NHS Greater Glasgow and Clyde
2011 Health and Wellbeing Survey

East Dunbartonshire Report

Final Report

Prepared for

NHS Greater Glasgow and Clyde

March 2013

Traci Leven Research

Contents

1 Introduction

1.1 Introduction

This report contains the findings of a research study on health and wellbeing carried out in 2011 on behalf of NHS Greater Glasgow and Clyde. The fieldwork and data entry were performed by Progressive. Analysis and reporting were performed by Traci Leven Research. It is the follow up in a series of studies which started in 1999 when NHS Greater Glasgow conducted a health and wellbeing study of their population. The study has been repeated every three years. In 2008 the study expanded to take in the area covered by NHS Greater Glasgow and Clyde, this study represents the first follow-up of the expanded study and also allows trends to be explored in the area administered by the former NHS Greater Glasgow.

Background

The original aims of the study were:

- to provide intelligence to inform the health promotion directorate;
- to explore the different experience of health and wellbeing in our most deprived communities[1] compared to other areas; and
- to provide information that would be useful for monitoring health promotion interventions.

There have been many policy changes over the decade the health and wellbeing study has been in operation. For example, the dissolution of social inclusion partnership areas (SIPs) as a focus of tackling area based deprivation and the emergence of using the Scottish Index of Multiple Deprivation (SIMD) as the main tool for measuring area based deprivation and focusing of resources; the emergence of Community Health (and Care) Partnerships as a vehicle for integrated planning and delivery of health (and social) care services at a local level and changes to the performance assessment framework have led to an increased focus on some health behaviours such as use of alcohol; diet and exercise.

The health and wellbeing survey was formed around core questions which have remained the same and allow the monitoring of trends over time. However, the survey has also been adapted over time to take into account emerging health and wellbeing issues and new geographies.

The survey provides a snapshot in time of the views and experience of the resident adult population. Whilst we cannot attribute causal relationships between the findings and the changing policy context we can explore our findings alongside wider changes in NHS Greater Glasgow and Clyde (NHSGGC).

Our local survey has provided flexible options to explore health and wellbeing at a local level. In 2011 many of the CH(C)Ps and Glasgow South Sector bought into the survey. Separate reports are available for each of these areas. In addition, Glasgow South West, Glasgow South and East Dunbartonshire bought into the survey at enhanced levels to allow for local exploration between the most deprived areas and other areas. All the reports will be posted on http://www.phru.net as they become available.

Thanks are due to the working group that led the survey:

Allan Boyd Senior Analyst

[1] In 1999, our most deprived communities were given additional resources with the aim of reducing the gap between deprived and least deprived areas. The initiative was part of an umbrella programme of support which focused on Social Inclusion Partnership areas.

Norma Greenwood	Head of Public Health Resource Unit
Margaret McGranachan	Public Health Researcher
Julie Truman	Senior Researcher

In addition the project benefited from the support and advice of the advisory group:

Heather Cunningham	Renfrewshire CHP
Linda de Caestecker	NHS Greater Glasgow and Clyde
Liz Holms	East Renfrewshire CHCP
Russell Jones	Glasgow Centre for Population Health
Jacqui McGinn	West Dunbartonshire CHCP
Karen McNiven	Glasgow City CHP (South Sector)
David Radford	East Dunbartonshire CHP
Clare Walker	Renfrewshire CHP
Helen Watson	Inverclyde CHCP

Objectives

The objectives of the study are:

- to continue to monitor the core health indicators
- to determine whether the changes found in the first three follow-ups were the beginning of a trend in the NHSGG area
- to compare attitudes and behaviour of those living in the bottom 15% SIMD areas and other areas and address whether changes in attitudes and behaviour apply across the board or just in the most deprived/other areas, thereby tracking progress towards reducing health inequalities
- to provide the first follow–up of health and wellbeing measures for NHSGGC
- to provide intelligence for health improvement policy, programmes and information to enhance performance management.

Summary of Methodology

In total, 6,101 face-to-face in-home interviews were conducted with adults (aged 16 or over) in the NHSGGC area. The fieldwork was conducted between mid August and mid December 2011. The response rate for all in-scope attempted contacts was 71% as illustrated in Table A3 in Appendix A.

The sample was stratified proportionately by local authority and SIMD quintile (for definition of SIMD see section 1.2), with addresses selected at random from the residential postcode address file within each stratum. Adults were randomly selected within each sampled household using the last birthday technique.

A full account of the sampling procedures, fieldwork and survey response can be found in Appendix A. The survey questionnaire is in Appendix E.

1.2 Sample Profile

The 1,086 completed interviews in East Dunbartonshire were weighted to account for under/over representation of groups within the sample to ensure the 2011 sample was as representative as possible of the adult population in East Dunbartonshire as a whole. A full explanation of the weighting method and the data sources used can be found in Appendix B. The breakdown of the final weighted dataset - and how this compares with the known population profile - is shown in Tables 1.1 - 1.2.

Table 1.1: Age and Gender Breakdown
Base: 1,077

Age	Men (% of sample)	Women (% of sample)	Total (% of sample)	East Dunbartonshire % of population (aged 16+)
16-24	7.4%	6.5%	14.0%	13.9%
25-34	5.8%	5.2%	11.0%	10.9%
35-44	7.4%	8.6%	16.0%	16.0%
45-54	9.4%	10.6%	20.0%	20.1%
55-64	7.9%	8.6%	16.5%	16.5%
65-74	5.6%	6.6%	12.2%	12.3%
75+	4.0%	6.3%	10.4%	10.4%

The Scottish Index of Multiple Deprivation (SIMD) 2009 is a relative measure of deprivation used to identify the most deprived areas in Scotland. It is constructed using 38 indicators within 7 'domains' (Income, Employment, Health, Education, Skills & Training, Geographic Access, Housing and Crime) each of which describes a specific aspect of deprivation. The SIMD is a weighted combination of these domains.

The SIMD is based on small geographical areas called datazones. The average population of a datazone in NHSGGC is 820 and unlike previous deprivation measures, which were based on much larger geographies (e.g. postcode sectors, average population 5,000), they enable the identification of small pockets of deprivation. In order to compare the most deprived small areas with other cut-off points, the most deprived 15% datazones are used. There are 6,505 datazones in Scotland. They are ranked from 1 (most deprived) to 6,505 (least deprived). The NHSGGC area contains the most deprived datazone in Scotland and in total 45.3% of the most deprived 15% datazones in Scotland lie within it.

Survey sampling and analysis for all other reports for the health and wellbeing survey have compared those in the 15% most deprived areas compared to other areas. However, due to low levels of deprivation in East Dunbartonshire, this was widened to those in the **20% most deprived** areas.

Table 1.2: Most Deprived 20% Datazones Versus Other Datazones
Base: All (1,086)

Group	% in sample	East Dunbartonshire % of population (aged 16+)
Most deprived 20% datazones	4.3%	4.2%
Other datazones	95.7%	95.8%

1.3 This Report

Chapters 2-6 report on all the survey findings, with each subject chapter containing its own summary. For each indicator, tables are presented showing the proportion of the sample which met the criteria, with comparisons with the NHS Greater Glasgow & Clyde (NHSGGC) area as a whole, and break-downs by demographic (independent) variables. Only comparisons with NHSGGC and independent variables which were found to be significantly different ($p<0.05$) are reported. The independent variables which were tested were:

- Gender;
- Age;

- Age and gender
- Most deprived 20% datazones versus other datazones;
- Whether all household income is from benefits;
- SIMD quintile;
- Whether feel isolated from family and friends;
- Whether have control over decisions affecting daily life;
- Self assessed general health;
- Self assessed physical wellbeing;
- Self assessed mental/emotional wellbeing;
- Self assessed quality of life;
- GHQ12 score (high/low);
- Whether has a limiting illness/condition;
- Whether exposed to second hand smoke (most/some of the time);
- Smoking status;
- Whether exceeds recommended weekly alcohol limits;
- Whether consumes 5+ portions of fruit/veg per day;
- BMI (obese/not obese);
- Whether has any educational qualifications.

Ethnicity is not included in the above list because (a) only a very small proportion of the sample is from an ethnic minority (reflecting the make-up of the population), and (b) it would be inadvisable to analyse all 'non-white' ethnic groups as one group, as the opinions, behaviour and cultural experiences of these groups do not necessarily have anything in common.

An explanation of how the independent variables were derived is in Appendix C.

2 People's Perceptions of Their Health & Illness

2.1 Chapter Summary

Table 2.1 below shows the indicators relating to perceptions of health and illness.

Table 2.1: Indicators for Perceptions of Health and Illness

Indicator	% of sample	Unweighted base (n)
Self-perceived health very good or good (Q1)	78%	1,086
Positive perception of general physical wellbeing (Q35b)	82%	1,084
Positive perception of general mental or emotional wellbeing (Q35c)	88%	1,080
Positive perception of happiness (Q44)	91%	1,086
Feel definitely in control of decisions affecting daily life (Q45)	62%	1,074
Positive perception of quality of life (Q35a)	93%	1,084
Has long term illness/condition that interferes with daily life (Q3)	18%	1,075
Receiving treatment for at least one condition (Q2)	42%	1,078
GHQ12 score of 4 or above (indicating poor mental health) (Q13)	23%	1,086
Have some/all of own teeth (Q10)	90%	1,081
Brushes teeth twice or more per day – based on those with some/all of own teeth (Q11)	78%	860

More than three in four (78%) respondents rated their general health positively. Those less likely to rate their general health positively were older respondents, those in the most deprived areas, those without qualifications, those receiving all household income from benefits, those who did not definitely feel in control of the decisions affecting their life, those with a high GHQ12 score (i.e. poor mental health), those with a limiting condition/illness, smokers and those consuming fewer than five portions of fruit/vegetables per day.

More than four in five (82%) respondents rated their physical wellbeing positively. Those less likely to rate their physical wellbeing positively included older respondents, those without qualifications, those who exhibited factors associated with social exclusion, those with a high GHQ12 score (i.e. poor mental health), those with a limiting condition or illness, smokers, obese people and those consuming fewer than five portions of fruit/vegetables per day.

Just under nine in ten (88%) respondents rated their mental or emotional wellbeing positively. Those less likely to rate their mental or emotional wellbeing positively included those aged 75 or over, those in the most deprived areas, those without qualifications, those who exhibited factors associated with social exclusion, respondents with a high GHQ12 score (indicating poor mental health), those with a limiting condition or illness, smokers, those exposed to second hand smoke and those consuming fewer than five portions of fruit/vegetables per day.

Nine in ten (91%) respondents gave a positive rating of their happiness. Those less likely to rate their happiness positively included those aged 75 or over, those in the most deprived areas, those without qualifications, those who exhibited factors associated with social exclusion, those with a high GHQ12 score, those with a limiting condition or illness, smokers, those exposed to second hand smoke and those who consumed fewer than five portions of fruit/vegetables per day.

Three in five (62%) respondents felt 'definitely' in control over the decisions affecting their lives. Those less likely to feel definitely in control of decisions included those in the youngest and oldest age groups, those in the 3rd and 5th SIMD quintiles, those without qualifications, those receiving all household income from benefits, those feeling isolated from family/friends, those with a High GHQ12 score, those with a limiting condition or illness and smokers.

More than nine in ten (93%) respondents gave a positive view of their overall quality of life. Those less likely to give a positive view included those aged 75 or over, those in the most deprived areas, those without qualifications, those who exhibited factors associated with social exclusion, those with a high GHQ12 score, and those with a limiting condition or illness.

Just under one in five (18%) respondents said that they had a long-term illness or condition that interfered with their daily life. Those more likely to have a long-term limiting illness/condition included those in the older age groups, those in the most deprived areas, those without qualifications, those who received all household income from benefits, those who did not definitely feel in control of decisions affecting their life and those with a high GHQ12 score.

Two in five (42%) respondents were receiving treatment for at least one condition or illness. Those more likely to be receiving treatment for a condition/illness were older people, those without qualifications, those who received all household income from benefits, those with a limiting illness/condition, those with a high GHQ12 score and obese people.

Just under one in four (23%) respondents had a high GHQ12 score, indicating poor mental health. Those more likely to have a high GHQ12 score included those aged 45-54, those without qualifications, those who exhibited factors associated with social exclusion, those with a limiting illness or condition, smokers and those who exceeded the recommended weekly limit for alcohol consumption.

Nine in ten (90%) respondents had some or all of their own teeth. Those less likely to have any of their own teeth included older respondents, those in the most deprived areas, those without qualifications, those whose household income comes entirely from benefits and those with a limiting condition or illness.

Of those with at least some of their own teeth, four in five (78%) said they brushed their teeth twice or more per day. Those less likely to brush their teeth twice or more per day included those aged 65 and over, men, those in the most deprived areas, those without qualifications, those who received all household income from benefits, smokers, those who exceeded the recommended weekly limit for alcohol consumption and obese people.

2.2 Self-Perceived Health and Wellbeing

General Health

Respondents were asked to describe their general health over the last year on a four point scale (excellent, good, fair or poor). Overall, more than three in four (78%) gave a positive view of their health, with 37% saying their health was very good and 41% saying their health was good. However, 22% gave a negative view of their health, with 14% saying their health was fair, 7% saying it was bad and 2% saying it was very bad.

As Table 2.2 shows, the likelihood of giving a positive view of general health generally decreased with age. Those rating their general health as very good or good ranged from 44% of those aged 75 or over to 97% of those aged 16-24.

Table 2.2: Self-Perceived General Health (Q1) by Age and Gender

	Very good	Good	Fair	Bad	Very bad	V good/ good	Fair/ bad	Unweighted base (n)
Age:								
16-24	63%	33%	3%	0%	0%	97%	3%	79
25-34	44%	38%	9%	9%	0%	83%	17%	127
35-44	58%	34%	5%	2%	1%	92%	8%	160
45-54	29%	54%	9%	4%	3%	83%	17%	176
55-64	28%	47%	14%	8%	3%	74%	26%	164
65-74	18%	39%	32%	10%	1%	57%	43%	187
75+	8%	36%	30%	23%	4%	44%	56%	184
Men 16-44	56%	33%	8%	3%	0%	89%	11%	128
Women 16-44	57%	37%	2%	3%	<1%	94%	6%	238
Men 45-64	30%	51%	10%	7%	2%	81%	19%	139
Women 45-64	27%	50%	13%	5%	5%	78%	22%	201
Men 65+	12%	38%	32%	15%	4%	50%	50%	143
Women 65+	15%	37%	29%	17%	1%	53%	47%	228
All	37%	41%	14%	7%	2%	78%	22%	1,086

As shown in Table 2.3, those living in the most deprived areas were the less likely to give a positive view of their general health. Also, 64% of those with no qualifications gave a positive view of their general health compared to 81% those with at least one qualification.

Table 2.3: Self-Perceived General Health (Q1) by Deprivation and Socio Economic Measures

	Very good	Good	Fair	Bad	Very bad	V good/ good	Fair/ bad	Unweighted base (n)
Bottom 20% datazones	25%	45%	19%	8%	3%	70%	30%	556
Other datazones	37%	41%	13%	7%	2%	78%	22%	530
SIMD quintile								
1 (most deprived)	25%	45%	19%	8%	3%	70%	30%	556
2	16%	52%	24%	8%	0%	68%	32%	72
3	29%	49%	11%	8%	4%	77%	23%	81
4	34%	38%	14%	10%	3%	73%	27%	99
5 (least deprived)	45%	37%	12%	5%	1%	82%	18%	278
At least one qualification	40%	41%	12%	6%	1%	81%	19%	746
No qualifications	22%	42%	21%	13%	3%	64%	36%	331

As Table 2.4 shows, respondents who did not feel in control of the decisions affecting their life tended to have less positive perceptions about their general health. Also, those who received all household income from benefits were particularly less likely to have positive views of their general health - just 37% of those receiving all household income from benefits described their general health as good or very good.

Table 2.4: Self-Perceived General Health (Q1) by Factors Associated with Social Exclusion

	Very good	Good	Fair	Bad	Very bad	V good/ good	Fair/ bad	Unweighted base (n)
All income from benefits	5%	31%	41%	18%	5%	37%	63%	273
Not in control of decisions affecting daily life, or only 'to some extent'	33%	38%	17%	11%	2%	71%	29%	366

Table 2.5 shows that a number of health and wellbeing measures were associated with less positive perceptions of general health. These were:

- Having a limiting condition or illness;
- Having a high GHQ12 score (indicating poor mental health);
- Being a smoker; and
- Consuming fewer than five portions of fruit/veg per day.

Health and wellbeing measures associated with more positive perceptions about general health were:

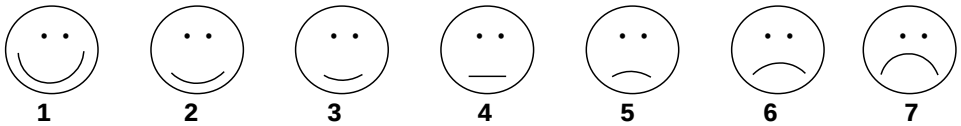
- Having a positive view of physical wellbeing;
- Having a positive view of mental/emotional wellbeing; and
- Having a positive view of quality of life.

Table 2.5: Self-Perceived General Health (Q1) by Health and Wellbeing Measures

	Very good	Good	Fair	Bad	Very bad	V good/ good	Fair/ bad	Unweighted base (n)
Positive view of physical wellbeing	42%	44%	9%	4%	1%	86%	14%	847
Positive view of mental/emotional wellbeing	39%	44%	12%	5%	1%	82%	18%	885
Positive view of quality of life	39%	42%	12%	6%	1%	81%	19%	920
High GHQ12 Score	29%	30%	22%	15%	4%	59%	41%	262
Limiting condition or illness	5%	22%	35%	28%	10%	26%	74%	274
Current smoker	34%	35%	17%	10%	4%	69%	31%	324
Consumes fewer than 5 portions of fruit/veg per day	37%	38%	16%	7%	2%	75%	25%	832

Physical Wellbeing

Respondents were presented with a 7-point 'faces' scale, with the expressions on the faces ranging from very happy to very unhappy:



Using this scale, they were asked to rate their general physical well-being and general mental or emotional well-being. Those selecting any of the three 'smiling' faces (1-3) were categorised as having a positive perception.

Eight in ten (82%) respondents gave a positive view of their physical wellbeing, using this scale.

Comparison with NHS Greater Glasgow & Clyde

Compared to the NHS Greater Glasgow & Clyde area as a whole, those in East Dunbartonshire were more likely to have a positive perception of their physical wellbeing (82% East Dunbartonshire; 78% NHS Greater Glasgow & Clyde).

As Table 2.6 shows, there was a clear relationship between age and perceptions of physical wellbeing – the younger the respondent the more likely they were to have a positive perception, ranging from 96% for 16-24 year olds to 65% for those aged 75 years old and over.

Table 2.6: Positive Perception of Physical Wellbeing (Q35b) by Age and Gender

	Positive Perception	Unweighted base (n)
Age:		
16-24	96%	79
25-34	87%	126
35-44	89%	160
45-54	75%	176
55-64	86%	163
65-74	75%	187
75+	65%	184
Men 16-44	87%	128
Women 16-44	94%	237
Men 45-64	74%	138
Women 45-64	86%	201
Men 65+	73%	143
Women 65+	69%	228
All	82%	1,084

Table 2.7 shows that those with no qualifications were less likely to have a positive perception of their physical wellbeing.

Table 2.7: Positive Perception of Physical Wellbeing (Q35b) by Deprivation and Socio Economic Measures

	Positive Perception	Unweighted base (n)
At least one qualification	85%	745
No qualifications	69%	330

As shown in Table 2.8, all three factors associated with social exclusion were associated with a lower likelihood of giving a positive view of physical wellbeing.

Table 2.8: Positive Perception of Physical Wellbeing (q35b) by Factors Associated with Social Exclusion

	Positive Perception	Unweighted base (n)
All income from benefits	58%	271
Feel isolated from friends/family	61%	81
Not in control of decisions affecting daily life, or only 'to some extent'	70%	364

The following health and wellbeing factors were associated with less positive views of physical wellbeing:

- Having a limiting condition or illness;
- Having a high GHQ12 score (indicating poor mental health);
- Being a smoker;
- Being obese; and
- Consuming fewer than five portions of fruit/vegetables per day.

Health and wellbeing measures associated with more positive perceptions about physical wellbeing were:

- Having a positive view of general health;
- Having a positive view of mental/emotional wellbeing; and
- Having a positive view of quality of life.

Table 2.9: Positive Perception of Physical Wellbeing (q35b) by Health and Wellbeing Measures

	Positive Perception	Unweighted base (n)		Positive Perception	Unweighted base (n)
Positive view of general health	91%	706	Limiting condition or illness	40%	273
Positive view of mental health	87%	884	Current smoker	73%	324
Positive view of quality of life	87%	920	Obese	77%	172
High GHQ12 Score	58%	262	Consumes fewer than 5 portions of fruit/veg per day	80%	831

Mental or Emotional Wellbeing and Happiness

Using the 'faces' scale, 88% of respondents gave a positive view of their mental or emotional wellbeing.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were more likely than those in the NHS Greater Glasgow & Clyde area as a whole to have a positive view of their mental or emotional wellbeing (88% East Dunbartonshire; 82% NHS Greater Glasgow & Clyde).

