland, as in other countries, there are stark inequalities in dental health related to levels of deprivation. The inequalities relate to inequalities in access to dental services, access to healthy nutrition and dental hygiene, all affected by deprivation and poverty. Within each of the three places there are inequalities in child dental health related to levels of deprivation, see Figure 45.

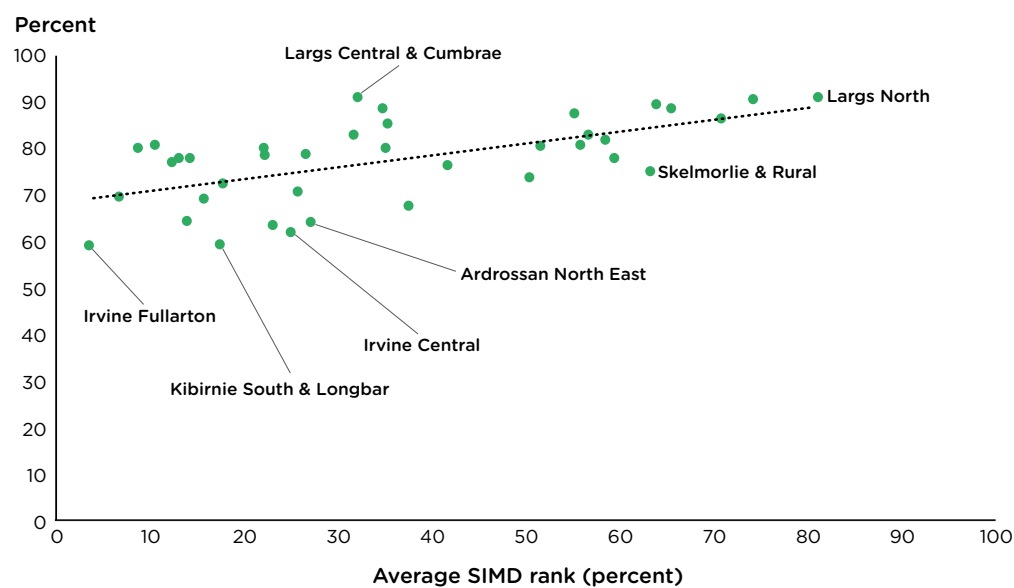
Figure 45: Percentage of children with no obvious dental decay in primary 7, Intermediate Zones (IZ) within the three intervention areas by average SIMD rank of each IZ, 2022/23 school year

a) Aberdeen City



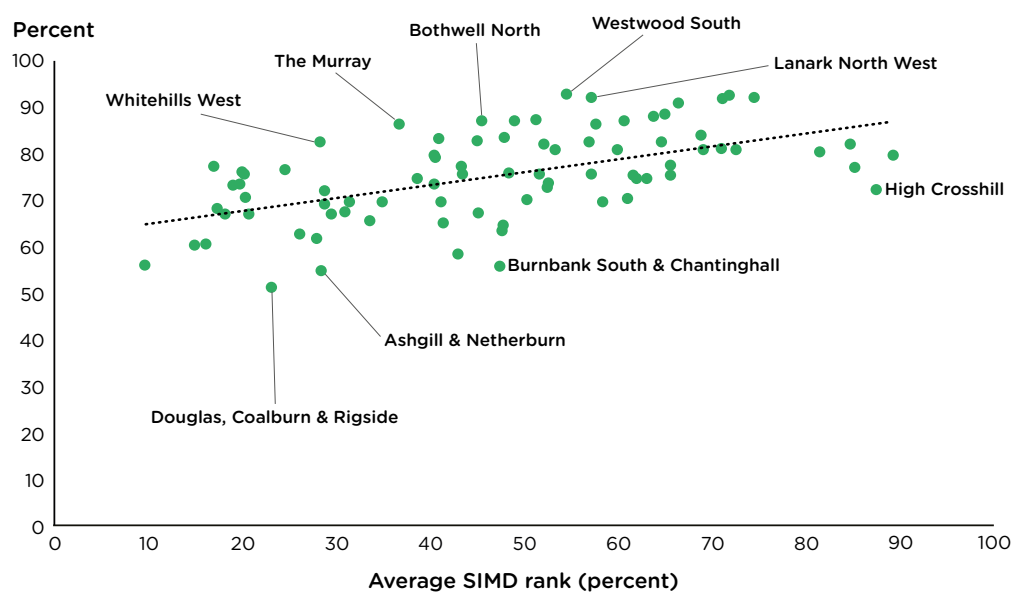
Source: ScotPHO profiles, based on data from National Dental Inspection Programme Basic Inspection (2024) [17]
Notes: Percentage of Primary 7 children receiving a letter 'C' - no obvious decay experience but should continue to see the family dentist on a regular basis at basic inspection