Table 2.10 shows that perceptions of mental or emotional wellbeing varied for different age groups. Those aged 16-24 were the most likely to give a positive view (96% in this age group did so). Those aged 75 or over and those aged 35-44 were among the least likely to have a positive view of their mental/emotional wellbeing.

Table 2.10: Positive Perception of Mental or Emotional Wellbeing (Q35c) by Age and Gender

	Positive Perception	Unweighted base (n)
Age:		
16-24	96%	79
25-34	90%	127
35-44	84%	160
45-54	89%	176
55-64	85%	164
65-74	92%	185
75+	82%	181
All	88%	1,080

Table 2.11 shows that those living in the most deprived areas were less likely to give a positive view of their mental or emotional wellbeing. Also, respondents without qualifications were less likely to have a positive view of their mental or emotional wellbeing than those with at least one qualification (79% and 90% respectively).

Table 2.11: Positive Perception of Mental or Emotional Wellbeing (Q35c) by Deprivation and Socio Economic Measures

	Positive Perception	Unweighted base (n)
Bottom 20% datazones	79%	555
Other datazones	89%	525
SIMD quintile		
1 (most deprived)	79%	555
2	86%	72
3	86%	81
4	93%	99
5 (least deprived)	89%	273
At least one qualification	90%	745
No qualifications	79%	327

As Table 2.12 shows, all three factors associated with social exclusion were associated with less positive perceptions of mental or emotional wellbeing.

Table 2.12: Positive Perception of Mental or Emotional Wellbeing (q35c) by Factors Associated with Social Exclusion

	Positive Perception	Unweighted base (n)
All income from benefits	63%	273
Feel isolated from friends/family	71%	76
Not in control of decisions affecting daily life, or only 'to some extent'	77%	360

Table 2.13 shows that more positive views of mental or emotional wellbeing were associated with those with a positive view of their general health, physical health and quality of life. Those least likely to give a positive view were respondents with a high GHQ12 score (indicating poor mental health) and those with a limiting condition or illness. Other factors associated with less positive views of mental or emotional wellbeing were smoking, being exposed to second hand smoke and consuming fewer than five portions of fruit/vegetables per day.

Table 2.13: Positive Perception of Mental or Emotional Wellbeing (q35c) by Health and Wellbeing Measures

	Positive Perception	Unweighted base (n)		Positive Perception	Unweighted base (n)
Positive view of general health	93%	707	Limiting condition or illness	68%	271
Positive view of physical health	94%	846	Exposed to second hand smoke	84%	377
Positive view of quality of life	92%	918	Current smoker	78%	324
High GHQ12 Score	59%	256	Consumes fewer than 5 portions of fruit/veg per day	86%	826

Respondents were also asked to use the 'faces' scale to indicate how happy they are, taking everything into account. Overall, nine in ten (91%) respondents gave a positive view of their happiness.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were more likely than those in the NHS Greater Glasgow & Clyde area as a whole to have a positive view of their happiness (91% East Dunbartonshire; 85% NHS Greater Glasgow & Clyde).

Views of happiness varied for different age groups, with 16-24 year olds being the most likely to give a positive perception of their happiness (99% did) and those aged 75 or over were the least likely to give a positive view (83%). This is shown in Table 2.14.

Table 2.14: Positive Perception of Happiness (Q44) by Age and Gender

	Positive Perception	Unweighted base (n)
Age:		
16-24	99%	79
25-34	86%	127
35-44	91%	160
45-54	90%	176
55-64	92%	164
65-74	95%	187
75+	83%	184
Men 16-44	91%	128
Women 16-44	94%	238
Men 45-64	96%	139
Women 45-64	86%	201
Men 65+	92%	143
Women 65+	87%	228
All	91%	1,086

Table 2.15 shows that those living in the most deprived areas and those with no qualifications were less likely to give a positive view of their happiness.

Table 2.15: Positive Perception of Happiness (Q44) by Deprivation and Socio Economic Measures

	Positive Perception	Unweighted base (n)
Bottom 20% datazones	79%	556
Other datazones	91%	530
SIMD quintile		
1 (most deprived)	79%	556
2	89%	72
3	88%	81
4	96%	99
5 (least deprived)	91%	278
At least one qualification	94%	746
No qualifications	78%	331

All three factors associated with social exclusion were associated with less positive perceptions of happiness, as shown in Table 2.16.

Table 2.16: Positive Perception of Happiness (Q44) by Factors Associated with Social Exclusion

	Positive Perception	Unweighted base (n)
All income from benefits	59%	273
Feel isolated from friends/family	67%	81
Not in control of decisions affecting daily life, or only 'to some extent'	79%	366

Table 2.17 shows that those with a positive view of their general health, their physical health, their mental/emotional wellbeing and their quality of life were more likely to have a positive perception of their happiness. Those with a high GHQ12 score (indicating poor mental health) and those with a limiting condition or illness were particularly less likely to have a positive view of their happiness. Other measures associated with less positive views of happiness were smoking, being exposed to second hand smoke and consuming fewer than five portions of fruit/vegetables per day.

Table 2.17: Positive Perception of Happiness (Q44) by Health and Wellbeing Measures

	Positive Perception	Unweighted base (n)		Positive Perception	Unweighted base (n)
Positive view of general health	96%	707	Limiting condition or illness	73%	274
Positive view of physical health	96%	847	Exposed to second hand smoke	88%	377
Positive view of mental/ emotional wellbeing	96%	885	Current smoker	82%	324
Positive view of quality of life	95%	920	Consumes fewer than 5 portions of fruit/veg per day	89%	832
High GHQ12 Score	71%	262			

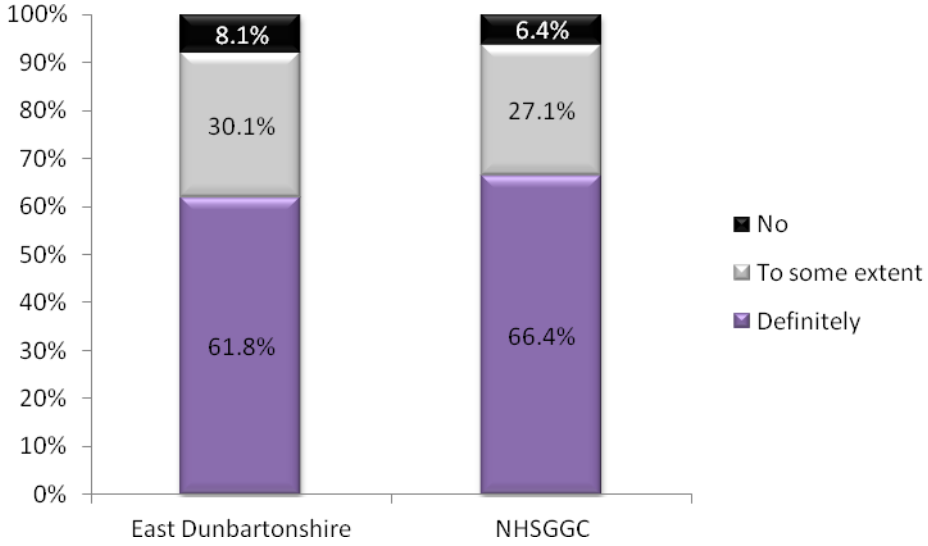
Feeling in Control of Decisions Affecting Life

Respondents were asked whether they feel in control of decisions that affect their life, such as planning their budget, moving house or changing job. Three in five (62%) said that they 'definitely' feel in control of these decisions, while 30% said that they felt in control 'to some extent' and 8% did not feel in control of these decisions.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde as a whole to definitely feel in control of decisions that affect their life (62% East Dunbartonshire; 66% NHS Greater Glasgow & Clyde).

Figure 2.1: Extent Feel in Control of Decisions Affecting Life (Q45): East Dunbartonshire and NHS Greater Glasgow & Clyde



The youngest and oldest age groups were the least likely to say that they definitely felt in control of the decisions affecting their lives. This is shown in Table 2.18.

Table 2.18: 'Definitely' Feel in Control of Decisions Affecting Life (Q45) by Age and Gender

	Definitely in Control	Unweighted base (n)
Age:		
16-24	45%	76
25-34	69%	127
35-44	55%	159
45-54	69%	175
55-64	74%	162
65-74	67%	187
75+	50%	179
Men 16-44	61%	125
Women 16-44	50%	237
Men 45-64	62%	137
Women 45-64	79%	200
Men 65+	66%	142
Women 65+	54%	224
All	62%	1,074

Those living in the 20% most deprived areas were more likely than those in other areas to say they definitely felt in control of their lives (69% and 61% respectively). However, those in those fourth SIMD quintile (second least deprived) were the most likely to feel in control of decisions affecting their life. Those with no qualifications were less likely than those with at least one qualification to say that they were definitely in control of decisions.

Table 2.19: 'Definitely' Feel in Control of Decisions Affecting Life (Q45) by Deprivation and Socio Economic Measures

	Definitely in Control	Unweighted base (n)
Bottom 20% datazones	69%	549
Other datazones	61%	525
SIMD quintile		
1 (most deprived)	69%	549
2	67%	72
3	54%	80
4	82%	97
5 (least deprived)	56%	276
At least one qualification	65%	741
No qualifications	45%	324

Perceived lack of control over the decisions affecting one's life is used throughout this report as a measure of social exclusion. Respondents exhibiting either of the other two measures of social exclusion (all income from benefits and feelings of isolation) were associated with a lower likelihood of feeling 'definitely' in control over decisions affecting life. This is shown in Table 2.20. Less than a quarter of those who felt isolated from their friends/family or felt definitely in control over the decisions affecting their life.

Table 2.20: 'Definitely' Feel in Control of Decisions Affecting Life (Q45) by Factors Associated with Social Exclusion

	Definitely in Control	Unweighted base (n)
All income from benefits	42%	267
Feel isolated from friends/family	23%	80

Table 2.21 shows that positive views of general health, physical health, mental/emotional wellbeing and quality of life were associated with a higher likelihood of feeling definitely in control of the decisions affecting life. Those less likely to feel in control of decisions were those with a High GHQ12 score, those with a limiting condition or illness and smokers.

Table 2.21: 'Definitely' Feel in Control of Decisions Affecting Life (Q45) by Health and Wellbeing Measures

	Definitely in Control	Unweighted base (n)		Definitely in Control	Unweighted base (n)
Positive view of general health	65%	701	High GHQ12 Score	32%	257
Positive view of physical health	67%	841	Limiting condition or illness	49%	269
Positive view of mental/ emotional wellbeing	67%	880	Exposed to second hand smoke	53%	370
Positive view of quality of life	65%	914			

2.3 Self Perceived Quality of Life

Using the 'faces' scale, respondents were asked to rate their overall quality of life. Overall, 93% of respondents gave a positive rating of their quality of life.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were more likely than those in the NHS Greater Glasgow & Clyde area as a whole to have a positive view of their quality of life (93% East Dunbartonshire; 84% NHS Greater Glasgow & Clyde).

Those aged 16-24 were the most likely to give a positive view of their overall quality of life (100% did so) and those aged 75 or over were the least likely (81%).

Table 2.22: Positive Perception of Quality of Life (Q35a) by Age and Gender

	Positive Perception	Unweighted base (n)
Age:		
16-24	100%	79
25-34	93%	126
35-44	96%	160
45-54	91%	176
55-64	95%	163
65-74	93%	187
75+	81%	184
Men 16-44	97%	128
Women 16-44	96%	237
Men 45-64	93%	138
Women 45-64	92%	201
Men 65+	92%	143
Women 65+	83%	228
All	93%	1,084

Table 2.23 shows that less positive views of overall quality of life were given by those living in the most deprived areas and those with no qualifications.

Table 2.23: Positive Perception of Quality of Life (Q35a) by Deprivation and Socio Economic Measures

	Positive Perception	Unweighted base (n)
Bottom 20% datazones	83%	555
Other datazones	93%	529
SIMD quintile		
1 (most deprived)	83%	555
2	87%	71
3	96%	81
4	97%	99
5 (least deprived)	92%	278
At least one qualification	94%	745
No qualifications	85%	330

Table 2.24 shows that all three factors associated with social exclusion were associated with less positive perceptions of overall quality of life.

Table 2.24: Positive Perception of Quality of Life (Q35a) by Factors Associated with Social Exclusion

	Positive Perception	Unweighted base (n)
All income from benefits	73%	271
Feel isolated from friends/family	80%	81
Not in control of decisions affecting daily life, or only 'to some extent'	84%	364

Respondents with a positive view of their general health, physical health or mental/emotional wellbeing were also more likely to have a positive view of their overall quality of life. Those with a high GHQ12 score (indicating poor mental health) and those with a limiting condition or illness were less likely to have a positive view of their quality of life. This is shown in Table 2.25.

Table 2.25: Positive Perception of Quality of Life (Q35a) by Health and Wellbeing Measures

	Positive Perception	Unweighted base (n)		Positive Perception	Unweighted base (n)
Positive view of general health	97%	706	High GHQ12 Score	74%	262
Positive view of physical health	98%	847	Limiting condition or illness	75%	273
Positive view of mental/ emotional wellbeing	97%	884			

2.4 Illness

Just under one in five (18%) respondents said that they had a long-term condition or illness that substantially interfered with their day to day activities.

Of those who said they had a long-term condition or illness that interfered with their day to day activities:

- 58% said that they had a physical disability;
- 21% said they had a mental or emotional health problem; and
- 64% said they had a long-term illness.

Of those with a limiting long-term condition or illness:

- 70% said it interfered with taking up training;
- 67% said it interfered with holding down or obtaining a job;
- 80% said it interfered with taking exercise/physical activity; and
- 80% said it interfered with socialising.

The likelihood of having a limiting condition or illness increased with age, ranging from 4% of 16-24 year olds to 44% of those aged 75 or over.

Table 2.26: Limiting Long-Term Condition or Illness (Q3) by Age and Gender

	Long-Term Condition / Illness	Unweighted base (n)
Age:		
16-24	4%	78
25-34	14%	126
35-44	6%	158
45-54	17%	173
55-64	19%	162
65-74	31%	186
75+	44%	183
Men 16-44	10%	125
Women 16-44	4%	237
Men 45-64	15%	136
Women 45-64	20%	199
Men 65+	43%	141
Women 65+	32%	228
All	18%	1,075

Table 2.27 shows that those living in the most deprived areas were more likely than others to have a limiting long-term condition/illness. Also, limiting conditions/illnesses were more common among those with no qualifications than those with qualifications (26% and 16% respectively).

Table 2.27: Limiting Long-Term Condition or Illness (Q3) by Deprivation and Socio Economic Measures

	Long-term condition / illness	Unweighted base (n)
Bottom 20% datazones	23%	546
Other datazones	18%	529
At least one qualification	16%	742
No qualifications	26%	324

Those who received all household income from benefits and those who did not definitely feel in control of the decisions affecting their life were more likely to have a limiting long-term condition or illness.

Table 2.28: Limiting Long-Term Condition or Illness (Q3) by Factors Associated with Social Exclusion

	Long-term condition / illness	Unweighted base (n)
All income from benefits	53%	264
Not in control of decisions affecting daily life, or only 'to some extent'	24%	227

Table 2.29 shows that those less likely to have a limiting long-term condition or illness were:

- Those with a positive view of their general health;
- Those with a positive view of their physical health;

- Those with a positive view of their mental/emotional wellbeing; and
- Those with a positive view of their quality of life.

Those with a high GHQ12 score (indicating poor mental health) were more likely to have a limiting condition or illness.

Table 2.29: Limiting Long-Term Condition or Illness (Q3) by Health and Wellbeing Measures

	Long-term condition / illness	Unweighted base (n)		Long-term condition / illness	Unweighted base (n)
Positive view of general health	6%	702	Positive view of quality of life	14%	913
Positive view of physical health	9%	843	High GHQ12 Score	41%	257
Positive view of mental/ emotional wellbeing	14%	881			

Illnesses/Conditions for Which Treatment is Being Received

Two in five (42%) respondents were receiving treatment for at least one illness or condition.

The likelihood of being in receipt of treatment for at least one illness/condition rose with age – from 4% of those aged 16-24 to 88% of those aged 75 or over.

Table 2.30: At Least One Illness/Condition Being Treated (Q2) by Age and Gender

	Being Treated for Condition / Illness	Unweighted base (n)
Age:		
16-24	4%	78
25-34	19%	126
35-44	24%	159
45-54	39%	174
55-64	55%	162
65-74	76%	186
75+	88%	184
Men 16-44	18%	125
Women 16-44	13%	238
Men 45-64	45%	137
Women 45-64	47%	199
Men 65+	79%	142
Women 65+	83%	228
All	42%	1,078

Those with no qualifications were much more likely than those with at least one qualification to be receiving treatment for an illness or condition. This is shown in Table 2.31.

Table 2.31: At Least One Illness/Condition Being Treated (Q2) by Deprivation and Socio Economic Measures

	Being Treated for Condition/ Illness	Unweighted base (n)
At least one qualification	36%	745
No qualifications	71%	324

Table 2.32 shows that nearly three in four of those who received all household income from benefits were receiving treatment for at least one illness or condition.

Table 2.32 At Least One Illness/Condition Being Treated (Q2) by Factors Associated with Social Exclusion

	Being Treated for Condition/ Illness	Unweighted base (n)
All income from benefits	73%	266

Table 2.33 shows that the following groups were less likely to be receiving treatment for one or more illness/condition:

- Those with a positive view of their general health;
- Those with a positive view of their physical health;
- Those with a positive view of their mental/emotional wellbeing;
- Those with a positive view of their quality of life; and
- Those exposed to second hand smoke.

As would be expected most (96%) of those who said they had a limiting illness or condition were currently being treated for an illness or condition. Being obese and having a high GHQ12 score (indicating poor mental health) were also associated with a high likelihood of receiving treatment.

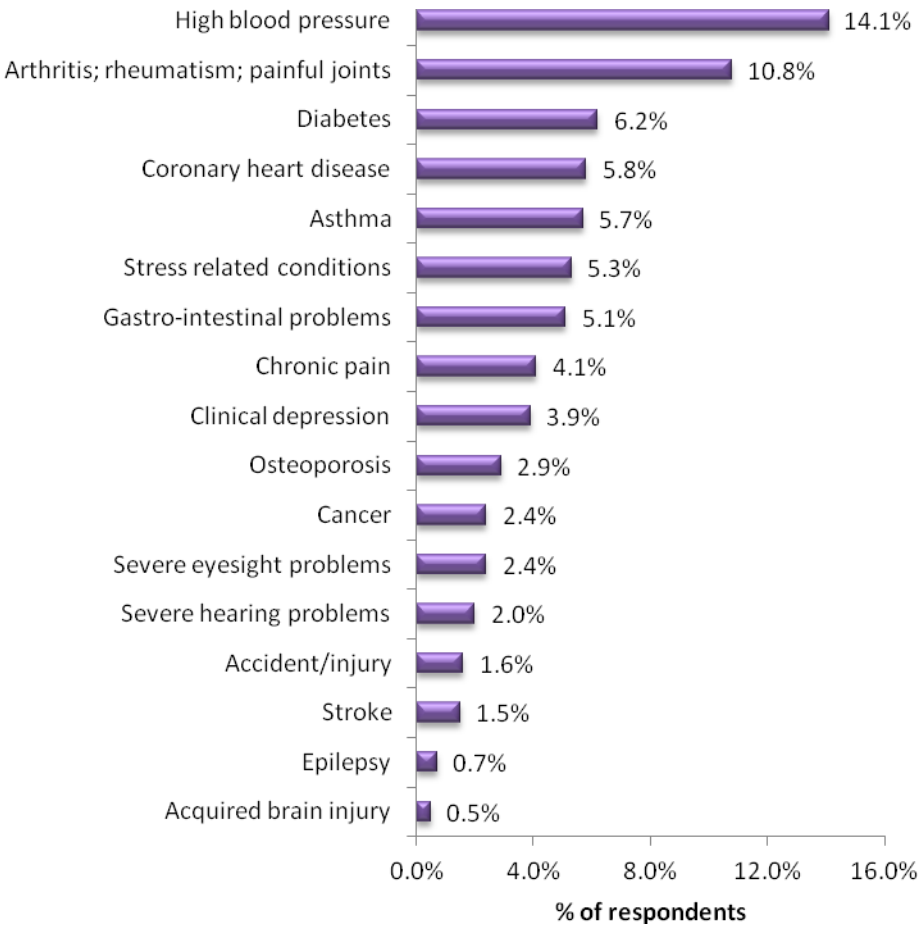
Table 2.33: At Least One Illness/Condition Being Treated (Q2) by Health and Wellbeing Measures

	Being Treated for Condition/ Illness	Unweighted base (n)		Being Treated for Condition/ Illness	Unweighted base (n)
Positive view of general health	27%	700	High GHQ12 Score	61%	260
Positive view of physical health	33%	844	Limiting condition or illness	96%	274
Positive view of mental/ emotional wellbeing	37%	883	Exposed to second hand smoke	32%	370
Positive view of quality of life	38%	916	Obese	62%	172

Figure 2.2 below shows the proportion of respondents who were being treated for each type of illness/condition (for all those with a proportion of 0.5% or more).

The most common condition being treated was high blood pressure, for which 14% of respondents were being treated. Also, 11% of respondents were being treated for arthritis/rheumatism/painful joints.

Figure 2.2: Conditions / Illnesses for Which Treatment is Being Received (Q2)



2.5 Mental Health

GHQ12 Scores

The survey used the General Health Questionnaire (GHQ) to assess the mental health of respondents. The GHQ was designed to be a self-administered questionnaire which could be used to detect psychiatric disorders in the general population. The version used for this survey is based on twelve questions (GHQ12) which ask respondents about their general level of happiness, depression, anxiety, self-confidence, and stress in the few weeks before the interview. Respondents were asked to complete the responses themselves. Interviewers recorded whether they actually did so, or whether they asked the interviewer to help.

Each respondent was given a score between 0 and 12, based on his/her responses to the 12 questions. The number of questions for which the respondent claimed to have experienced a particular symptom or type of behaviour 'more than usual' or 'much more than usual' over the past few weeks is counted, and the total is the score for that person. The higher the score, the greater the likelihood that the respondent has a psychiatric disorder.

The questions on the GHQ12 ask about changes from normal functioning but not about how long those changes have persisted. As a result, the GHQ detects psychiatric disorders of a range of durations, including those that may be of very short duration. This should be borne in mind when interpreting the results. The prevalence figures presented in this chapter estimate the percentages of the population with a possible psychiatric disorder at a

particular point in time and are most useful for comparing sub-groups within the population. It is not possible to deduce the incidence of psychiatric disorders from these data.

A score of four or more on the GHQ12 has been used to identify those with a potential psychiatric disorder (and references to respondents with a 'high' GHQ12 score refer to those with scores at this level). This is the same method of scoring that is used in the Scottish Health Survey series.

Overall, 23% of respondents had a GHQ12 score of four or more, indicating poor mental health.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were more likely than those in the NHS Greater Glasgow area as a whole to have a high GHQ12 score (23% East Dunbartonshire; 15% NHSGGC).

The likelihood of having a high GHQ12 score varied for different age groups, ranging from 13% of those aged 25-34 to 30% of those aged 45-54.

Table 2.34: High GHQ12 Score (Q13) by Age and Gender

	High GHQ12 Score	Unweighted base (n)
Age:		
16-24	20%	79
25-34	13%	127
35-44	23%	160
45-54	30%	176
55-64	19%	164
65-74	21%	187
75+	28%	184
All	23%	1,086

High GHQ12 scores were more common for those with no qualifications, as shown in Table 2.35.

Table 2.35: High GHQ12 Score (Q13) by Deprivation and Socio Economic Measures

	High GHQ12 Score	Unweighted base (n)
At least one qualification	21%	746
No qualifications	29%	331

Table 2.36 shows that all three factors associated with social exclusion were associated with a higher likelihood of having a high GHQ12 score. Half (49%) of those who felt isolated from friends/family had a GHQ12 score of four or more.

Table 2.36 High GHQ12 Score (Q13) by Factors Associated with Social Exclusion

	High GHQ12 Score	Unweighted base (n)
All income from benefits	36%	273
Feel isolated from friends/family	49%	81
Not in control of decisions affecting daily life, or only 'to some extent'	40%	366

Table 2.37 shows that those with a positive view of their general health, physical health, mental/emotional wellbeing or quality of life were less likely to have a high GHQ12 score. Those who had a limiting illness or condition were much more likely than others to have a high GHQ12 score (52% did). Other factors associated with a higher likelihood of having a high GHQ12 score were smoking and exceeding the recommended weekly limit for alcohol consumption.

Table 2.37: High GHQ12 Score (Q13) by Health and Wellbeing Measures

	High GHQ12 Score	Unweighted base (n)		High GHQ12 Score	Unweighted base (n)
Positive view of general health	17%	707	Limiting condition or illness	52%	274
Positive view of physical health	16%	847	Current smoker	35%	324
Positive view of mental/ emotional wellbeing	15%	885	Exceeds weekly alcohol limit	33%	170
Positive view of quality of life	18%	920			

Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) Scores

The survey also used the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) to assess positive mental health (mental wellbeing). This uses 14 positively worded questions. Scores are derived by summing responses to each of the 14 questions on a 1-5 likert scale. Thus, the maximum score is 70 and the minimum score in 14. The scale is designed to allow the measurement of mean scores in population samples. The provisional mean score for the Scottish population is 50.7.

The overall mean WEMWBS score for respondents was 52.1.

Mean WEMWBS scores indicate that mental wellbeing decreased with age, from 55.8 for those aged 16-24 to 49.0 for those aged 75 or over.

Table 2.38: Mean WEMWBS Score (Q14) by Age and Gender

	Mean WEMWBS Score	Unweighted base (n)
Age:		
16-24	55.8	75
25-34	53.7	123
35-44	52.3	157
45-54	50.3	174
55-64	52.9	161
65-74	51.6	180
75+	49.0	174
Men 16-44	53.9	124
Women 16-44	53.8	231
Men 45-64	50.6	137
Women 45-64	52.2	198
Men 65+	51.5	138
Women 65+	49.5	216
All	52.1	1,052

Those who live in the least deprived areas and those with qualifications had higher mean WEMEBS scores, indicating better mental wellbeing. This is shown in Table 2.39.

Table 2.39: Mean WEMWBS Score (Q14) by Deprivation and Socio Economic Measures

	Mean WEMWBS Score	Unweighted base (n)
Bottom 20% datazones	48.0	546
Other datazones	52.3	506
SIMD quintile		
1 (most deprived)	48.0	546
2	49.5	71
3	49.8	77
4	54.1	97
5 (least deprived)	53.1	261
At least one qualification	52.7	730
No qualifications	48.4	313

Table 2.40 shows that all three factors associated with social exclusion were associated with lower WEMEBS scores, indicating poorer mental wellbeing.

Table 2.40: Mean WEMWBS Score (Q14) by Factors Associated with Social Exclusion

	Mean WEMWBS Score	Unweighted base (n)
All income from benefits	43.4	264
Feel isolated from friends/family	46.9	75
Not in control of decisions affecting daily life, or only 'to some extent'	48.4	345

Health and wellbeing factors associated with lower WEMWBS scores were:

- Having a high GHQ12 score;
- Having a limiting condition or illness;
- Being a smoker;
- Being exposed to second hand smoke;
- Being obese; and
- Consuming fewer than five portions of fruit/vegetables per day.

Factors associated with a higher WEMWBS score were having a positive view of general health, physical health, mental/emotional wellbeing and quality of life.

Table 2.41: Mean WEMEBS Score (Q14) by Health and Wellbeing Measures

	Mean WEMWBS Score	Unweighted base (n)		Mean WEMWBS Score	Unweighted base (n)
Positive view of general health	53.7	689	Limiting condition or illness	46.7	259
Positive view of physical health	53.8	830	Exposed to second hand smoke	50.5	369
Positive view of mental/ emotional wellbeing	53.6	861	Current smoker	47.7	317
Positive view of quality of life	53.1	897	Obese	50.8	169
High GHQ12 Score	43.6	250	Consumes fewer than 5 portions of fruit/veg per day	51.5	804

2.6 Oral Health

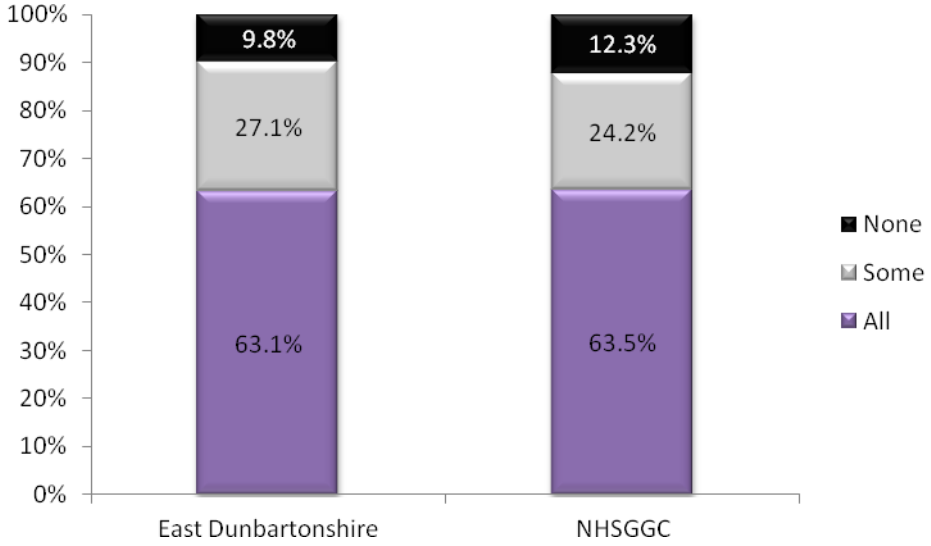
Proportion of Own Teeth

Respondents were asked what proportion of their teeth were their own. Most (90%) respondents said that they had all (63%) or some (27%) of their own teeth, while 10% had none of their own teeth.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were more likely than those in the NHG Greater Glasgow & Clyde area as a while to have any of their own teeth (90% East Dunbartonshire; 88% NHSGGC)

Figure 2.3: Proportion of Own Teeth (Q10): East Dunbartonshire and NHS Greater Glasgow & Clyde



The proportion with all or some of their own teeth ranged from 59% among those aged 75 or over to 100% of those aged under 35.

Table 2.42: Proportion of Own Teeth (Q10) by Age and Gender

	All	Some	None	All/some	Unweighted base (n)
Age:					
16-24	97%	3%	0%	100%	79
25-34	94%	6%	0%	100%	126
35-44	80%	18%	2%	98%	160
45-54	58%	40%	1%	99%	176
55-64	56%	34%	10%	90%	163
65-74	27%	48%	25%	75%	187
75+	25%	34%	41%	59%	182
Men 16-44	86%	12%	2%	98%	128
Women 16-44	93%	7%	0%	100%	237
Men 45-64	54%	43%	3%	97%	138
Women 45-64	61%	32%	7%	93%	201
Men 65+	28%	38%	34%	66%	143
Women 65+	24%	45%	31%	69%	226
All	63%	27%	10%	90%	1,081

Those in the least deprived areas were more likely to have all or some of their own teeth. Also, those with no qualifications were more likely to say that they had none of their own teeth. This is shown in Table 2.43.

Table 2.43: Proportion of Own Teeth (Q10) by Deprivation and Socio Economic Measures

	All	Some	None	All/some	Unweighted base (n)
Bottom 20% datazones	50%	33%	17%	83%	554
Other datazones	64%	27%	9%	91%	527
SIMD quintile					
1 (most deprived)	50%	33%	17%	83%	554
2	52%	32%	16%	84%	72
3	69%	20%	11%	89%	81
4	61%	31%	8%	92%	98
5 (least deprived)	66%	26%	8%	92%	276
At least one qualification	69%	25%	6%	94%	745
No qualifications	32%	40%	28%	72%	328

Those who received all household income from benefits were less likely to have all/some of their own teeth. This is shown in Table 2.44.

Table 2.44: Proportion of Own Teeth (Q10) by Factors Associated with Social Exclusion

	All	Some	None	All/some	Unweighted base (n)
All income from benefits	32%	37%	32%	68%	271

For health and wellbeing measures, those more likely to have all or some of their own teeth were those who:

- Had a positive view of their general health;
- Had a positive view of their physical wellbeing; and
- Had a positive view of their quality of life.

Those with a limiting condition or illness were less likely to have any of their own teeth.

Table 2.45: Proportion of Own Teeth (Q10) by Health and Wellbeing Measures

	All	Some	None	All/some	Unweighted base (n)
Positive view of general health	68%	26%	5%	95%	706
Positive view of physical wellbeing	67%	25%	8%	92%	845
Positive view of quality of life	64%	27%	9%	91%	917
Limiting condition or illness	47%	29%	24%	76%	273

Frequency of Brushing Teeth

Those with at least some of their own teeth were asked how often they brushed their teeth. Four in five (78%) said they brushed their teeth at least twice a day.

Those aged under 35 were the most likely to say that they brushed their teeth twice or more per day. Women were more likely than men to brush their teeth at least twice per day (86% of women and 69% of men did so).

Table 2.46: Brushes Teeth Twice or More Per Day (Q11) by Age and Gender

	Brushes Teeth 2x or more per day	Unweighted base (n)
Age:		
16-24	83%	79
25-34	84%	123
35-44	78%	157
45-54	80%	162
55-64	79%	135
65-74	66%	123
75+	72%	74
Men	86%	331
Women	69%	529
Men 16-44	72%	124
Women 16-44	90%	235
Men 45-64	69%	124
Women 45-64	90%	173
Men 65+	63%	80
Women 65+	72%	117
All	78%	860

Those in the most deprived areas and those with no qualifications were less likely to brush their teeth twice or more per day.

Table 2.47: Brushes Teeth Twice or More Per Day (Q11) by Deprivation and Socio Economic Measures

	Brushes Teeth 2x or more per day	Unweighted base (n)
Bottom 20% datazones	64%	417
Other datazones	79%	443
SIMD quintile		
1 (most deprived)	64%	417
2	69%	54
3	71%	64
4	83%	85
5 (least deprived)	82%	240
At least one qualification	80%	649
No qualifications	64%	205

As Table 2.48 shows, those who received all household income from benefits were much less likely to brush their teeth twice or more per day (just two in five did so). Also, those who did not definitely feel in control of the decisions affecting their life were less likely to brush their teeth at least twice a day.

Table 2.48: Brushes Teeth Twice or More Per Day (Q11) by Factors Associated with Social Exclusion

	Brushes Teeth 2x or more per day	Unweighted base (n)
All income from benefits	40%	181
Not in control of decisions affecting daily life, or only 'to some extent'	70%	289

As Table 2.49 shows, health and wellbeing measures associated with a higher likelihood of brushing teeth at least twice per day were having a positive view of general health, physical health, mental/emotional health and quality of life.

Measures associated with a lower likelihood of brushing teeth twice per day were:

- Being a smoker;
- Exceeding the recommended weekly alcohol limit; and
- Being obese.

Table 2.49: Brushes Teeth Twice or More Per Day (Q11) by Health and Wellbeing Measures

	Brushes Teeth 2x or more per day	Unweighted base (n)		Brushes Teeth 2x or more per day	Unweighted base (n)
Positive view of general health	80%	614	Current smoker	65%	252
Positive view of physical health	81%	691	Exceeds weekly alcohol limit	70%	153
Positive view of mental/ emotional wellbeing	79%	705	Obese	73%	132
Positive view of quality of life	80%	736			

3 The Use of Health Services

3.1 Chapter Summary

Table 3.1: Indicators for Use of Health Services

Indicator	% of sample	Unweighted base (n)
Seen a GP at least once in last year (Q6a)	76%	1,083
Outpatient to see doctor at least once in last year (Q7d)	28%	1,086
Accident and emergency at least once in last year (Q7c)	13%	1,086
Hospital stay in last year (q7e)	14%	1,086
Seen Pharmacist for health advice in last year (Q7a)	11%	1,084
Contacted NHS24 in last year (Q7b)	8%	1,086
Used GP out of hours service in last year (q7f)	5%	1,085
Been to the dentist within past six months (Q9)	64%	901
Difficulty reaching hospital for an appointment (Q12d)	8%	795
Difficulty getting GP appointment (Q12a)	14%	1,011
Difficulty getting hospital appointment (Q12c)	10%	710
Difficulty getting GP consultation within 48 hours (Q12f)	8%	869
Difficulty accessing health services in an emergency (Q12b)	5%	723
Difficulty getting dentist appointment (Q12e)	4%	793

Three in four (76%) respondents had seen a GP in the last year. Those more likely to have seen a GP were older respondents, women, those in the most deprived areas, those with no qualifications, those with a limiting condition or illness, those with a high GHQ12 and those who consumed fewer than five portions of fruit/vegetables per day.

Three in ten (28%) respondents had visited hospital as an outpatient to see a doctor in the last year. Those most likely to have been outpatients were those aged 75 or over, women, those with no qualifications, those who received all household income from benefits, those with a limiting condition or illness, those with a high GHQ12 score and obese people.

Thirteen percent of respondents had visited accident and emergency in the last year. Those most likely to have visited accident and emergency were 16-24 year olds, men, those with a limiting condition/illness and those exposed to second hand smoke.

One in seven (14%) had been admitted to hospital in the last year. Those most likely to have been admitted to hospital were older people, those who received all household income from benefits, those with a limiting condition or illness and those with a high GHQ12 score.

One in nine (11%) had seen a pharmacist for health advice in the last year. Those most likely to have consulted a pharmacist were men, those who did not definitely feel in control of the decisions affecting their life and those who exceeded the recommended weekly limit for alcohol consumption.

Eight percent had contacted NHS24 in the last year. Those most likely to have contacted NHS24 were those with a limiting illness or condition, those with a high GHQ12 score, smokers and obese people.

Five percent of respondents had used the GP out of hours service in the last year. Those more likely to have done so were those with a high GHQ12 score and those with a limiting illness or condition.

Just under two in three (64%) respondents had visited the dentist within the last six months. Those less likely to have visited the dentist in the last six months were those in the oldest age groups, men, those who exhibited factors associated with social exclusion,

smokers, those with a limiting condition or illness, those exposed to second hand smoke, obese people and those who consumed fewer than five portions of fruit/vegetables per day.

One in 12 (8%) respondents said that it was difficult for them to reach hospital for an appointment. Those who were more likely to have difficulty reaching hospital were those aged 65 or over, those in the most deprived areas, those without qualifications, those who received all household income from benefits, those with a high GHQ12 score and smokers.

One in seven (14%) said that they had difficulty getting a GP appointment. Those more likely to have difficulty getting a GP appointment were those aged under 25, women, those in the most deprived areas, those who received all household income from benefits, smokers, those exposed to second hand smoke and those who consumed fewer than five portions of fruit/vegetables per day.

One in ten (10%) respondents said that it was difficult to get a hospital appointment. Those more likely to say this were those who felt isolated, those who did not definitely feel in control of the decisions affecting their life and those with a high GHQ12 score.

One in twelve (8%) said it was difficult to get a GP consultation within 48 hours when needed. Those more likely to say this were those aged 25-34, those who felt isolated, obese people, smokers, those who had a high GHQ12 score, those who exceeded the recommended weekly limit for alcohol consumption and those who were exposed to second hand smoke.

One in 20 (5%) felt that it was difficult to access health services in an emergency. Those more likely to say that this was difficult were those aged 75 and over, those in the least deprived areas, those who did not feel in control of the decisions affecting their life, those with a high GHQ12 score and those who exceeded the recommended limit for alcohol consumption.

Four percent of respondents said that it was difficult to get an appointment to see the dentist. Those most likely to report difficulty getting a dentist appointment were those aged 25-34, those who felt isolated, those who did not definitely feel in control of decisions, those with a limiting condition or illness, those exposed to second hand smoke and those who consumed fewer than five portions of fruit/vegetables per day.

3.2 Use of Specific Health Services

General Practitioners (GPs)

Three in four (76%) respondents had seen a GP at least once in the last year. Of those who had visited a GP, three in five (60%) had visited the GP either once (32%) or twice (28%) in the last year, although the number of visits made in the last year ranged from 1 to 50. For all those who had visited their GP in the last year, the mean number of GP visits was 3.56.

The proportion of respondents who had seen a GP in the last year varied by age, ranging from 65% of 16-24 year olds to 91% of those aged 75 or over. Women were more likely than men to have visited a GP in the last year (79% of women compared to 72% of men), although the difference for gender was only apparent for those aged under 65.

Table 3.2: Seen GP at Least Once and Mean Number of Visits (Q6a) by Age and Gender

	% at least once	Mean number of visits (excluding 'never')	Unweighted base (n)
Age:			
16-24	65%	3.92	79
25-34	75%	3.10	127
35-44	70%	2.49	160
45-54	83%	3.06	176
55-64	68%	5.18	164
65-74	85%	3.50	186
75+	91%	4.14	182
Gender:			
Men	72%	3.45	413
Women	79%	3.66	669
Men 16-44	66%	2.66	128
Women 16-44	73%	3.54	238
Men 45-64	69%	3.96	139
Women 45-64	82%	3.86	201
Men 65+	89%	4.15	142
Women 65+	86%	3.53	226
All	76%	3.56	1,083

The likelihood of having visited a GP in the last year was higher for those in the most deprived areas and those with no qualifications. This is shown in Table 3.3.

Table 3.3: Seen GP at Least Once and Mean Number of Visits (Q6a) by Deprivation and Socio Economic Measures

	% at least once	Mean number of visits (excluding 'never')	Unweighted base (n)
Bottom 20% datazones	84%	4.48	554
Other datazones	75%	3.52	529
SIMD quintile			
1 (most deprived)	84%	4.48	554
2	84%	3.46	72
3	64%	4.03	81
4	80%	4.18	99
5 (least deprived)	76%	3.19	277
At least one qualification	75%	3.50	746
No qualifications	86%	3.90	328

The health and wellbeing measures associated with a higher likelihood of visiting a GP in the last year were having a limiting condition or illness, having a high GHQ12 score and consuming fewer than five portions of fruit/vegetables per day. Positive views of general health, physical wellbeing, mental/emotional wellbeing and quality of life were associated with a lower likelihood of having seen a GP in the last year. This is shown in Table 3.4.