b) North Ayrshire



Source: ScotPHO profiles, based on data from National Dental Inspection Programme Basic Inspection (2024) [17]
Notes: Percentage of Primary 7 children receiving a letter 'C' - no obvious decay experience but should continue to see the family dentist on a regular basis at basic inspection

c) South Lanarkshire



Source: ScotPHO profiles, based on data from National Dental Inspection Programme Basic Inspection (2024) [17]
Notes: Percentage of Primary 7 children receiving a letter 'C' - no obvious decay experience but should continue to see the family dentist on a regular basis at basic inspection

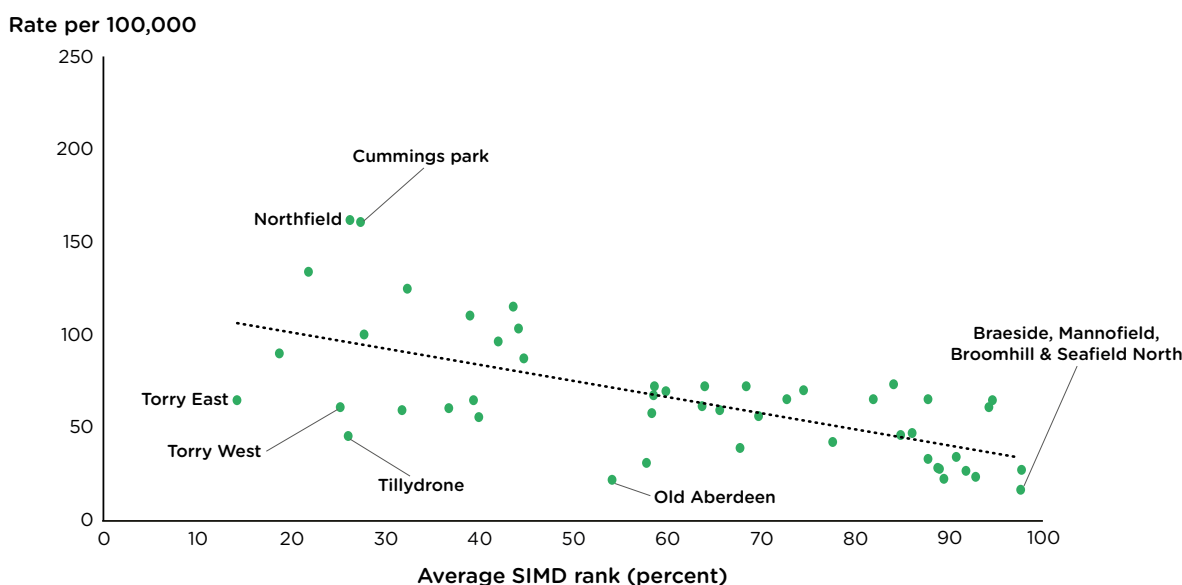


ASTHMA

Rates of hospitalisation for asthma vary widely within each Council. As highlighted previously these asthma hospitalisations relate to levels of air pollution and housing quality as well as adherence to treatment plans. Notably in each area there is a link with area level deprivation and more deprived areas tend to have much higher rates of hospitalisation. More deprived areas in both North Ayrshire and South Lanarkshire have particularly high rates, over 200 per 100,000 people, although the average for the Councils are rates of 88 and 80 per 100,000 respectively, see Figure 46.