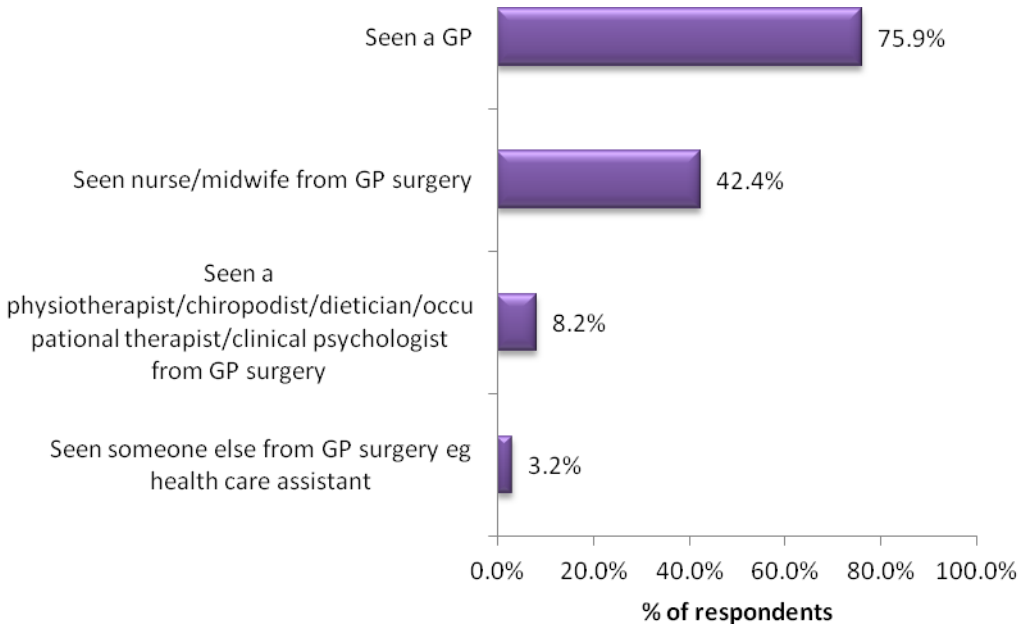
Table 3.4: Seen GP at Least Once and Mean Number of Visits (Q6a) by Health and Wellbeing Measures

	% at least once	Mean number of visits (excluding 'never')	Unweighted base (n)
Positive view of general health	72%	2.52	707
Positive view of physical wellbeing	73%	2.98	846
Positive view of mental/emotional wellbeing	74%	3.14	885
Positive view of quality of life	74%	3.40	920
High GHQ12 Score	88%	3.92	262
Limiting condition or illness	92%	6.81	271
Consumes fewer than five portions of fruit/veg per day	77%	3.74	829

Other Uses of GP Surgery

Figure 3.1 below shows the extent of other uses of GP surgeries in the last year. In addition to the 76% of respondents who had seen a GP in the last year, 42% had seen a nurse or midwife from the GP surgery (mean number of visits was 2.91). One in 12 (8%) had seen staff such as physiotherapist, chiropodist, dietician, occupational therapist or clinical psychologist (mean number of visits was 2.58). Also, 3% had seen some other type of staff at a GP surgery (mean number of visits was 1.28).

Figure 3.1: Seen Specific GP Practice Staff in Last Year (Q6)



Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde area as a whole to have seen staff at their GP surgery such as physiotherapist, chiropodist, dietician, occupational therapist or clinical psychologist (8% East Dunbartonshire; 12% NHSGGC).

Outpatients

Just under three in ten (28%) respondents had visited a hospital outpatient department to see a doctor at least once in the last year. Of those who had made such a visit, two in three (66%) had done so just once (37%) or twice (29%), although the number of visits ranged from one to 52. The average number of outpatient visits in the last year was 3.53.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were more likely than those in the NHS Greater Glasgow area as a whole to have visited hospital as an outpatient in the last year (28% East Dunbartonshire; 24% NHSGGC).

Those aged under 35 were the least likely to have visited hospital as an outpatient, and those aged 75 and over were the most likely to have done so. Women were more likely than men to have been hospital outpatients in the last year. This is shown in Table 3.5.

Table 3.5: Visited Hospital as an Outpatient at Least Once and Mean Number of Visits (Q7d) by Age and Gender

	% at least once	Mean number of visits	Unweighted base (n)
Age:			
16-24	15%	2.21	79
25-34	8%	2.42	127
35-44	23%	2.96	160
45-54	29%	5.70	176
55-64	35%	2.85	164
65-74	40%	3.48	187
75+	47%	3.17	184
Gender:			
Men	23%	2.86	414
Women	32%	3.96	671
Men 16-44	13%	2.10	128
Women 16-44	20%	3.00	238
Men 45-64	24%	3.08	139
Women 45-64	38%	4.99	201
Men 65+	41%	3.22	143
Women 65+	44%	3.39	228
All	28%	3.53	1,086

Those with no qualifications were more likely than others to have been a hospital outpatient in the last year.

Table 3.6: Visited Hospital as an Outpatient at Least Once and Mean Number of Visits (Q7d) by Deprivation and Socio Economic Measures

	% at least once	Mean number of visits	Unweighted base (n)
At least one qualification	25%	3.84	746
No qualifications	41%	2.68	331

Those who received all household income from benefits were more likely to have been a hospital outpatient in the last year. However, those who felt isolated from family and friends were less likely to have been a hospital outpatient.

Table 3.7: Visited Hospital as an Outpatient at Least Once and Mean Number of Visits (Q7d) by Factors Associated with Social Exclusion

	% at least once	Mean number of visits	Unweighted base (n)
All income from benefits	43%	2.94	273
Feel isolated from family/friends	15%	12.75	81

Those with positive views of their general health, physical wellbeing, mental/emotional wellbeing and quality of life were less likely to have visited hospital as an outpatient in the last year. Those exposed to second hand smoke, smokers and those who exceed the recommended weekly limit for alcohol consumption were also less likely to have visited hospital as an outpatient. Health and wellbeing measures associated with a higher likelihood of being a hospital outpatient were having a limiting condition or illness, having a high GHQ12 score and being obese.

Table 3.8: Visited Hospital as an Outpatient at Least Once and Mean Number of Visits (Q7d) by Health and Wellbeing Measures

	% at least once	Mean number of visits	Unweighted base (n)
Positive view of general health	19%	2.46	707
Positive view of physical wellbeing	24%	2.92	847
Positive view of mental/emotional wellbeing	26%	2.88	885
Positive view of quality of life	26%	3.07	920
High GHQ12 Score	37%	4.51	262
Limiting condition or illness	57%	5.79	274
Exposed to second hand smoke	19%	2.78	377
Current smoker	20%	3.00	324
Exceeds weekly alcohol limit	21%	2.73	170
Obese	34%	2.39	172

Accident and Emergency

One in eight (13%) respondents had been to accident and emergency in the last year. Of those who had visited accident and emergency, 81% had been once in the last year, but the number of visits ranged from one to 30. The mean number of visits was 1.32.

Those aged 16-24 were the most likely to have visited Accident and Emergency in the last year, and men were more likely than women to have done so.

Table 3.9: Visited Accident and Emergency at Least Once and Mean Number of Visits (Q7c) by Age and Gender

	% at least once	Mean number of visits	Unweighted base (n)
Age:			
16-24	26%	1.13	79
25-34	7%	1.51	127
35-44	10%	1.47	160
45-54	16%	1.42	176
55-64	7%	1.16	164
65-74	8%	1.12	187
75+	13%	1.59	184
Gender:			
Men	16%	1.20	414
Women	9%	1.51	671
Men 16-44	21%	1.23	128
Women 16-44	8%	1.09	238
Men 45-64	13%	1.29	139
Women 45-64	12%	1.40	201
Men 65+	13%	1.62	143
Women 65+	9%	1.48	228
All	13%	1.32	1,086

Those with a limiting condition or illness and those who were exposed to second hand smoke were more likely to have visited Accident & Emergency in the last year.

Table 3.10: Visited Accident and Emergency at Least Once and Mean Number of Visits (Q7c) by Health and Wellbeing Measures

	% at least once	Mean number of visits	Unweighted base (n)
Limiting condition or illness	21%	1.67	274
Exposed to second hand smoke	19%	1.36	377

Hospital Admissions

One in seven (14%) respondents had been admitted to hospital at least once in the last year. Of those who had been admitted to hospital, 77% had been admitted once in the last year, although the number of admissions ranged from one to 30. The mean number of admissions was 1.48.

Respondents aged 25-44 were the least likely to have been admitted to hospital in the last year, while those aged 75 or over were the most likely to have been admitted to hospital.

Table 3.11: Admitted to Hospital at Least Once and Mean Number of Visits (Q7e) by Age and Gender

	% at least once	Mean number of admissions	Unweighted base (n)
Age:			
16-24	14%	1.44	79
25-34	10%	1.12	127
35-44	11%	2.18	160
45-54	14%	1.60	176
55-64	13%	1.18	164
65-74	12%	1.13	187
75+	25%	1.57	184
All	14%	1.48	1,086

Those who received all household income from benefits were more likely to have been admitted to hospital in the last year.

Table 3.12: Admitted to Hospital at Least Once and Mean Number of Visits (Q7e) by Factors Associated with Social Exclusion

	% at least once	Mean number of admissions	Unweighted base (n)
All income from benefits	24%	1.55	273

Those with positive views of their general health, physical wellbeing, mental/emotional wellbeing and quality of life were less likely to have been admitted to hospital in the last year. Those who had exceeded the recommended limit for alcohol consumption in the previous week were also less likely to have been admitted to hospital in the last year.

Those with a limiting condition or illness and those with a high GHQ12 score were more likely to have been admitted to hospital in the last year. This is shown in Table 3.13.

Table 3.13: Admitted to Hospital at Least Once and Mean Number of Visits (Q7e) by Health and Wellbeing Measures

	% at least once	Mean number of admissions	Unweighted base (n)
Positive view of general health	8%	1.13	707
Positive view of physical wellbeing	11%	1.24	847
Positive view of mental/emotional wellbeing	13%	1.36	885
Positive view of quality of life	13%	1.40	920
High GHQ12 Score	19%	1.87	262
Limiting condition or illness	33%	1.95	274
Exceeds weekly alcohol limit	7%	1.04	170

Use of Pharmacy for Health Advice

One in nine (11%) respondents had seen a pharmacist for health advice in the last year. Of those who had done so, 73% had done so only once. The number of visits to the pharmacist for health advice ranged from one to 150, and the mean number of visits to the pharmacist was 1.60.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde area as a whole to have seen a pharmacist for health advice in the last year (11% East Dunbartonshire; 19% NHSGGC).

As Table 3.14 shows, men were more likely than women to have seen a pharmacist for health advice in the last year (14% of men and 9% of women had done so).

Table 3.14: Seen Pharmacist for Health Advice Least Once and Mean Number of Visits (Q7a) by Age and Gender

	% at least once	Mean number of visits	Unweighted base (n)
Gender:			
Men	14%	1.59	412
Women	9%	1.61	671
Men 16-44	13%	1.70	128
Women 16-44	6%	1.85	238
Men 45-64	16%	1.17	138
Women 45-64	12%	1.63	201
Men 65+	11%	2.43	142
Women 65+	12%	1.41	228
All	11%	1.60	1,084

Those who did not feel definitely in control of the decisions affecting their life were more likely to have sought health advice from a pharmacist.

Table 3.15: Seen Pharmacist for Health Advice Least Once and Mean Number of Visits (Q7a) by Factors Associated with Social Exclusion

	% at least once	Mean number of admissions	Unweighted base (n)
Not in control of decisions affecting daily life, or only 'to some extent'	16%	1.55	366

Those with a positive view of their physical wellbeing were less likely to have asked a pharmacist for health advice in the last year. Those who exceeded the recommended weekly limit for alcohol consumption were more likely to have sought health advice from a pharmacist.

Table 3.16: Seen Pharmacist for Health Advice Least Once and Mean Number of Visits (Q7a) by Health and Wellbeing Measures

	% at least once	Mean number of visits	Unweighted base (n)
Positive view of physical wellbeing	10%	1.33	846
Exceeds weekly alcohol limit	18%	2.11	169

Contacting NHS24

One in 12 (8%) respondents had contacted NHS24 at least once in the last year. Of those who had contacted NHS24, 67% had done so just once. The number of contacts ranged from one to 16 and the mean number of contacts was 1.68.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde area as a whole to have contacted NHS24 in the last year (8% East Dunbartonshire; 10% NHSGGC)

Health and wellbeing measures associated with a higher likelihood of having contacted NHS24 in the last year were having a limiting illness or condition, having a high GHQ12 score, being a smoker and being obese.

Those with positive views of their general, physical and mental/emotional health and quality of life were less likely to have contacted NHS24 in the last year.

Table 3.17: Contacted NHS24 at Least Once and Mean Number of Visits (Q7b) by Health and Wellbeing Measures

	% at least once	Mean number of contacts	Unweighted base (n)
Positive view of general health	5%	1.15	707
Positive view of physical wellbeing	6%	1.58	847
Positive view of mental/emotional wellbeing	7%	1.57	885
Positive view of quality of life	7%	1.58	920
High GHQ12 score	16%	1.49	262
Limiting condition or illness	18%	2.10	274
Smoker	12%	1.64	324
Obese	11%	1.05	172

Use of GP Out of Hours Service

One in 20 (5%) respondents had used the GP out of hours service in the last year. Of those who had used the service, the number of uses of the service ranged from one to five and the mean number of uses was 1.53.

Those with a positive view of their general health, physical wellbeing and mental/emotional wellbeing were less likely to have used the GP out of hours service. Those with a high GHQ12 score and those with a limiting condition or illness were more likely to have used the GP out of hours service.

Table 3.18: Used GP Out of Hours Service at Least Once and Mean Number of Visits (Q7f) by Health and Wellbeing Measures

	% at least once	Mean number of visits	Unweighted base (n)
Positive view of general health	4%	1.02	707
Positive view of physical wellbeing	4%	1.52	847
Positive view of mental/emotional wellbeing	4%	1.54	885
High GHQ12 Score	10%	1.87	261
Limiting condition or illness	10%	1.87	273

3.3 Dental Services

Frequency of Visits to the Dentist

Of those who were able to say when they last visited the dentist, nearly two in three (64%) said that they had visited the dentist within the last six months, 16% had visited the dentist between six and 15 months ago, and 21% had last visited the dentist over 15 months ago.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were more likely than those in the NHS Greater Glasgow & Clyde area as a whole to say they had visited the dentist within the last six months (64% East Dunbartonshire; 55% NHSGGC).

Figure 3.2: When Last Visited Dentist (Q9) - East Dunbartonshire and NHS Greater Glasgow & Clyde

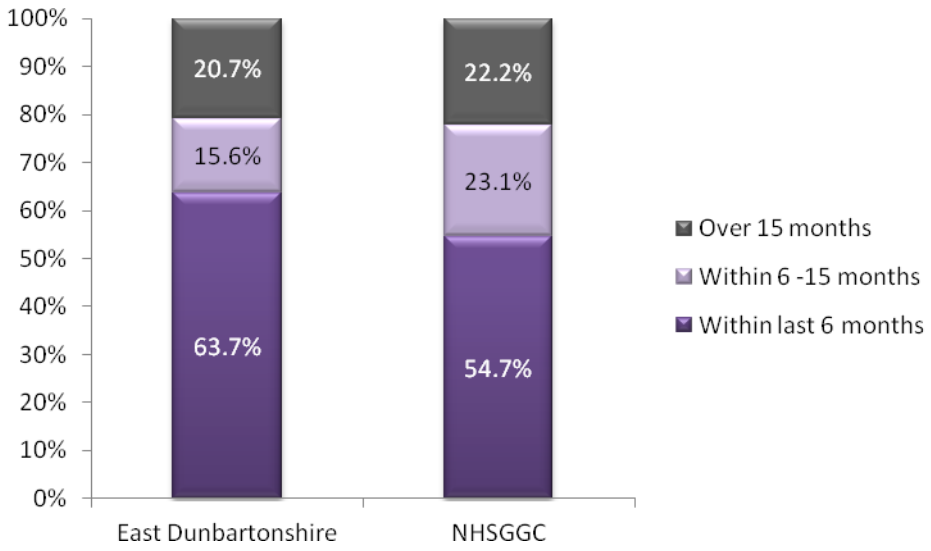


Table 3.19 shows that those in the oldest age groups were least likely to have visited the dentist within the last six months, and women were more likely than men to have visited the dentist within the last six months.

Table 3.19: When Last Visited Dentist (Q9) by Age and Gender

	Within Last 6 Months	6-15 months ago	Over 15 months ago	Unweighted base (n)
Age:				
16-24	64%	7%	29%	75
25-34	63%	28%	9%	121
35-44	69%	14%	16%	146
45-54	66%	17%	18%	151
55-64	69%	18%	13%	148
65-74	51%	18%	31%	136
75+	53%	10%	37%	119
Gender:				
Men	59%	19%	22%	335
Women	68%	13%	19%	566
Men 16-44	58%	20%	22%	115
Women 16-44	74%	11%	15%	227
Men 45-64	64%	17%	19%	120
Women 45-64	70%	17%	13%	179
Men 65+	51%	21%	29%	99
Women 65+	53%	9%	37%	156
All	64%	16%	21%	901

Table 3.20 shows that those living in the most deprived areas and those with no qualifications were less likely to have visited the dentist in the last six months.

Table 3.20: When Last Visited Dentist (Q9) by Deprivation and Socio Economic Measures

	Within Last 6 Months	6-15 months ago	Over 15 months ago	Unweighted base (n)
Bottom 20% datazones	51%	17%	32%	418
Other datazones	64%	16%	20%	483
SIMD quintile				
1 (most deprived)	51%	17%	32%	418
2	56%	25%	19%	61
3	52%	13%	34%	79
4	76%	14%	10%	81
5 (least deprived)	66%	14%	19%	262
At least one qualification	67%	16%	18%	666
No qualifications	45%	17%	38%	228

Table 3.21 shows that all three measures of social exclusion were associated with a lower likelihood of having visited the dentist in the last six months.

Table 3.21: When Last Visited Dentist (Q9) by Factors Associated with Social Exclusion

	Within Last 6 Months	6-15 months ago	Over 15 months ago	Unweighted base (n)
All income from benefits	31%	25%	44%	188
Feel isolated from family/friends	47%	16%	36%	69
Not in control of decisions affecting daily life, or only 'to some extent'	56%	14%	29%	325

Health and wellbeing measures associated with a lower likelihood of having visited the dentist in the last six months were:

- Being a smoker;
- Having a limiting condition/illness;
- Being exposed to second hand smoke;
- Being obese; and
- Consuming fewer than five portions of fruit/vegetables per day.

Those with positive perceptions of their general health, physical wellbeing, mental/emotional wellbeing and quality of life were more likely to have visited the dentist within the last six months.

Table 3.22: When Last Visited Dentist (Q9) by Health and Wellbeing Measures

	Within Last 6 Months	6-15 months ago	Over 15 months ago	Unweighted base (n)
Positive view of general health	67%	14%	19%	611
Positive view of physical wellbeing	68%	14%	18%	714
Positive view of mental/emotional wellbeing	65%	15%	20%	745
Positive view of quality of life	65%	15%	20%	783
Limiting condition or illness	52%	21%	27%	218
Exposed to second hand smoke	53%	14%	33%	297
Smoker	42%	18%	40%	251
Obese	55%	16%	29%	147
Consumes fewer than 5 portions of fruit/veg per day	59%	18%	23%	676

3.4 Involvement in Decisions Affecting Health Service Delivery

Information about Condition or Treatment

Of those who had accessed any health services over the last year, 52% felt that they had 'definitely' been given adequate information about their condition or treatment, 43% felt that they had 'to some extent', and 6% felt that they had not.

Women were more likely than men to say that they had definitely been given adequate information (57% of women compared to 45% of men).

Table 3.23: Given adequate information about your condition or treatment (Q8a) by Age and Gender

	Definitely	To some extent	No	Definitely/to some extent	Unweighted base (n)
Gender:					
Men	45%	47%	8%	92%	343
Women	57%	39%	3%	97%	611
Men 16-44	39%	54%	7%	93%	101
Women 16-44	61%	37%	2%	98%	212
Men 45-64	51%	42%	7%	93%	112
Women 45-64	51%	44%	4%	96%	185
Men 65+	47%	43%	10%	90%	127
Women 65+	59%	37%	4%	96%	211
All	52%	43%	6%	94%	955

Those who felt isolated from family and friends were less likely to feel that they were definitely given adequate information about their condition or treatment.

Table 3.24: Given adequate information about your condition or treatment (Q8a) by Factors Associated with Social Exclusion

	Definitely	To some extent	No	Definitely/to some extent	Unweighted base (n)
Feel isolated from family/friends	32%	56%	11%	89%	67

For health and wellbeing measures, those less likely to feel they had definitely or to some extent been given adequate information about their condition or treatment were:

- Those with a limiting condition or illness;
- Obese people; and
- Those with a high GHQ12 score.

Smokers, those exposed to second hand smoke and those with positive views of their general health and physical wellbeing were more likely to feel they had definitely or to some extent been given adequate information about their condition or treatment.