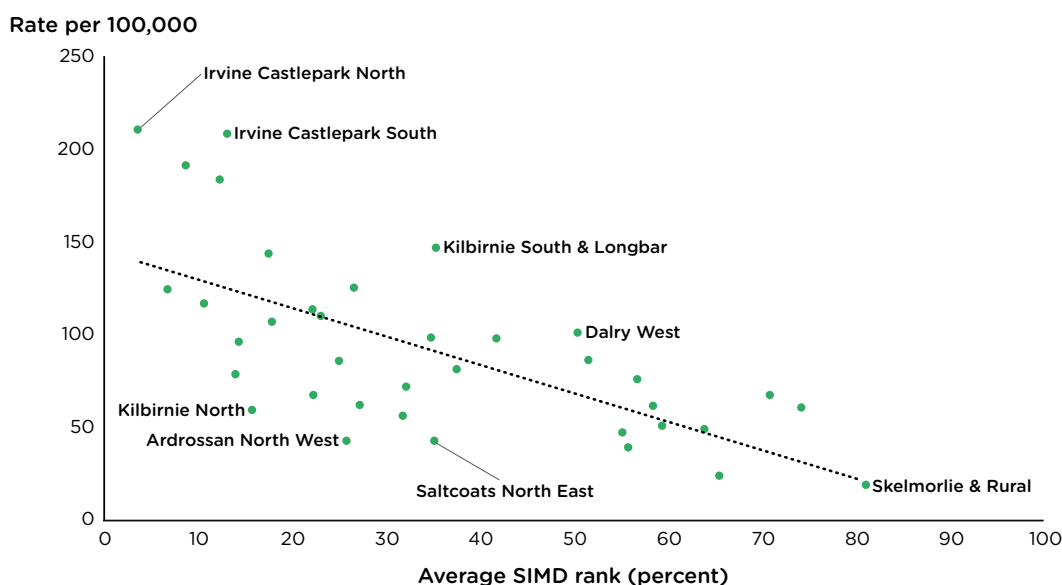
Figure 46: Asthma patient hospitalisations, Intermediate Zones (IZ) within the three intervention areas by average SIMD rank of each IZ, 2019/20-2021/22 financial years

a) Aberdeen City



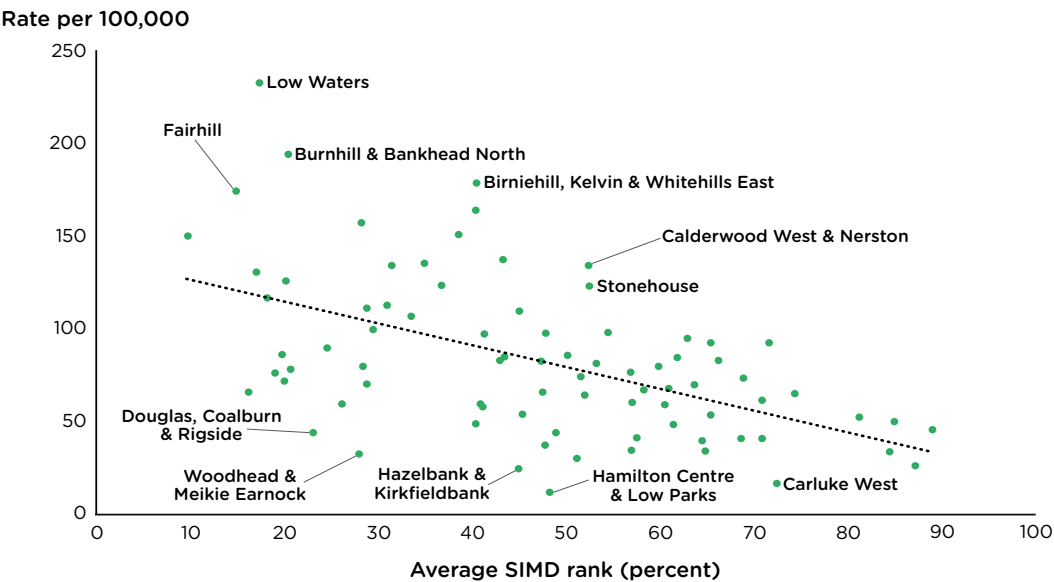
Source: ScotPHO profiles, based on data from Public Health Scotland [12]

b) North Ayrshire



Source: ScotPHO profiles, based on data from Public Health Scotland [12]

c) South Lanarkshire



Source: ScotPHO profiles, based on data from Public Health Scotland [12]