Table 3.25: Given adequate information about your condition or treatment (Q8a) by Health and Wellbeing Measures

	Definitely	To some extent	No	Definitely/to some extent	Unweighted base (n)
Positive view of general health	52%	45%	3%	97%	598
Positive view of physical wellbeing	55%	41%	3%	97%	734
High GHQ12 Score	46%	45%	9%	91%	237
Limiting condition or illness	45%	41%	14%	86%	256
Exposed to second hand smoke	49%	48%	3%	97%	337
Current smoker	56%	43%	1%	99%	286
Obese	49%	41%	10%	90%	156

Encouragement to Participate in Decisions Affecting Health or Treatment

More than four in five (82%) of those who had used health services in the last year felt that they had been encouraged to participate in decisions affecting their health or treatment either definitely (38%) or to some extent (44%).

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde to feel they were encouraged to participate in decisions affecting their health or treatment to any extent (82% East Dunbartonshire; 86% NHSGGC).

Those aged under 35 were the most likely to say they definitely or to some extent felt encouraged to participate in decisions affecting their health or treatment and those aged 75 or over were the least likely.

Women were more likely than men to feel they had definitely been encouraged to participate in decisions.

Table 3.26: Encouraged to participate in decisions affecting health or treatment (Q8b) by Age and Gender

	Definitely	To some extent	No	Definitely/to some extent	Unweighted base (n)
Age:					
16-24	43%	50%	7%	93%	44
25-34	35%	56%	9%	91%	89
35-44	38%	51%	11%	89%	104
45-54	37%	41%	22%	78%	125
55-64	39%	44%	22%	84%	113
65-74	34%	44%	22%	78%	141
75+	35%	35%	30%	70%	124
Gender:					
Men	29%	52%	19%	81%	268
Women	46%	37%	17%	83%	479
Men 16-44	17%	78%	6%	94%	68
Women 16-44	59%	29%	12%	88%	169
Men 45-64	39%	36%	25%	75%	88
Women 45-64	37%	47%	16%	84%	150
Men 65+	27%	49%	24%	76%	108
Women 65+	42%	33%	25%	75%	157
All	38%	44%	18%	82%	748

Table 3.27 shows that those in the most deprived areas and those with no qualifications were less likely to feel that they had to any extent been encouraged to participate in the decisions affecting their health or treatment. However, those in the 5th SIMD quintile (least deprived areas) were the least likely to definitely feel they had been encouraged to participate in these decisions.

Table 3.27: Encouraged to participate in decisions affecting health or treatment (Q8b) by Deprivation and Socio Economic Measures

	Definitely	To some extent	No	Definitely/to some extent	Unweighted base (n)
Bottom 20% datazones	37%	36%	27%	73%	435
Other datazones	38%	45%	18%	82%	313
SIMD quintile					
1 (most deprived)	37%	36%	27%	73%	435
2	41%	51%	8%	92%	57
3	66%	25%	9%	91%	37
4	46%	39%	14%	86%	67
5 (least deprived)	28%	49%	24%	76%	152
At least one qualification	39%	46%	16%	84%	516
No qualifications	35%	34%	32%	68%	226

Table 3.28 shows that those who felt isolated from family/friends were less likely to feel that they were encouraged to participate in decisions affecting their health or treatment.

Table 3.28: Encouraged to participate in decisions affecting health or treatment (Q8b) by Factors Associated with Social Exclusion

	Definitely	To some extent	No	Definitely/to some extent	Unweighted base (n)
Feel isolated from family/friends	21%	49%	30%	70%	47

The health and wellbeing measures associated with a lower likelihood of people feeling that they were encouraged (to any extent) to participate in decisions affecting their health or treatment were:

- Being a smoker;
- Having a high GHQ12 score (indicating poor mental health);
- Being exposed to second hand smoke; and
- Consuming fewer than five portions of fruit/vegetables per day.

Table 3.29: Encouraged to participate in decisions affecting health or treatment (Q8b) by Health and Wellbeing Measures

	Definitely	To some extent	No	Definitely/to some extent	Unweighted base (n)
Positive view of physical wellbeing	42%	43%	15%	85%	440
High GHQ12 Score	31%	44%	26%	74%	192
Exposed to second hand smoke	37%	39%	25%	75%	270
Current smoker	37%	34%	29%	72%	241
Consumes fewer than five portions of fruit/veg per day	38%	41%	20%	80%	557

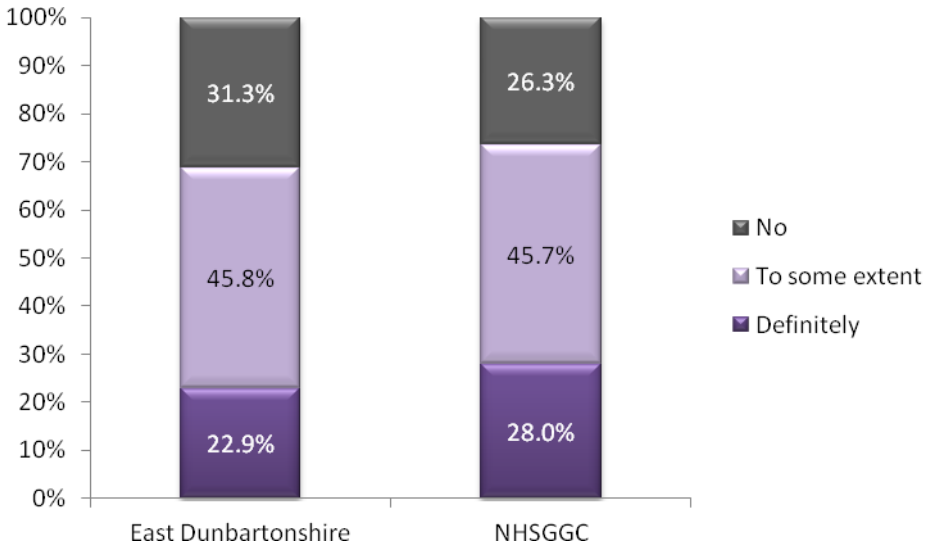
Having a Say in How Health Services are Delivered

Seven in ten (69%) of those who had used health services in the last year felt that they had had a say in how these services are delivered, either definitely (23%) or to some extent (46%).

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde area as a whole to feel that they had a say in how health services are delivered (69% East Dunbartonshire; 74% NHSGGC).

Figure 3.3: Have a say in how health services are delivered (Q8c) - East Dunbartonshire and NHS Greater Glasgow & Clyde



Women were more likely than men to say they definitely had a say in how services are delivered.

Table 3.30: Have a say in how health services are delivered (Q8c) by Age and Gender

	Definitely	To some extent	No	Definitely/to some extent	Unweighted base (n)
Gender:					
Men	17%	53%	30%	70%	255
Women	28%	40%	32%	68%	450
Men 16-44	11%	53%	36%	64%	68
Women 16-44	41%	33%	27%	73%	156
Men 45-64	18%	58%	24%	76%	82
Women 45-64	22%	44%	34%	66%	147
Men 65+	23%	47%	30%	70%	101
Women 65+	22%	41%	37%	63%	145
All	23%	46%	31%	69%	706

Those in the least deprived areas were the least likely to feel they definitely had a say in how health services are delivered. Those without qualifications were less likely than those with qualifications to feel that they had a say in how health services were delivered to any extent.

Table 3.31: Have a say in how health services are delivered (Q8c) by Deprivation and Socio Economic Measures

	Definitely	To some extent	No	Definitely/to some extent	Unweighted base (n)
Bottom 20% datazones	31%	35%	33%	67%	417
Other datazones	22%	47%	31%	69%	289
SIMD quintile					
1 (most deprived)	31%	35%	33%	67%	417
2	28%	56%	16%	84%	56
3	48%	31%	21%	79%	33
4	27%	40%	33%	67%	66
5 (least deprived)	13%	49%	39%	61%	134
At least one qualification	22%	49%	29%	71%	487
No qualifications	26%	30%	44%	56%	213

Those who felt isolated from family or friends and those who did not definitely feel in control of the decisions affecting their life were less likely than others to feel that they had a say in how health services are delivered to any extent. This is shown in Table 3.32.

Table 3.32: Have a say in how health services are delivered (Q8c) by Factors Associated with Social Exclusion

	Definitely	To some extent	No	Definitely/to some extent	Unweighted base (n)
Feel isolated from friends/family	4%	39%	57%	43%	46
Not in control of decisions affecting daily life, or only 'to some extent'	10%	48%	42%	58%	183

Those with a positive view of their general health were more likely to feel that they had a say in how health services are delivered. Smokers and those exposed to second hand smoke were less likely to feel they had a say in how health services were delivered.

Table 3.33: Have a say in how health services are delivered (Q8c) by Health and Wellbeing Measures

	Definitely	To some extent	No	Definitely/to some extent	Unweighted base (n)
Positive view of general health	20%	52%	28%	72%	415
Exposed to second hand smoke	19%	38%	43%	57%	259
Current smoker	26%	32%	42%	58%	235

Feel that Views and Circumstances are Understood and Valued

Nine in ten (89%) of those who had used health services in the last year felt that their views and circumstances were understood and valued, either definitely (45%) or to some extent (44%).

Women were more likely than men to feel that their views and circumstances were 'definitely' understood and valued. This is shown in Table 3.34.

Table 3.34: Feel that views and circumstances are understood and valued (Q8d) by Age and Gender

	Definitely	To some extent	No	Definitely/to some extent	Unweighted base (n)
Men	34%	54%	13%	87%	282
Women	55%	35%	10%	90%	504
Men 16-44	23%	70%	7%	93%	72
Women 16-44	68%	26%	6%	94%	177
Men 45-64	39%	43%	19%	81%	92
Women 45-64	45%	42%	13%	87%	153
Men 65+	41%	53%	6%	94%	114
Women 65+	52%	38%	10%	90%	171
All	45%	44%	11%	89%	787

Those who felt isolated from family or friends were less likely to feel that their views and circumstances were definitely understood and valued. This is shown in Table 3.35.

Table 3.35: Feel that views and circumstances are understood and valued (Q8d) by Factors Associated with Social Exclusion

	Definitely	To some extent	No	Definitely/to some extent	Unweighted base (n)
Feel isolated from friends/family	21%	74%	5%	95%	48

Those with a high GHQ12 score and obese people were less likely to feel that they views and circumstances were understood and valued to any extent. Those with a positive view of their physical wellbeing were more likely to feel that they views and circumstances were understood and valued.

Table 3.36: Feel that views and circumstances are understood and valued (Q8d) by Health and Wellbeing Measures

	Definitely	To some extent	No	Definitely/to some extent	Unweighted base (n)
Positive view of physical wellbeing	49%	42%	9%	91%	591
High GHQ12 Score	41%	38%	21%	79%	211
Obese	41%	43%	16%	84%	133

3.5 Accessing Health Services

Respondents were asked on a scale of 1 to 5, (1 being 'very difficult' and 5 being 'very easy') how easy or difficult it was to access a number of specific health services. The

tables in this section have categorised responses so that 1 and 2 are 'difficult', 3 is 'neither difficult nor easy', and 4 and 5 are 'easy'.

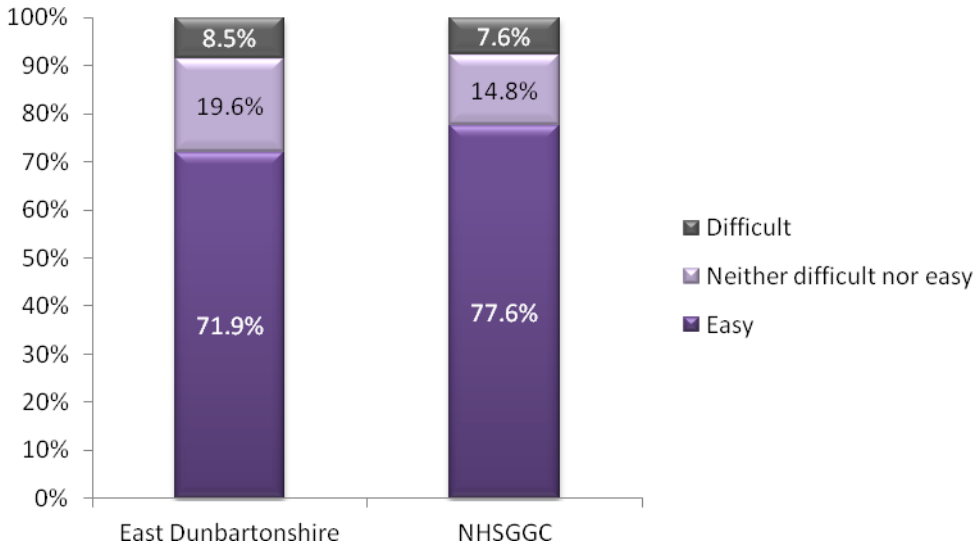
Travelling to Hospital for an Appointment

Seven in ten (72%) respondents indicated that they found it easy to travel to hospital for an appointment, while 20% found it neither difficult nor easy and 8% found it difficult.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde area as a whole to say they found it easy to travel to hospital for an appointment (72% East Dunbartonshire; 78% NHSGGC)

Figure 3.4: Difficulty/Ease of Travelling to Hospital for an Appointment (Q12d) - East Dunbartonshire and NHS Greater Glasgow & Clyde



Those aged 65 or over were the most likely to say they found it difficult to travel to hospital for an appointment.

Table 3.37: Difficulty/Ease of Travelling to Hospital for an Appointment (Q12d) by Age and Gender

	Difficult	Neither	Easy	Unweighted base (n)
Age:				
16-24	3%	14%	83%	48
25-34	10%	12%	78%	85
35-44	10%	25%	65%	111
45-54	7%	18%	76%	126
55-64	2%	18%	80%	122
65-74	12%	23%	65%	145
75+	15%	22%	63%	152
Men 16-44	4%	23%	72%	73
Women 16-44	11%	14%	75%	171
Men 45-64	5%	20%	75%	97
Women 45-64	4%	16%	79%	151
Men 65+	10%	18%	72%	119
Women 65+	17%	26%	57%	178
All	8%	20%	72%	795

For deprivation and socio economic measures, those most likely to find it difficult to travel to hospital for an appointment were those living in the most deprived areas and those with no qualifications.

Table 3.38: Difficulty/Ease of Travelling to Hospital for an Appointment (Q12d) by Deprivation and Socio Economic Measures

	Difficult	Neither	Easy	Unweighted base (n)
Bottom 20% datazones	33%	11%	57%	425
Other datazones	7%	20%	73%	370
SIMD quintile				
1 (most deprived)	33%	11%	57%	425
2	8%	34%	58%	59
3	9%	19%	72%	39
4	10%	15%	75%	75
5 (least deprived)	6%	18%	76%	197
At least one qualification	6%	19%	74%	539
No qualifications	14%	20%	66%	250

Those who received all household income from benefits and those who did not definitely feel in control of the decisions affecting their life were less likely to find it easy to travel to hospital for an appointment, as shown in Table 3.39.

Table 3.39: Difficulty/Ease of Travelling to Hospital for an Appointment (Q12d) by Factors Associated with Social Exclusion

	Difficult	Neither	Easy	Unweighted base (n)
All income from benefits	24%	31%	45%	220
Not in control of decisions affecting daily life, or only 'to some extent'	10%	27%	64%	214

Table 3.40 shows that the health and wellbeing measures associated with a higher likelihood of reporting difficulty travelling to hospital for an appointment were having a high GHQ12 score and being a smoker. The measures associated with a higher likelihood of saying it was easy to travel to hospital for an appointment were exceeding the recommended weekly alcohol limit and having a positive view of quality of life.

Table 3.40: Difficulty/Ease of Travelling to Hospital for an Appointment (Q12d) by Health and Wellbeing Measures

	Difficult	Neither	Easy	Unweighted base (n)
Positive view of quality of life	8%	17%	75%	672
High GHQ12 Score	12%	24%	64%	210
Current smoker	13%	27%	60%	239
Exceeds weekly alcohol limit	3%	16%	82%	114

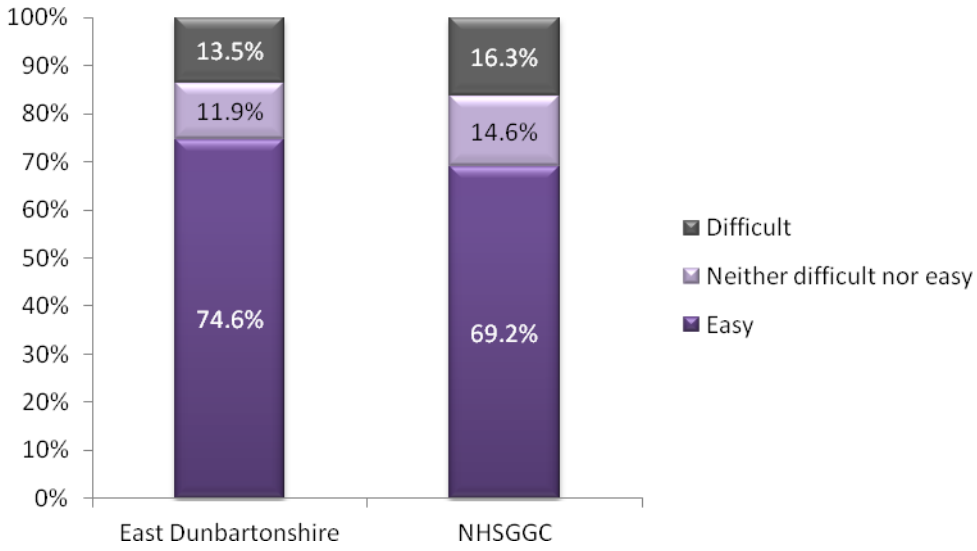
Getting a GP appointment

One in seven (14%) respondents said that it was difficult to obtain an appointment to see their GP, 12% said that it was neither easy nor difficult and 75% said that it was easy.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were more likely than those in the NHS Greater Glasgow & Clyde area as a whole to say that it was easy to get a GP appointment (75% East Dunbartonshire; 69% NHSGGC).

Figure 3.5: Difficulty/Ease of Getting Appointment to See GP (Q12a) - East Dunbartonshire & NHS Greater Glasgow & Clyde



Those aged under 25 were the most likely to say that it was easy to get an appointment to see their GP and those aged 25-44 were the most likely to say that it was difficult. Women were more likely than men to say that it was difficult to get an appointment to see their GP.

Table 3.41: Difficulty/Ease of Getting Appointment to See GP (Q12a) by Age and Gender

	Difficult	Neither	Easy	Unweighted base (n)
Age:				
16-24	8%	1%	91%	70
25-34	17%	10%	74%	117
35-44	17%	15%	68%	145
45-54	13%	14%	73%	165
55-64	14%	14%	72%	149
65-74	12%	19%	68%	179
75+	10%	7%	82%	179
Gender:				
Men	9%	11%	80%	372
Women	18%	12%	70%	638
Men 16-44	11%	8%	81%	110
Women 16-44	17%	10%	73%	222
Men 45-64	4%	12%	85%	122
Women 45-64	22%	16%	62%	192
Men 65+	10%	18%	72%	137
Women 65+	12%	11%	77%	221
All	14%	12%	75%	1,011

Those in the most deprived areas were more likely to sat that it was difficult to obtain a GP appointment, while those in the least deprived areas were the most likely to say that it was easy to get a GP appointment. Those with no qualifications were more likely than those with qualifications to say that it was either difficult or easy (rather than 'neither'). This is shown in Table 3.42.

Table 3.42: Difficulty/Ease of Getting Appointment to See GP (Q12a) by Deprivation and Socio Economic Measures

	Difficult	Neither	Easy	Unweighted base (n)
Bottom 20% datazones	27%	13%	60%	525
Other datazones	13%	12%	75%	486
SIMD quintile				
1 (most deprived)	27%	13%	60%	525
2	5%	33%	62%	66
3	26%	10%	64%	70
4	20%	11%	69%	94
5 (least deprived)	9%	8%	83%	256
At least one qualification	13%	14%	74%	690
No qualifications	17%	4%	79%	312

Those who received all household income from benefits were less likely to say it was easy to get a GP appointment. However, those who did not definitely feel in control of the decisions affecting their life were more likely to say it was easy to get a GP appointment.

Table 3.43: Difficulty/Ease of Getting Appointment to See GP (Q12a) by Factors Associated with Social Exclusion

	Difficult	Neither	Easy	Unweighted base (n)
All income from benefits	20%	27%	53%	264
Not in control of decisions affecting daily life, or only 'to some extent'	11%	10%	79%	326

Those with positive views of their physical wellbeing, mental/emotional wellbeing or quality of life were less likely to say it was difficult to get a GP appointment. Smokers, those exposed to second hand smoke and those who consumed fewer than five portions of fruit/vegetables per day were more likely to say it was difficult to get an appointment to see their GP.