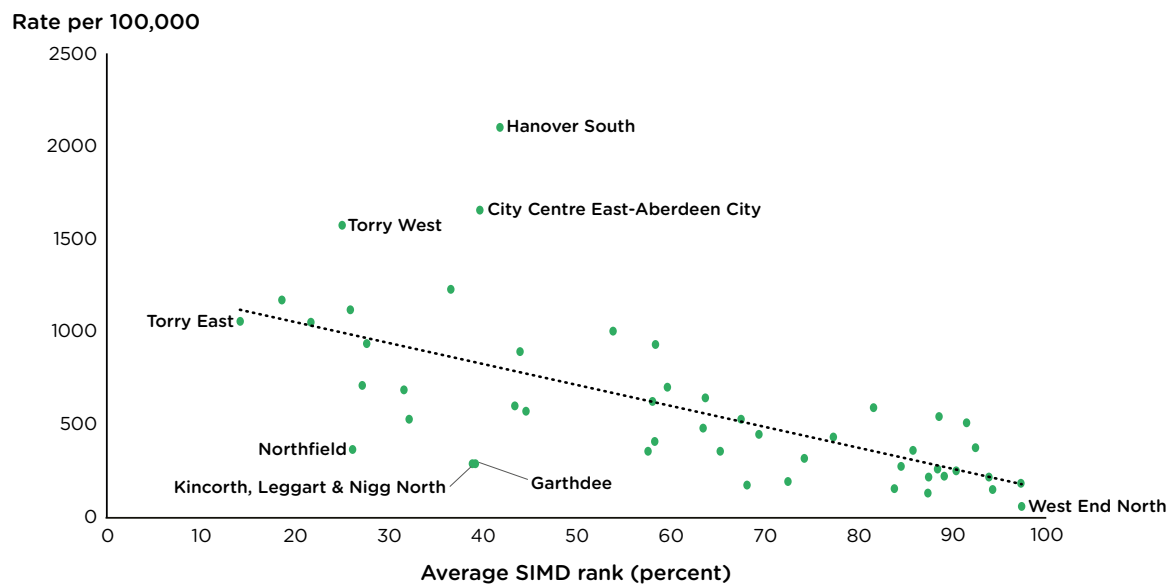


ALCOHOL

All three Council areas have rates of alcohol-related hospital admissions which are close to the Scottish average of 532 per 100,000 population. However, rates vary markedly within each of the three places and in Aberdeen City there is a rate of over 2,000 admissions annually in Hanover South, compared with just under 100 in West End North, a 20 fold difference, see Figure 47.

Figure 47: Age-sex standardised rate of alcohol-related hospital admissions per 100,000 population at all ages, Intermediate Zones (IZ) within the three intervention areas by average SIMD rank of each IZ, 2022/23 financial year

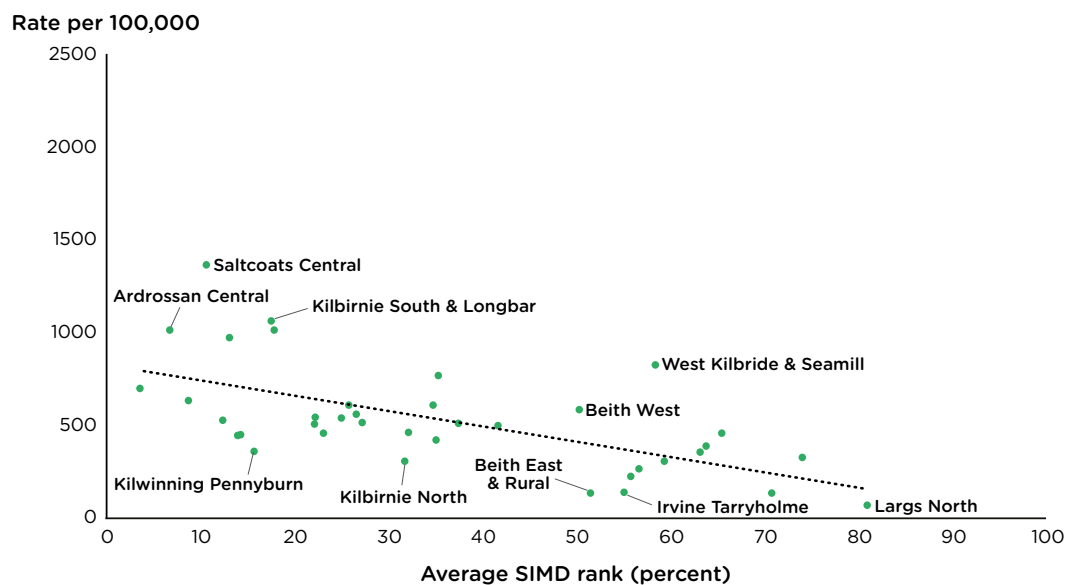
a) Aberdeen City



Source: ScotPHO profiles, based on data from Public Health Scotland (2024) [17]

In North Ayrshire rates of admissions are also related to level of deprivation and vary from 71 per 100,000 admissions per 100,000 in Largs North to over 1,300 in Saltcoats Central.

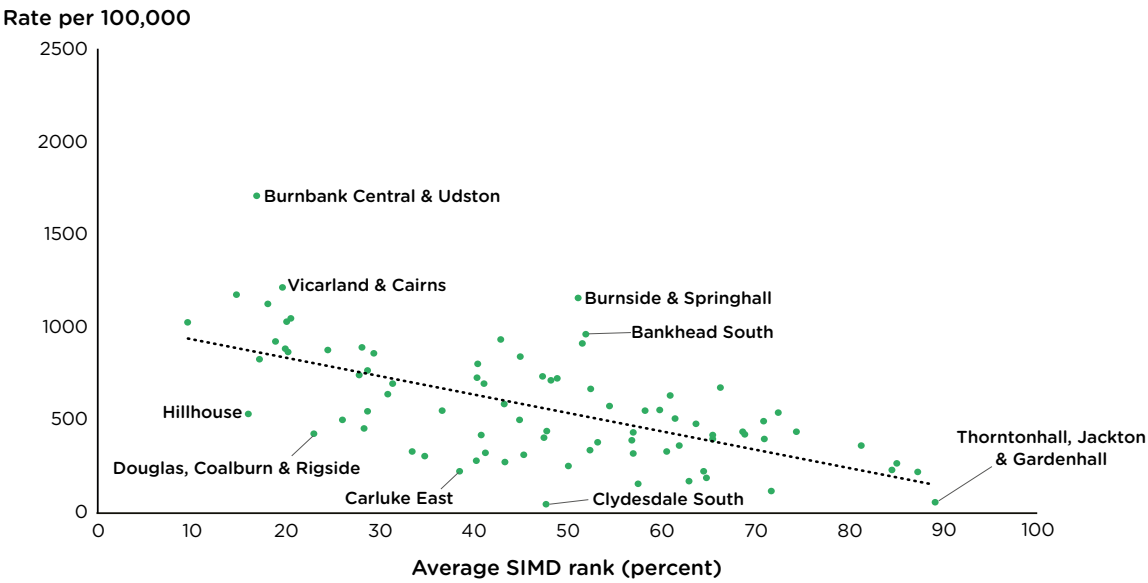
b) North Ayrshire



Source: ScotPHO profiles, based on data from Public Health Scotland (2024) [17]

In South Lanarkshire there are again, wide differences in rates of admissions for alcohol, from rates of over 1,700 in Burnbank Central and Udston to rates of only 51 in Clydesdale South.

c) South Lanarkshire



Source: ScotPHO profiles, based on data from Public Health Scotland (2024) [17]