Table 3.44: Difficulty/Ease of Getting Appointment to See GP (Q12a) by Health and Wellbeing Measures

	Difficult	Neither	Easy	Unweighted base (n)
Positive view of physical wellbeing	12%	12%	76%	777
Positive view of mental/emotional wellbeing	12%	10%	77%	817
Positive view of quality of life	13%	11%	75%	852
Exposed to second hand smoke	19%	13%	68%	354
Current smoker	22%	20%	58%	306
Consumes fewer than 5 portions of fruit/veg per day	15%	12%	72%	783

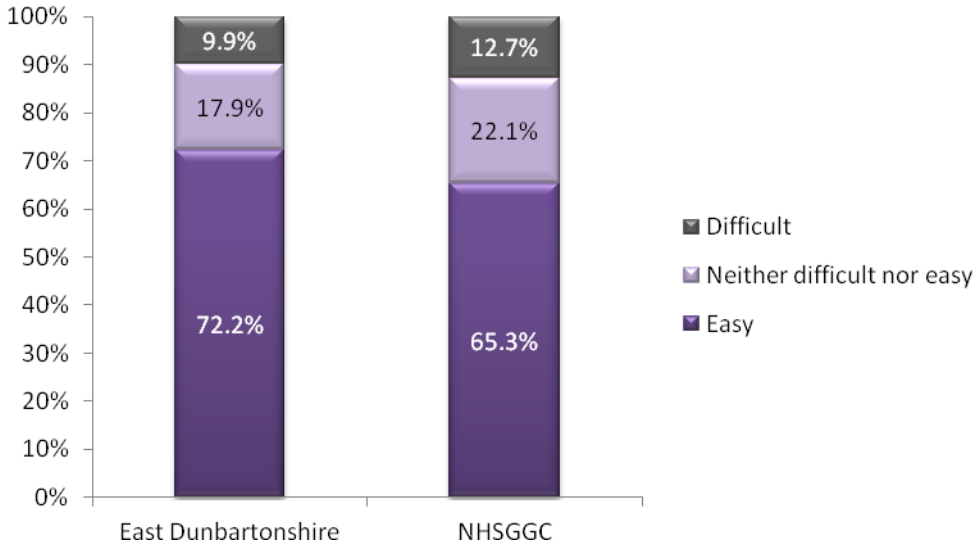
Obtaining an Appointment at the Hospital

One in ten (10%) respondents said that it was difficult to obtain a hospital appointment, 18% said that it was neither easy nor difficult and 72% said that it was easy.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were more likely than those in the NHS Greater Glasgow & Clyde area as a whole to say that it was easy to get an appointment at the hospital (72% East Dunbartonshire; 65% NHSGGC).

Figure 3.6: Difficulty/Ease of Obtaining Hospital Appointment - East Dunbartonshire and NHS Greater Glasgow & Clyde



Those who exhibited factors associated with social exclusion were less likely to say that they found it easy to obtain a hospital appointment. Those who felt isolated from family and friends and those who did not definitely feel in control of the decisions affecting their life were more likely to say that it was difficult to get a hospital appointment. This is shown in Table 3.45.

Table 3.45: Difficulty/Ease of Obtaining Hospital Appointment (Q12c) by Factors Associated with Social Exclusion

	Difficult	Neither	Easy	Unweighted base (n)
All income from benefits	6%	32%	62%	200
Feel isolated from friends/family	30%	28%	42%	38
Not in control of decisions affecting daily life, or only 'to some extent'	15%	22%	63%	192

Those with a positive view of their quality of life, smokers and those exposed to second hand smoke were less likely to find it difficult to get a hospital appointment. Those with a high GHQ12 score were more likely to find it difficult.

Table 3.46: Difficulty/Ease of Obtaining Hospital Appointment (Q12c) by Health and Wellbeing Measures

	Difficult	Neither	Easy	Unweighted base (n)
Positive view of quality of life	9%	17%	74%	605
High GHQ12 Score	15%	18%	67%	188
Exposed to second hand smoke	4%	26%	70%	235
Current smoker	6%	37%	57%	208

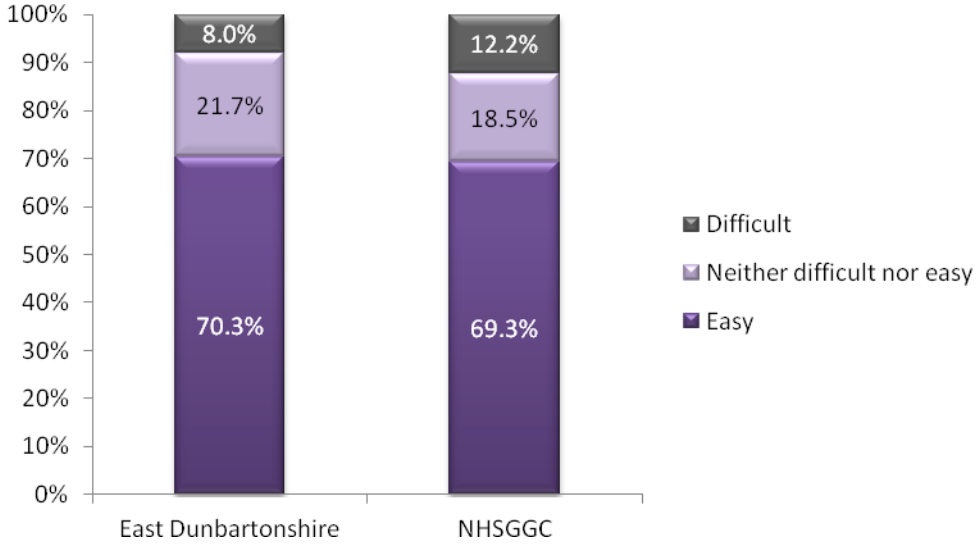
Getting a Consultation at GP Surgery within 48 Hours

Respondents were asked how easy or difficult it was to get a consultation with someone at their GP surgery within 48 hours when needed. Seven in ten (70%) said that it was easy, 22% said that it was neither easy nor difficult and 8% said that it was difficult.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde area as a whole to say that it was difficult to get a GP consultation within 48 hours (8% East Dunbartonshire; 12% NHSGGC).

Figure 3.7: Difficulty/Ease of Getting a Consultation at GP Surgery Within 48 Hours (Q12f) - East Dunbartonshire & NHS Greater Glasgow & Clyde



Those aged 75 or over were the most likely to say that it was easy to get a GP consultation within 48 hours. Those aged 25-34 were the most likely to say it was difficult. Men were less likely than women to say that it was easy to get a GP consultation within 48 hours.

Table 3.45: Difficulty/Ease of Getting a Consultation at GP Surgery Within 48 Hours (Q12f) by Age and Gender

	Difficult	Neither	Easy	Unweighted base (n)
Age:				
16-24	6%	18%	76%	54
25-34	15%	25%	60%	101
35-44	4%	37%	58%	129
45-54	11%	15%	75%	142
55-64	8%	18%	74%	126
65-74	9%	23%	68%	156
75+	1%	16%	82%	153
Gender:				
Men	9%	28%	63%	303
Women	7%	17%	76%	565
Men 16-44	6%	41%	53%	84
Women 16-44	8%	17%	74%	200
Men 45-64	15%	16%	70%	93
Women 45-64	7%	16%	77%	175
Men 65+	5%	23%	72%	122
Women 65+	7%	17%	77%	187
All	8%	22%	70%	869

Those in the most deprived areas were more likely than those in other areas to say that it was easy to obtain a GP consultation within 48 hours.

Table 3.46: Difficulty/ease of Getting a Consultation at GP Surgery Within 48 Hours (Q12f) by Deprivation and Socio Economic Measures

	Difficult	Neither	Easy	Unweighted base (n)
Bottom 20% datazones	7%	9%	84%	483
Other datazones	8%	22%	70%	386
SIMD quintile				
1 (most deprived)	7%	9%	84%	483
2	2%	32%	66%	63
3	12%	19%	69%	53
4	5%	5%	89%	86
5 (least deprived)	10%	27%	63%	184

Those who felt isolated from family and friends and those who did not definitely feel in control of the decisions affecting their life were less likely to find it easy to get a consultation within 48 hours.

Table 3.47: Difficulty/Ease of Getting a Consultation at GP Surgery Within 48 Hours (Q12f) by Factors Associated with Social Exclusion

	Difficult	Neither	Easy	Unweighted base (n)
Feel isolated from friends/family	12%	48%	40%	54
Not in control of decisions affecting daily life, or only 'to some extent'	9%	32%	60%	251

For health and wellbeing measures, those more likely to say that it was difficult to get a GP consultation within 48 hours were:

- Obese people;
- Smokers;
- Those with a high GHQ12 score;
- Those who exceed the recommended weekly limit for alcohol consumption; and
- Those exposed to second hand smoke.

Table 3.48: Difficulty/Ease of Getting a Consultation at GP Surgery Within 48 Hours (Q12f) by Health and Wellbeing Measures

	Difficult	Neither	Easy	Unweighted base (n)
Positive view of physical wellbeing	7%	20%	74%	662
High GHQ12 Score	13%	27%	60%	214
Exposed to second hand smoke	12%	32%	56%	308
Current smoker	14%	39%	47%	268
Exceeds weekly alcohol limit	13%	22%	65%	129
Obese	16%	23%	60%	145

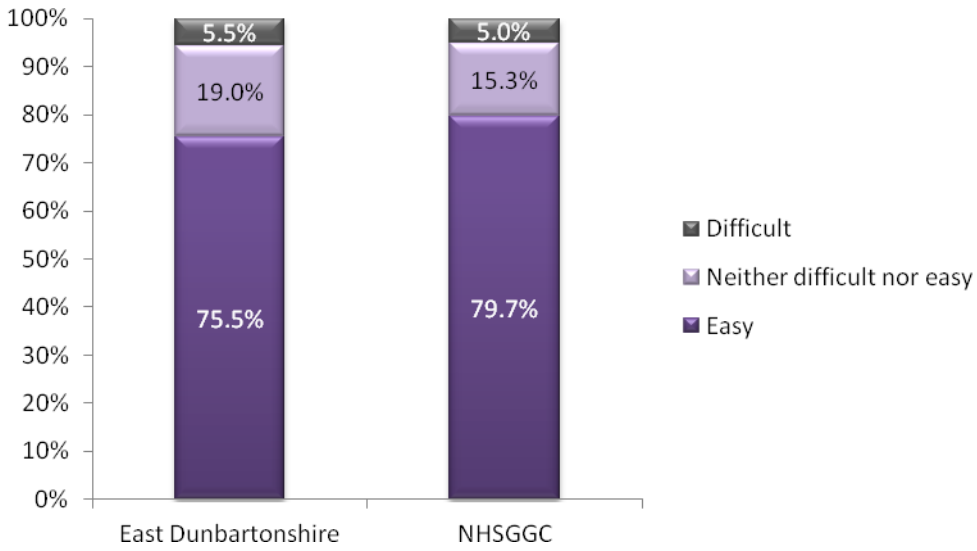
Accessing Health Services in an Emergency

Three in four (75%) respondents said that it was easy to access health services in an emergency, while 19% said that it was neither easy nor difficult and 5% said that it was difficult.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde area as a whole to say that it was easy to access health services in an emergency (75% East Dunbartonshire; 80% NHSGGC).

Figure 3.8: Difficulty/Ease of Accessing Health Services in an Emergency (Q12b) - East Dunbartonshire & NHSGGC



Those aged 75 or over were the most likely to say it was difficult to access health services in an emergency. Those aged under 25 were the most likely to say it was easy.

Table 3.49: Difficulty/Ease of Accessing Health Services in an Emergency (Q12b) by Age and Gender

	Difficult	Neither	Easy	Unweighted base (n)
Age:				
16-24	0%	10%	89%	49
25-34	9%	12%	80%	90
35-44	6%	19%	75%	116
45-54	5%	24%	71%	113
55-64	3%	18%	79%	96
65-74	2%	27%	71%	132
75+	10%	14%	76%	119
Men 16-44	9%	16%	76%	89
Women 16-44	1%	14%	85%	166
Men 45-64	4%	25%	71%	79
Women 45-64	5%	17%	78%	130
Men 65+	1%	19%	79%	103
Women 65+	9%	24%	67%	148
All	5%	19%	75%	723

Those in the least deprived areas were the most likely to say that it was difficult to access health services in an emergency. This is shown in Table 3.50

Table 3.50: Difficulty/Ease of Accessing Health Services in an Emergency (Q12b) by Deprivation and Socio Economic Measures

	Difficult	Neither	Easy	Unweighted base (n)
SIMD quintile				
1 (most deprived)	3%	16%	80%	409
2	0%	35%	65%	55
3	0%	14%	86%	35
4	0%	12%	88%	63
5 (least deprived)	10%	19%	72%	161

Those who felt isolated from family and friends and those who did not feel in control of the decisions affecting their life were more likely to feel it was difficult to access health services in an emergency.

Table 3.51: Difficulty/Ease of Accessing Health Services in an Emergency (Q12b) by Factors Associated with Social Exclusion

	Difficult	Neither	Easy	Unweighted base (n)
Feel isolated from friends/family	12%	33%	56%	44
Not in control of decisions affecting daily life, or only 'to some extent'	8%	28%	63%	182

Table 3.52 shows that for health and wellbeing measures, those more likely to find it difficult to access health services in an emergency were those with a high GHQ12 score, those who exceeded the recommended weekly limit for alcohol consumption and smokers.

Table 3.52: Difficulty/Ease of Accessing Health Services in an Emergency (Q14b) by Health and Wellbeing Measures

	Difficult	Neither	Easy	Unweighted base (n)
Positive view of physical wellbeing	4%	17%	79%	552
Positive view of quality of life	5%	18%	78%	610
High GHQ12 Score	15%	18%	68%	190
Current smoker	10%	26%	64%	240
Exceeds weekly alcohol limit	12%	10%	78%	115

Getting an Appointment to See the Dentist

More than four in five (84%) of respondents said that it was easy to get an appointment to see the dentist, while 12% said that it was neither easy nor difficult and 4% said that it was difficult.

Those in the oldest and youngest age groups were the most likely to say that it was easy to get an appointment to see the dentist. Those aged 25-34 were the most likely to say it was difficult.

Table 3.53: Difficulty/ease of Getting an Appointment to See the Dentist (Q12e) by Age and Gender

	Difficult	Neither	Easy	Unweighted base (n)
Age:				
16-24	0%	4%	96%	62
25-34	11%	15%	74%	112
35-44	7%	9%	84%	135
45-54	4%	19%	77%	139
55-64	1%	9%	89%	121
65-74	3%	16%	80%	119
75+	1%	6%	93%	101
Men 16-44	8%	13%	80%	98
Women 16-44	5%	6%	89%	211
Men 45-64	2%	17%	81%	98
Women 45-64	3%	13%	83%	162
Men 65+	4%	9%	87%	87
Women 65+	1%	14%	85%	133
All	4%	12%	84%	793

All three measures of social exclusion were associated with a lower likelihood of finding it easy to get an appointment to see the dentist. Those who felt isolated from family and friends and those who did not feel in control of the decisions affecting their life were more likely to find it difficult to get an appointment to see the dentist.

Table 3.54: Difficulty/ease of Getting an Appointment to See the Dentist (Q12e) by Factors Associated with Social Exclusion

	Difficult	Neither	Easy	Unweighted base (n)
All income from benefits	2%	37%	60%	168
Feel isolated from friends/family	13%	28%	59%	53
Not in control of decisions affecting daily life, or only 'to some extent'	7%	12%	81%	249

For health and wellbeing measures, those more likely to find it difficult to get an appointment to see the dentist were those with a limiting condition or illness, those exposed to second hand smoke and those who consume fewer than five portions of fruit/vegetables per day. Also, smokers were less likely to say it was easy to get an appointment to see the dentist.

Table 3.55: Difficulty/ease of Getting an Appointment to See the Dentist (Q12e) by Health and Wellbeing Measures

	Difficult	Neither	Easy	Unweighted base (n)
Positive view of physical wellbeing	3%	10%	87%	632
Positive view of quality of life	4%	11%	85%	699
Limiting condition or illness	8%	12%	80%	173
Exposed to second hand smoke	8%	19%	73%	257
Current smoker	5%	29%	66%	210
Consumes fewer than five portions of fruit/veg per day	6%	12%	82%	591

4 Health Behaviours

4.1 Chapter Summary

Table 4.1 shows the core indicators relating to health behaviours.

Table 4.1: Indicators for Health Behaviours

Indicator	% of sample	Unweighted base (n)
Exposed to second hand smoke most or some of the time (Q15)	25%	1,085
Current smoker (Q16)	17%	1,086
Heavily addicted smoker (smoking 20 or more cigarettes per day), based on all smokers (Q17)	39%	324
Exceeds recommended limits for weekly units of alcohol (based on all respondents) (Q23)	17%	1,085
Exceeds recommended limits for weekly units of alcohol (based on all those who drank at all in the past week) (Q23)	34%	543
Binge drinker in the past week (based on all respondents) (Q23)	27%	1,085
Binge drinker in the past week (based on all those who drank at all in the past week) (Q23)	54%	543
Takes at least 30 minutes of moderate exercise 5 or more times per week (Q31)	42%	1,085
Participated in at least one sport or activity in the last week (Q32)	91%	1,086
Consumes 5 or more portions of fruit/vegetables per day (Q24 & Q25)	29%	1,085
Consumes at least 2 portions of oily fish per week (Q27)	28%	1,085
Consumes at least 2 portions of high fat snacks per day (Q26)	35%	1,084
Body Mass Index of 25 or over(Q28 & Q29)	52%	827
More than 1 of the following 5 'unhealthy' behaviours: smoking, BMI of 25+, not meeting recommended levels of physical activity, not meeting the recommended fruit/veg consumption, binge drinking	75%	826
More than 1 of the following 5 'healthy' behaviours: non-smoker, within normal BMI range (18.5-24.99), meet the physical activity recommendations, eat 5 or more portions of fruit/veg per day, drink within safe limits/not at all	78%	826

One in four (25%) respondents were exposed to second hand smoke most or some of the time. Those more likely to be exposed to second hand smoke were those aged under 25, those in the most deprived areas, those who received all household income from benefits, those who did not definitely feel in control of the decisions affecting their life, smokers and those who consume fewer than five portions of fruit/vegetables per day.

One in six (17%) respondents were smokers, smoking on at least some days. Those more likely to be smokers were those aged 25-44, men, those in the most deprived areas, those with no qualifications, those who received all household income from benefits, those exposed to second hand smoke, those who exceed the recommended weekly limit for alcohol consumption, those with a high GHQ12 score and those who consume fewer than five portions of fruit/vegetables per day.

Half (52%) of respondents drank alcohol weekly. Those more likely to drink alcohol at least once a week were men, those in the least deprived areas, those with qualifications, smokers and those with positive views of their health and physical wellbeing.

One in six (17%) respondents had exceeded the recommended weekly limit for alcohol consumption in the previous week. This equates to 34% of those who had drunk alcohol in the last week. Those more likely to have exceeded weekly limits were men, those who felt isolated from family/friends, those with a high GHQ12 score, smokers and obese people.

One in four (27%) respondents had been binge drinkers in the previous week. This equates to 54% of all those who had drunk alcohol in the last week. Those more likely to be binge drinkers were those aged under 55, men, those with a positive view of their health, smokers and those who consumed fewer than five portions of fruit/vegetables per day.

Two in five (42%) respondents met the target for physical activity (at least 30 minutes of moderate physical activity 5 times per week). Those less likely to meet this target were those aged 75 or over, men, those in the least deprived quintiles, those with no qualifications, those who felt isolated from family/friends, those who did not definitely feel in control of the decisions affecting their life, those who exceeded the recommended weekly limit for alcohol consumption, those with a limiting condition or illness, those with a high GHQ12 score, and those consuming fewer than five portions of fruit/vegetables per day.

Nine in ten (91%) respondents had participated in at least one sport or activity in the last week. Those less likely to have participated in sport/activity in the last week were those in the oldest age groups, women, those in the most deprived areas, those with no qualifications, those who received all household income from benefits, those with a limiting condition/illness, smokers and obese people.

Three in ten (29%) respondents met the target of consuming five or more portions of fruit/vegetables per day. Those less likely to meet this target were men, those in the most deprived areas, those who received all household income from benefits, smokers, and those exposed to second hand smoke.

Just under three in ten (28%) respondents consumed two or more portions of oily fish per week. Those less likely to do so were those aged under 45, those in the most deprived areas, those who received all household income from benefits, those exposed to second hand smoke, smokers and those who consumed fewer than five portions of fruit/vegetables per day.

Just over a third (35%) of respondents exceeded the recommended limit of one high fat/ sugary snack per day. Those more likely to exceed this limit were those aged 16-24, those in the most deprived areas, those who received all household income from benefits, those who did not definitely feel in control of their lives, those exposed to second hand smoke and those who consumed fewer than five portions of fruit/vegetables per day.

Half (52%) of respondents were overweight or obese. Using the BMI of 29.2 as a definition of obesity, one in five (19%) were obese. Those more likely to be obese were those aged 45-64, those with no qualifications and those who exceeded the recommended weekly limit for alcohol consumption.

Three in four (75%) exhibited at least two of the following 'unhealthy' behaviours - smoking, BMI of 25+, not not meeting recommended levels of physical activity, not meeting the recommended fruit/vegetable consumption, binge drinking. The mean number of 'unhealthy' behaviours from these five was 2.18. Those exhibiting more mean unhealthy behaviours were men aged 45-64, those in the most deprived areas, those with no qualifications, those who received all income from benefits and those who felt isolated from family and friends.

Just over three in four (78%) exhibited at least two of the following 'healthy' behaviours - non-smoker, within normal BMI range (18.5-24.99), meet the physical activity recommendations, eat 5 or more portions of fruit/vegetables per day, drink within safe limits/not at all. The mean number of 'healthy' behaviours from these five was 2.67. Those exhibiting fewer mean healthy behaviours were men aged 45-64, those in the most deprived areas, those with no qualifications and those who received all income from benefits.

4.2 Smoking

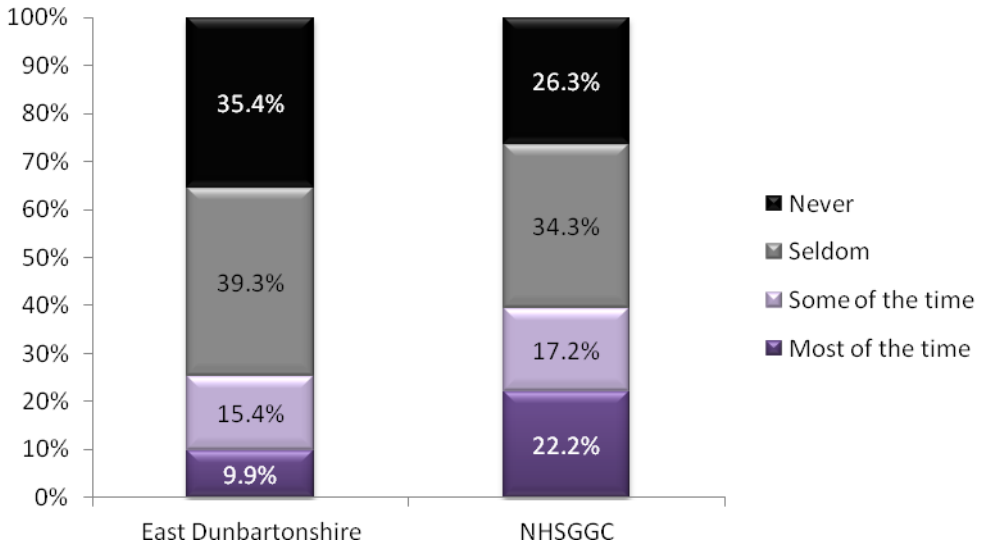
Exposure to Second Hand Smoke

Respondents were asked how often they were in places where there is smoke from other people smoking tobacco. One in four (25%) said that this happened most of the time (10%) or some of the time (15%). A further 39% said that they were seldom exposed to second hand smoke and 35% said they were never exposed.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde area as a whole to say they were exposed to second hand smoke most or some of the time (25% East Dunbartonshire; 39% NHSGGC).

Figure 4.1: Exposure to Second Hand Smoke (Q15) - East Dunbartonshire & NHS Greater Glasgow & Clyde



Those aged under 25 were the most likely to be exposed to second hand smoke, with 46% of respondents in that age group being exposed most or some of the time. Those aged 75 or over were the least likely to be exposed to second hand smoke, with 13% of those in that age group being exposed most or some of the time.

Table 4.2: Exposure to Second Hand Smoke (Q15) by Age and Gender

	Most of the time	Some of the time	Seldom	Never	Most/some of the time	Unweighted base (n)
Age:						
16-24	9%	38%	29%	25%	46%	79
25-34	16%	16%	38%	30%	32%	127
35-44	10%	18%	44%	29%	27%	160
45-54	10%	9%	56%	25%	19%	176
55-64	8%	9%	45%	38%	17%	164
65-74	13%	11%	34%	42%	24%	187
75+	5%	8%	19%	68%	13%	183
Men 16-44	11%	27%	38%	24%	38%	128
Women 16-44	12%	21%	36%	31%	32%	238
Men 45-64	10%	6%	57%	27%	16%	139
Women 45-64	8%	12%	46%	34%	20%	201
Men 65+	10%	10%	34%	47%	19%	143
Women 65+	9%	9%	22%	60%	18%	227
All	10%	15%	39%	35%	25%	1,085

Those in the most deprived areas were more likely to be exposed to second hand smoke most or some of the time - half of those in the most deprived 20% areas compared to a quarter of those in other areas were exposed most/some of the time to others' smoke. This is shown in Table 4.3.

Table 4.3: Exposure to Second Hand Smoke (Q15) by Deprivation and Socio Economic Measures

	Most of the time	Some of the time	Seldom	Never	Most/some of the time	Unweighted base (n)
Bottom 20% datazones	37%	15%	24%	25%	52%	555
Other datazones	9%	15%	40%	36%	24%	530
SIMD quintile						
1 (most deprived)	37%	15%	24%	25%	52%	555
2	21%	6%	46%	27%	27%	72
3	11%	29%	40%	20%	40%	81
4	10%	7%	45%	38%	16%	99
5 (least deprived)	5%	16%	37%	41%	22%	278

Those who received all household income from benefits and those who did not definitely feel in control of decisions were more likely to be exposed to second hand smoke most or some of the time.

Table 4.4: Exposure to Second Hand Smoke (Q15) by Factors Associated with Social Exclusion

	Most of the time	Some of the time	Seldom	Never	Most/some of the time	Unweighted base (n)
All income from benefits	32%	18%	24%	26%	50%	272
Not in control of decisions affecting daily life, or only 'to some extent'	11%	20%	32%	37%	31%	365

For health and wellbeing measures, those more likely to be exposed to second hand smoke most or some or the time were smokers and those who consumed fewer than five portions of fruit/vegetables per day. Those with a positive view of their mental/emotional wellbeing were less likely to be exposed to second hand smoke.

Table 4.5: Exposure to Second Hand Smoke (Q15) by Health and Wellbeing Measures

	Most of the time	Some of the time	Seldom	Never	Most/some of the time	Unweighted base (n)
Positive view of mental/emotional wellbeing	9%	15%	41%	35%	24%	885
Current smoker	52%	36%	8%	3%	88%	324
Consumes fewer than 5 portions of fruit/veg per day	12%	17%	37%	34%	29%	831

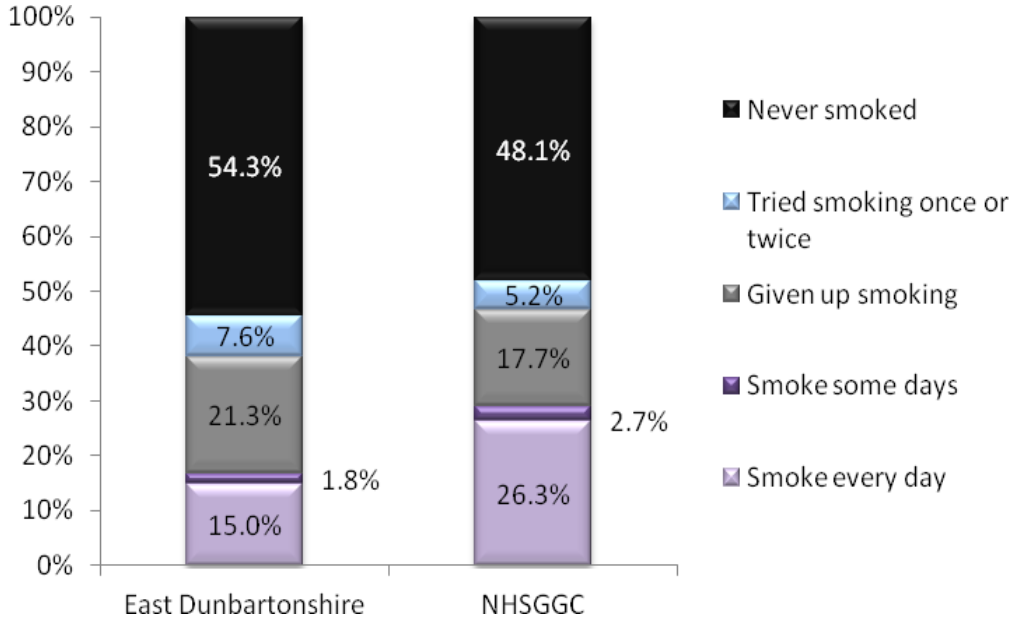
Smokers

One in six (17%) of respondents were smokers, smoking either every day (15%) or some days (2%).

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were much less likely than those in the NHS Greater Glasgow & Clyde area as a whole to be current smokers (17% East Dunbartonshire; 29% NHSGGC).

Figure 4.2: Current Smoking Status (Q16) - East Dunbartonshire & NHS Greater Glasgow & Clyde



Those aged 25-44 were the most likely to be current smokers. Men were more likely than women to be smokers (20% men; 14% women).

Table 4.6: Proportion of Current Smokers (Q16) by Age and Gender

	Current smoker	Unweighted base (n)
Age:		
16-24	11%	79
25-34	23%	127
35-44	26%	160
45-54	17%	176
55-64	10%	164
65-74	16%	187
75+	14%	184
Men	20%	414
Women	14%	671
Men 16-44	26%	128
Women 16-44	14%	238
Men 45-64	14%	139
Women 45-64	15%	201
Men 65+	17%	143
Women 65+	14%	228
All	17%	1,086

Table 4.7 shows that those in the most deprived areas were more likely to be smokers. More than two in five (45%) of those in the most deprived quintile were smokers compared to 15% of those in other areas. Also, those with no qualifications were more likely to be smokers than those with qualifications.

Table 4.7: Proportion of Current Smokers (Q16) by Deprivation and Socio Economic Measures

	Current smoker	Unweighted base (n)
Bottom 20% datazones	45%	556
Other datazones	15%	530
SIMD quintile		
1 (most deprived)	45%	556
2	22%	72
3	29%	81
4	11%	99
5 (least deprived)	12%	278
At least one qualification	15%	746
No qualifications	27%	331

Those who received all household income from benefits were more likely to be smokers. Indeed, half (51%) of those who received all income from benefits were smokers.

Table 4.8: Proportion of Current Smokers (Q16) by Factors Associated with Social Exclusion

	Current smoker	Unweighted base (n)
All income from benefits	51%	273

Table 4.9 shows that positive views of health, and physical and mental wellbeing were associated with a lower likelihood of being a smoker. Those more likely to be smokers were:

- Those exposed to second hand smoke;
- Those who exceed the recommended weekly limit for alcohol consumption;
- Those with a high GHQ12 score; and
- Those who consume fewer than five portions of fruit/vegetables per day.

Table 4.9: Proportion of Current Smokers (Q16) by Health and Wellbeing Measures

	Current smoker	Unweighted base (n)		Current smoker	Unweighted base (n)
Positive view of general health	15%	707	Exposed to second hand smoke	59%	377
Positive view of physical wellbeing	15%	847	Exceeds weekly alcohol limit	28%	170
Positive view of mental/emotional wellbeing	15%	885	Consumes fewer than 5 portions of fruit/veg per day	20%	832
High GHQ12 Score	26%	262			

Heavily Addicted Smokers

Among smokers, the mean number of cigarettes smoked per day was 14.9. Two in five (39%) smokers were 'heavily addicted smokers' i.e. smoking 20 or more cigarettes per day.

Intention to Stop Smoking

Half (49%) of smokers said that they intend to stop smoking while 17% said they did not and 33% were unsure.

Comparison with NHS Greater Glasgow & Clyde

Smokers in East Dunbartonshire were more likely than smokers in the NHS Greater Glasgow & Clyde area as a whole to say they intend to stop smoking (49% East Dunbartonshire; 33% NHSGGC).

4.3 Drinking

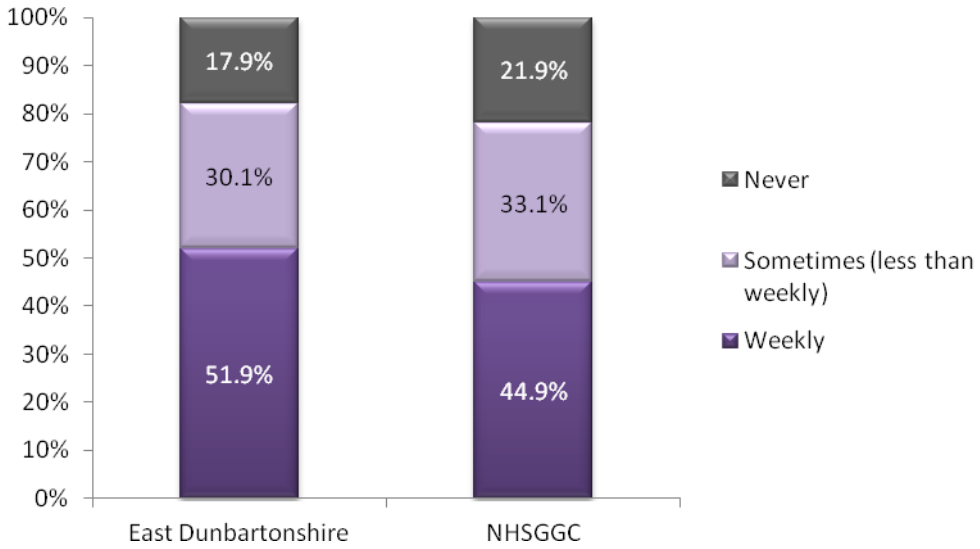
Frequency of Drinking Alcohol

Just under one in five (18%) respondents said that they never drank alcohol, 30% drank alcohol sometimes, but less than weekly and just over half (52%) drank alcohol at least once a week (including 19% who drank alcohol on three or more days per week).

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were more likely than those in the NHS Greater Glasgow & Clyde area as a whole to drink alcohol weekly (52% East Dunbartonshire; 45% NHSGGC).

Figure 4.3: Frequency Drink Alcohol (Q19) - East Dunbartonshire and NHS Greater Glasgow & Clyde



Those aged 75 or over were more likely than others to say that they never drank alcohol, and less likely to do so weekly. Men were more likely than women to drink weekly (63% men; 42% women).

Table 4.10: Frequency Drink Alcohol (Q19) by Age and Gender

	Never	Less than weekly	At least once a week	Unweighted base (n)
Age:				
16-24	17%	39%	45%	78
25-34	7%	35%	58%	127
35-44	10%	30%	60%	158
45-54	16%	31%	53%	174
55-64	11%	30%	59%	164
65-74	27%	23%	50%	186
75+	44%	22%	34%	184
Men	13%	24%	63%	408
Women	23%	35%	42%	669
Men 16-44	10%	31%	59%	125
Women 16-44	13%	38%	49%	238
Men 45-64	10%	22%	68%	139
Women 45-64	17%	38%	45%	199
Men 65+	22%	15%	64%	142
Women 65+	45%	28%	28%	228
All	18%	30%	52%	1,078

Those in the least deprived areas and those with qualifications were more likely to drink alcohol weekly.

Table 4.11: Frequency Drink Alcohol (Q19) by Deprivation and Socio Economic Measures

	Never	Less than weekly	At least once a week	Unweighted base (n)
Bottom 20% datazones	20%	38%	42%	551
Other datazones	18%	30%	52%	527
SIMD quintile				
1 (most deprived)	20%	38%	42%	551
2	13%	38%	49%	72
3	24%	25%	51%	80
4	20%	37%	43%	98
5 (least deprived)	17%	27%	56%	277
At least one qualification	14%	32%	54%	744
No qualifications	37%	21%	42%	325

Those who received all household income from benefits were more likely to say that they never drank alcohol.

Table 4.12: Frequency Drink Alcohol (Q19) by Factors Associated with Social Exclusion

	Never	Less than weekly	At least once a week	Unweighted base (n)
All income from benefits	38%	32%	30%	267

For health and wellbeing measures, those more likely to drink alcohol weekly were smokers, and those with positive views of their health and physical wellbeing. Those with a limiting condition or illness were more likely than others to say that they never drank alcohol.

Table 4.13: Frequency Drink Alcohol (Q19) by Health and Wellbeing Measures

	Never	Less than weekly	At least once a week	Unweighted base (n)
Positive view of general health	14%	31%	55%	701
Positive view of physical wellbeing	16%	31%	53%	844
Limiting condition/illness	31%	28%	41%	272
Current smoker	19%	19%	63%	317

Alcohol Consumption in Previous Week

Respondents were asked whether they had had a drink containing alcohol in the past seven days. Half (50%) of all respondents said they had drunk alcohol in the past week (therefore similar to the 52% who had said they drank alcohol weekly).

Respondents were asked how many of each type of drink they had consumed on each of the past seven days. Responses were used to calculate the total units of alcohol consumed on each day, and a total number of units for the week. For the 2008 and 2011 surveys, in calculating the number of units, new assumptions were applied for the number of units in each type of drink which differed from those which were applied in previous surveys. Appendix D shows the assumptions of units in each type of drink for both the current survey (and 2008 survey) and for the surveys up to 2005. The data presented here show indicators for both the new unit measures and the old unit measures for comparison.

The recommended weekly limit for alcohol consumption is 21 units per week for men and 14 units per week for women. Using the new unit measures, 17% of all respondents exceeded their weekly limit. This equates to 34% of all those who had drunk alcohol in the last week.

Comparison with NHS Greater Glasgow & Clyde

Although proportionately more respondents in East Dunbartonshire drank alcohol weekly, those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde area as a whole to have exceeded the recommended weekly limit for alcohol consumption (17% East Dunbartonshire; 20% NHSGGC). Among those who had drunk alcohol in the last week, 34% of those in East Dunbartonshire had exceeded the recommended limit compared to 42% of those in the whole NHSGGC area.

Men were more likely than women to have exceeded the weekly limit (25% men; 9% women).

Table 4.14: Proportion Exceeding Recommended Weekly Limits for Alcohol (old new and old unit measures) (Q23) by Age and Gender

	Exceeds Weekly Limit (new measures)	Exceeds Weekly Limit (old measures)	Unweighted base (n)
Men	25%	21%	414
Women	9%	6%	671
Men 16-44	26%	22%	128
Women 16-44	9%	7%	238
Men 45-64	25%	20%	139
Women 45-64	13%	7%	201
Men 65+	23%	18%	143
Women 65+	6%	2%	228
All	17%	13%	1,085

Those who felt isolated from family/friends were more likely to have exceeded the weekly alcohol limit in the last week.

Table 4.15: Proportion Exceeding Recommended Weekly Limits for Alcohol (old new and old unit measures) (Q23) by Factors Associated with Social Exclusion

	Exceeds Weekly Limit (new measures)	Exceeds Weekly Limit (old measures)	Unweighted base (n)
Feel isolated from family/friends	31%	26%	80

Table 4.16 shows that smokers, those with a high GHQ12 score and obese people were more likely to exceed the weekly limit for alcohol consumption.

Table 4.16: Proportion Exceeding Recommended Weekly Limits for Alcohol (old new and old unit measures) (Q23) by Health and Wellbeing Measures

	Exceeds Weekly Limit (new measures)	Exceeds Weekly Limit (old measures)	Unweighted base (n)
High GHQ12 score	25%	22%	262
Current smoker	29%	27%	324
Obese	23%	18%	172

Binge Drinking

Binge drinkers were defined as:

- Men who consumed eight or more units of alcohol on at least one day in the previous week;
- Women who consumed six or more units of alcohol on at least one day in the previous week.

Using the new measures for calculating unit totals, 27% of all respondents had been binge drinkers during the previous week. This equates to 54% of all those who had consumed alcohol in the previous week.

Comparison with NHS Greater Glasgow & Clyde

Again, although those in East Dunbartonshire were more likely to have drunk alcohol in the last week, East Dunbartonshire residents were less likely than those across the NHS Greater Glasgow & Clyde area to have been binge drinkers in the previous week (27% East Dunbartonshire; 31% NHSGGC). Among those who had drunk alcohol in the last week, 54% in East Dunbartonshire had been binge drinkers compared to 65% in NHSGGC.

Those aged under 55 were the most likely to have been binge drinkers in the previous week while those aged 75 and over were the least likely. Also, men were considerably more likely than women to be binge drinkers (39% men; 16% women). This is shown in Table 4.17.

Table 4.17: Proportion Binge Drinking During Previous Week (old new and old unit measures) (Q23) by Age and Gender

	Binge Drinker (new measures)	Binge Drinker (old measures)	Unweighted base (n)
Age:			
16-24	32%	28%	79
25-34	25%	20%	127
35-44	36%	26%	160
45-54	34%	25%	176
55-64	31%	18%	164
65-74	13%	12%	187
75+	7%	3%	184
Men	39%	30%	414
Women	16%	11%	671
Men 16-44	43%	36%	128
Women 16-44	20%	15%	238
Men 45-64	44%	33%	139
Women 45-64	21%	12%	201
Men 65+	19%	14%	143
Women 65+	4%	3%	228
All	27%	20%	1,085

Those who received all household income from benefits and those who did not definitely feel in control of the decisions affecting their life were less likely to be binge drinkers.

Table 4.18: Proportion Binge Drinking During Previous Week (old new and old unit measures) (Q23) by Factors Associated with Social Exclusion

	Binge Drinker (new measures)	Binge Drinker (old measures)	Unweighted base (n)
All income from benefits	16%	9%	273
Not in control of decisions affecting daily life, or only 'to some extent'	19%	13%	365

For health and wellbeing measures, those more likely to be binge drinkers were:

- Smokers;
- Those consuming fewer than five portions of fruit/vegetables per day; and
- Those with a positive view of their general health.