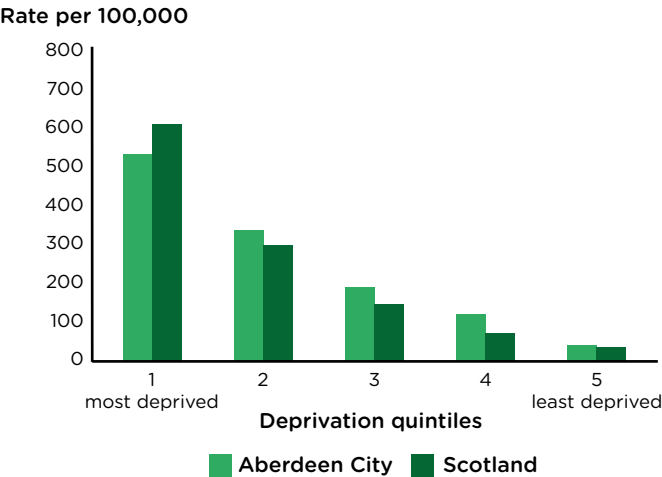


DRUG USE

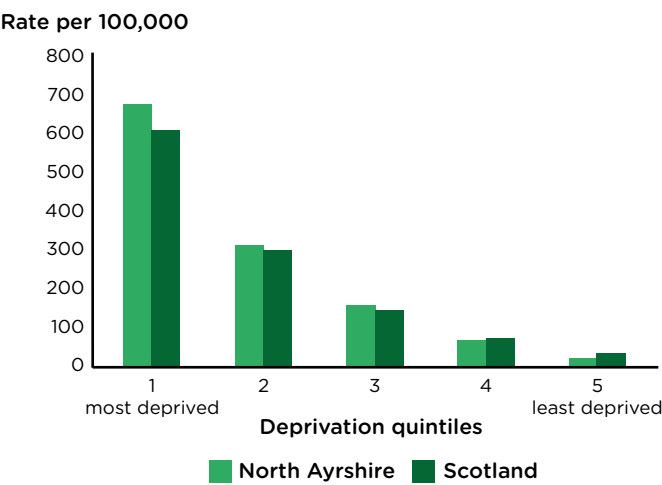
As indicated in the data for Scotland, drug related hospital admissions vary according to level of deprivation. There are very low rates in the least deprived 20 percent of the population, but markedly higher rates among people living in the 20 percent most deprived areas. This distribution is also apparent in each of the three places, see Figure 48.

Figure 48: Drug-related hospital admissions by deprivation quintile, age-sex standardised rate per 100,000, 2018/19-2020/21 financial years.

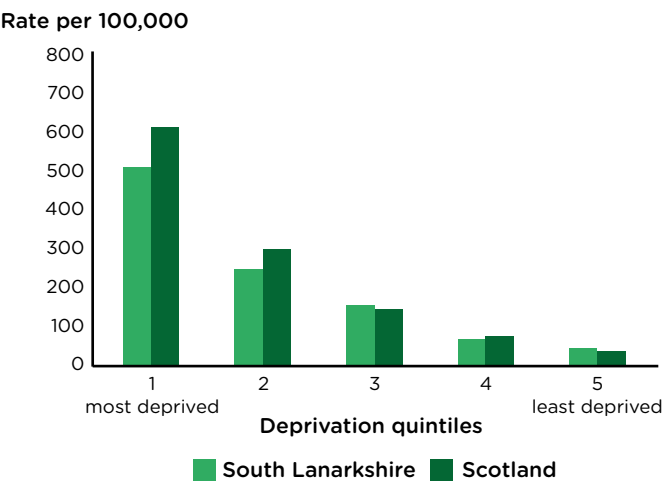
a) Aberdeen City and Scotland



b) North Ayrshire and Scotland



c) South Lanarkshire and Scotland



Source: ScotPHO profiles, based on data from Public Health Scotland (2024) [17]

CONCLUSIONS

This is the first overview of health inequalities in Scotland from the CHES. It confirms that there are wide inequalities in health across Scotland related to the extent of deprivation within Council areas. There are also inequalities in health related to gender, with more stark gender inequalities in more deprived areas, where men tend to have much shorter life expectancy than women.

We have highlighted that health in Scotland is deteriorating and inequalities in health widening and that there are gradients in life expectancy, healthy life expectancy and for most physical and mental health conditions we highlight. This initial analysis will be developed further throughout the programme in order to support development of programmes and policies to tackle health inequalities at national and local level.

We have also indicated that there are wide inequalities in health related to deprivation of areas (Intermediate Zones) within the three partner areas for the programme. This conclusion is based on calculation of an approximate indicator of deprivation for these areas. The analyses are created using publicly available data, and so elements could be recreated by other areas. In future reports we will also explore inequalities in the social determinants of health within the three areas. There is a need for an improved measure to capture small area deprivation and other dimensions of inequality.

In this report we have included healthcare system data, which is not a particularly robust measure to show inequalities in specific diseases. Next stages of the work will include further quantitative data analysis and qualitative data

The CHES will mostly be focussed on analysis and development and delivery of more effective policies and programmes to tackle health inequalities. This overview and subsequent analysis are intended to support that focus. Of particular note from this initial analysis is that the gradient in health requires programmes and policies which are proportionate to the scale of need – between and within Council areas in Scotland. While there has been a focus on universal programmes and policies in Scotland, the CHES will support the design and delivery of programmes and policies which are proportionate to the scale of need in order to raise and flatten the gradient.

There are also insights from this report which will feed into subsequent analyses, including the high proportion of more deprived populations in several Council areas. Next steps will include assessment of how far resource allocations from national to local systems are proportionate to the levels of deprivation in Council areas. The next report will provide an overview of inequalities in the social determinants of health across Scotland and within the three partner Council areas.

The CHES is currently working with teams in the local areas to identify particular approaches and priorities for the duration of the programme. These priority areas will be identified from initial data analysis, discussions with stakeholders and alignment with existing approaches.

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