Those with a limiting condition or illness were less likely to be binge drinkers.

Table 4.19: Proportion Binge Drinking During Previous Week (old new and old unit measures) (Q23) by Health and Wellbeing Measures

	Binge Drinker (new measures)	Binge Drinker (old measures)	Unweighted base (n)
Positive view of general health	30%	22%	707
Limiting condition/illness	19%	10%	274
Current smoker	38%	30%	324
Consumes fewer than five portions of fruit/vegetables per day	30%	22%	831

Alcohol Free Days

Just over nine in ten (92%) respondents had two or more days in the previous week in which they did not consume alcohol. This equates to 85% of those who had drunk alcohol in the previous week.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde area as a whole to have had two or more alcohol-free days in the previous week (92% East Dunbartonshire; 96% NHSGGC). Among those who had drunk alcohol in the previous week, 85% of those in East Dunbartonshire had had two or more alcohol-free days compared to 91% of those across NHSGGC.

Those aged under 25 were the most likely to have had two or more alcohol-free days in the last week. Women were more likely than men to have had two or more alcohol-free days.

Table 4.20: Proportion who had Two or More Alcohol-Free Days in Previous Week (Q23) by Age and Gender

	Two or More Alcohol-Free Days	Unweighted base (n)
Age:		
16-24	100%	79
25-34	96%	127
35-44	97%	160
45-54	94%	176
55-64	85%	164
65-74	86%	187
75+	86%	184
Men	89%	414
Women	95%	671
Men 16-44	100%	128
Women 16-44	96%	238
Men 45-64	84%	139
Women 45-64	96%	201
Men 65+	76%	143
Women 65+	94%	228
All	92%	1,086

Those in the most deprived areas were more likely than those in other areas to have had two or more alcohol-free days in the previous week. Those in the least deprived areas were the least likely to have had two or more alcohol-free days. This is shown in Table 4.21.

Table 4.21: Proportion who had Two or More Alcohol-Free Days in Previous Week (Q23) by Deprivation and Socio Economic Measures

	Two or More Alcohol-Free Days	Unweighted base (n)
Bottom 20% datazones	95%	556
Other datazones	92%	530
SIMD quintile		
1 (most deprived)	95%	556
2	98%	72
3	96%	81
4	96%	99
5 (least deprived)	88%	278

Those who received all household income from benefits were more likely to have had two or more alcohol-free days in the last week.

Table 4.22: Proportion who had Two or More Alcohol-Free Days in Previous Week (Q23) by Factors Associated with Social Exclusion

	Two or More Alcohol-Free Days	Unweighted base (n)
All household income from benefits	99%	273

For health and wellbeing measures, those less likely to have had two or more alcohol-free days in the previous week were those with a limiting condition or illness and those with a

high GHQ12 score. Those with a positive view of their physical health were more likely to have had two or more alcohol-free days.

Table 4.23: Proportion who had Two or More Alcohol-Free Days in Previous Week (Q23) by Health and Wellbeing Measures

	Two or More Alcohol-Free Days	Unweighted base (n)		Two or More Alcohol-Free Days	Unweighted base (n)
Positive view of physical wellbeing	93%	847	Limiting condition or illness	87%	274
High GHQ12 Score	89%	262			

4.4 Physical Activity[2]

Frequency of Physical Activity

Respondents were asked on how many days in the last week had they taken a total of 30 minutes or more of physical activity which was enough to raise their breathing rate. Just under half (48%) said that they had not done this on any day in the last week. One in eleven (9%) had done so on five or more days in the last week. The mean number of days for all respondents was 1.6.

Respondents were also asked, including all types of physical activity, how many days in the last week had they taken at least 30 minutes of moderate physical activity. This would include housework and work-based activity where relevant. One in five (19%) said that they had not done this on any day in the last week, and over a quarter (27%) said they had done this every day in the last week. The mean number of days was 3.8.

The target for physical activity is to take 30 minutes or more of moderate physical activity on five or more days per week. Two in five (42%) respondents met this target.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde area as a whole to meet the target for physical activity (42% East Dunbartonshire; 51% NHSGGC).

Those aged 25-44 were the most likely to meet the target for physical activity and those aged 75 or over were the least likely. Women were more likely than men to meet the target.

[2] In July 2011 the four UK Chief Medical Officers published new physical activity guidelines, however as this survey was commisioned prior to publication of the new guidelines, it uses the previous measure of 30 minutes on 5 or more days per week. The new guidelines are to accumulate 150 minutes (2.5 hours) of moderate intensity activty or accumulate 75 minutes of vigorous intensity activity in bouts of 10 minutes or more per week.

Table 4.24: Proportion Who Take 30 Minutes or More of Moderate Activity 5 or More Times Per Week (Q31) by Age and Gender

	Meet Physical Activity Target	Unweighted base (n)
Age:		
16-24	30%	79
25-34	55%	126
35-44	55%	160
45-54	46%	176
55-64	47%	164
65-74	35%	187
75+	16%	184
Gender:		
Men	37%	414
Women	46%	670
Men 16-44	37%	128
Women 16-44	56%	237
Men 45-64	41%	139
Women 45-64	51%	201
Men 65+	30%	143
Women 65+	23%	228
All	42%	1,085

Those with no qualifications were much less likely to meet the target for physical activity. Those in the second most deprived quintile were the most likely to meet the target for physical activity and those in the least deprived quintile were the least likely to meet the target. This is shown in Table 4.25.

Table 4.25: Proportion Who Take 30 Minutes or More of Moderate Activity 5 or More Times Per Week (Q31) by Deprivation and Socio Economic Measures

	Meet Physical Activity Target	Unweighted base (n)		Meet Physical Activity Target	Unweighted base (n)
SIMD quintile					
1 (most deprived)	39%	555	At least one	46%	745
2	73%	72	qualification		
3	43%	81			
4	44%	99	No	21%	331
5 (least deprived)	34%	278	qualifications		

Those who felt isolated and those who did not definitely feel in control of the decisions affecting their life were less likely to meet the target for physical activity, as shown in Table 4.26.

Table 4.26: Proportion Who Take 30 Minutes or More of Moderate Activity 5 or More Times Per Week (Q31) by Factors Associated with Social Exclusion

	Meet Physical Activity Target	Unweighted base (n)
Feel isolated from friends/family	26%	81
Not in control of decisions affecting daily life, or only 'to some extent'	31%	365

For health and wellbeing measures, those less likely to meet the target for physical activity were those who exceeded the recommended weekly limit for alcohol consumption, those with a limiting condition or illness, those with a high GHQ12 score, and those consuming fewer than five portions of fruit/vegetables per day.

Those more likely to meet the physical activity target were those with positive perceptions of their general health and physical wellbeing.

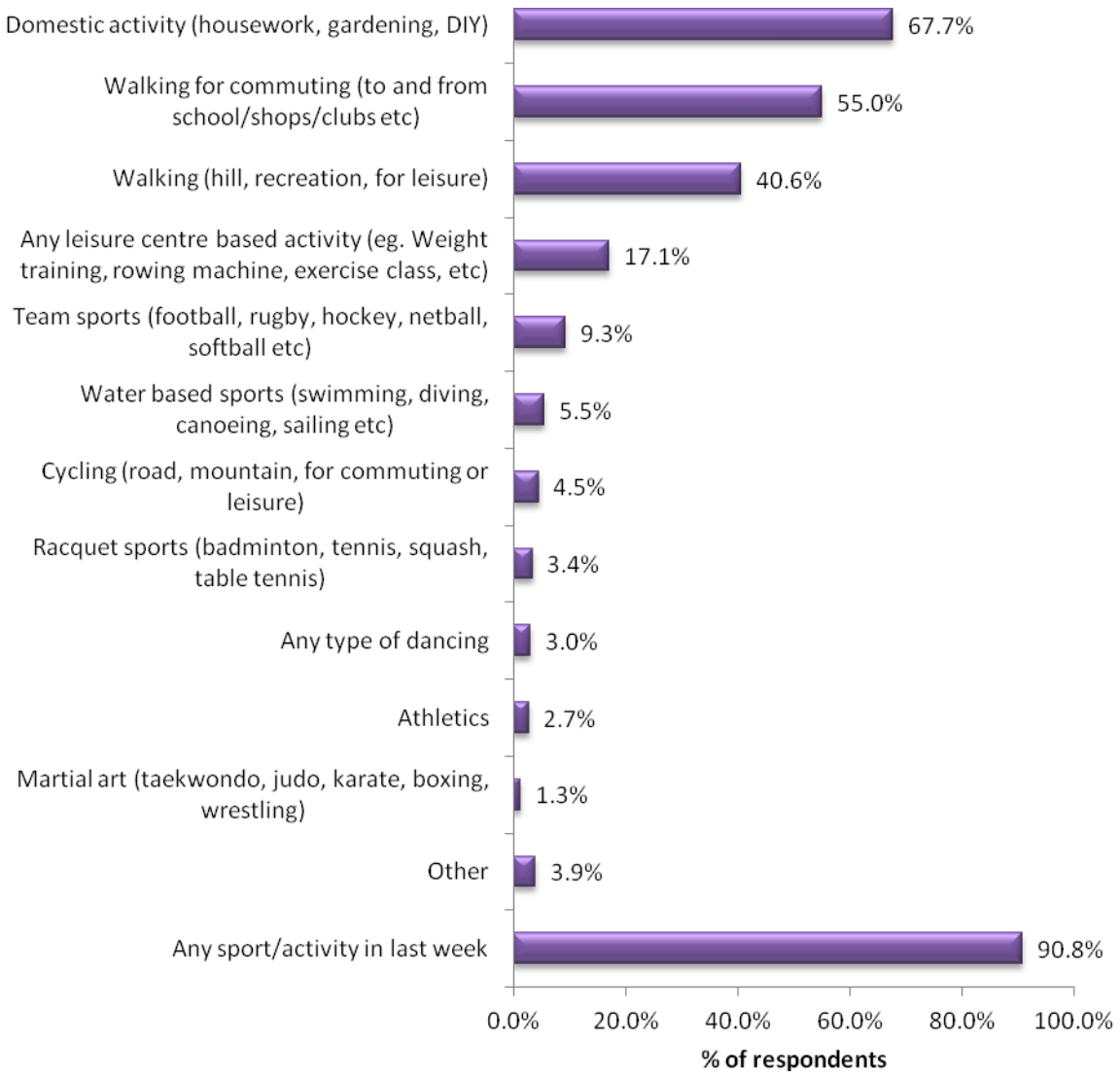
Table 4.27: Proportion Who Take 30 Minutes or More of Moderate Activity 5 or More Times Per Week (Q31)by Health and Wellbeing Measures

	Meet Physical Activity Target	Unweighted base (n)		Meet Physical Activity Target	Unweighted base (n)
Positive view of general health	44%	707	Limiting condition or illness	33%	274
Positive view of physical wellbeing	46%	847	Exceeds weekly alcohol limit	32%	170
High GHQ12 Score	33%	262	Consumes fewer than 5 portions of fruit/veg per day	39%	831

Participation in Sport and Activities in the Last Week

Respondents were asked whether they had participated in specific sports and activities in the last week. Responses are shown in Figure 4.4. Overall, 91% of respondents had participated in at least one sport or activity in the last week. The most common types of activity were domestic activity, walking for commuting and walking for recreation.

Figure 4.4: Proportion Participating in Sports in the Last Week



The most commonly described 'other' activity was golf, in which 3.2% of respondents had participated in the previous week.

Comparison with NHS Greater Glasgow & Clyde

Compared to those in the NHS Greater Glasgow & Clyde area as a whole, in the previous week those in East Dunbartonshire were less likely to have taken part in:

- Water based sports (6% East Dunbartonshire; 7% NHSGGC); and
- Dancing (3% East Dunbartonshire; 4% NHSGGC);

However, those in East Dunbartonshire were more likely than those in the NHSGGC area as a whole to have taken part in:

- Walking for leisure (41% East Dunbartonshire; 35% NHSGGC);
- Athletics (3% East Dunbartonshire; 2% NHSGGC); and
- Golf (3% East Dunbartonshire; 1% NHSGGC).

Those aged 25-44 were the most likely to have done at least one sport or activity in the previous week and those aged 75 or over were the least likely. Men were more likely than women to have participated in sport/activity in the last week.

Table 4.28: Proportion Who Participated in at Least One Sport or Activity in the Last Week (Q32) by Age and Gender

	Participated in Sport / Activity	Unweighted base (n)
Age:		
16-24	92%	79
25-34	97%	127
35-44	97%	160
45-54	92%	176
55-64	93%	164
65-74	86%	187
75+	77%	184
Men	93%	414
Women	89%	671
Men 16-44	98%	128
Women 16-44	93%	238
Men 45-64	94%	139
Women 45-64	91%	201
Men 65+	82%	143
Women 65+	83%	228
All	91%	1,086

Those in the most deprived areas and those with no qualifications were less likely to have participated in sport or activity in the last week.

Table 4.29: Proportion Who Participated in at Least One Sport or Activity in the Last Week (Q32) by Deprivation and Socio Economic Measures

	Participated in Sport / Activity	Unweighted base (n)
Bottom 20% datazones	72%	556
Other datazones	92%	530
SIMD quintile		
1 (most deprived)	71%	556
2	87%	72
3	90%	81
4	90%	99
5 (least deprived)	94%	278
At least one qualification	93%	746
No qualifications	79%	331

Those who received all household income from benefits were less likely to have participated in any sport or activity in the past week.

Table 4.30: Proportion Who Participated in at Least One Sport or Activity in the Last Week (Q32) by Factors Associated with Social Exclusion

	Participated in Sport / Activity	Unweighted base (n)
All income from benefits	64%	273

For health and wellbeing measures, those less likely to have participated in sport or activity in the last week were:

- Those with a limiting condition/illness;
- Smokers; and
- Obese people.

Factors associated with a higher likelihood of having participated in sport in the last week were having positive views of health, wellbeing or quality of life.

Table 4.31: Proportion Who Participated in at Least One Sport or Activity in the Last Week (Q32) by Health and Wellbeing Measures

	Participated in Sport	Unweighted base (n)		Participated in Sport	Unweighted base (n)
Positive view of general health	95%	707	Limiting condition or illness	74%	274
Positive view of physical wellbeing	92%	379	Current smoker	87%	324
Positive view of mental/emotional wellbeing	92%	885	Obese	89%	172
Positive view of quality of life	92%	920			

Travel to Work/Education

Respondents were asked how they usually travel to work (or school/college/university if in full-time education). Responses were categorised as follows:

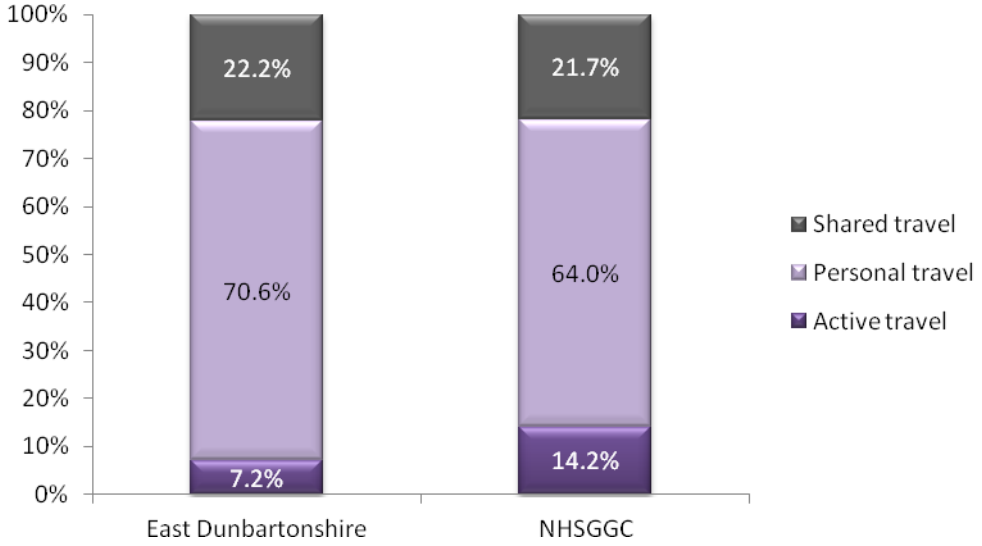
- Active travel (walking and cycling);
- Personal travel (car/van driver or other method);
- Shared travel (car/van passenger, bus or rail).

Of those who travelled to work or education, 7% used active travel, 71% used personal travel and 22% used shared travel.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were less likely than those in the NHSGGC area as a whole to use active travel methods (7% East Dunbartonshire; 14% NHSGGC) and more likely to use personal travel (71% East Dunbartonshire; 64% NHSGGC).

Figure 4.5: Method of Travel to Work/Education - East Dunbartonshire and NHS Greater Glasgow & Clyde



Those aged under 25 were the least likely to use personal travel methods and most likely to use active travel or shared travel methods.

Table 4.32: Method of Travel to Work/Education (Q34) by Age and Gender

	Active travel	Personal travel	Shared travel	Unweighted base (n)
Age:				
16-24	14%	42%	44%	44
25-34	8%	74%	18%	78
35-44	6%	68%	26%	100
45-54	5%	83%	12%	116
55-64	1%	89%	10%	61
65+	0%	91%	9%	13
Men 16-44	9%	61%	30%	88
Women 16-44	11%	59%	30%	134
Men 45-64	3%	84%	13%	79
Women 45-64	5%	86%	10%	98
Men 65+	0%	100%	0%	6
Women 65+	0%	80%	20%	7
All	7%	71%	22%	413

Those in the most deprived areas were more likely than those in other areas to use active travel methods and less likely to use personal travel methods.

Table 4.33: Method of Travel to Work/Education (Q34) by Deprivation and Socio Economic Measures

	Active travel	Personal travel	Shared travel	Unweighted base (n)
Bottom 20% datazones	17%	60%	23%	195
Other datazones	7%	71%	22%	218
SIMD quintile				
1 (most deprived)	17%	60%	23%	195
2	0%	84%	16%	26
3	15%	66%	19%	36
4	2%	77%	21%	35
5 (least deprived)	7%	69%	25%	121

4.5 Diet

Fruit and Vegetables

The national target for fruit and vegetable consumption is to have at least five portions of fruit and/or vegetables per day. Responses indicate that three in ten (29%) respondents met this target. One in forty (2%) had no fruit or vegetables in a day.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde area as a whole to meet the target for fruit/vegetable consumption (29% East Dunbartonshire; 33% NHSGGC). However, they were less likely to say they ate no fruit and vegetables (2% East Dunbartonshire; 5% NHSGGC).

Women were more likely than men to meet the target for fruit/vegetable consumption.

Table 4.34: Proportion Who Consume Target Amount of Fruit/Vegetables (Q24/Q25) by Age and Gender

	Meet Fruit/Veg Target	No fruit/veg	Unweighted base (n)
Men	26%	2%	414
Women	32%	2%	670
All	29%	2%	1,085

Those in the most deprived areas were much less likely than others to meet the target for fruit/vegetables consumption.

Table 4.35: Proportion Who Consume Target Amount of Fruit/Vegetables (Q24/Q25) by Deprivation and Socio Economic Measures

	Meet Fruit/Veg Target	No fruit/veg	Unweighted base (n)
Bottom 20% datazones	16%	12%	556
Other datazones	30%	2%	529
SIMD quintile			
1 (most deprived)	16%	12%	556
2	33%	6%	72
3	31%	1%	81
4	32%	2%	99
5 (least deprived)	29%	1%	277

Those who received all household income from benefits were less likely to meet the target for fruit/vegetable consumption.

Table 4.36: Proportion Who Consume Target Amount of Fruit/Vegetables (Q24/Q25) by Factors Associated with Social Exclusion

	Meet Fruit/Veg Target	No fruit/veg	Unweighted base (n)
All income from benefits	12%	7%	273

Table 4.37 shows that those less likely to consume the target amount of fruit/vegetables were smokers and those exposed to second hand smoke. Those with positive views of their health, wellbeing or quality of life were more likely to meet the target for fruit/vegetable consumption.

Table 4.37: Proportion Who Consume Target Amount of Fruit/Vegetables (Q32/Q33) by Health and Wellbeing Measures

	Meet Fruit/ Veg Target	No fruit/ veg	Un-weighted base (n)		Meet Fruit/ Veg Target	No fruit/ veg	Un-weighted base (n)
Positive view of general health	32%	1%	707	Positive view of quality of life	30%	2%	920
Positive view of physical wellbeing	31%	2%	847	Exposed to second hand smoke	19%	4%	377
Positive view of mental/ emotional wellbeing	31%	1%	885	Current smoker	16%	7%	324

Oily Fish

Just under three in ten (28%) respondents consumed two or more portions of oily fish per week.

Those aged under 45 were less likely to eat two or more portions of oily fish per week. This is shown in Table 4.38.

Table 4.38: Proportion Who Consume Two or More Portions of Oily Fish Per Week (Q27) by Age and Gender

	2+ Portions of Oily Fish Per Week	Unweighted base (n)
Age:		
16-24	21%	79
25-34	19%	127
35-44	22%	160
45-54	29%	176
55-64	31%	164
65-74	42%	187
75+	34%	183
Men 16-44	21%	128
Women 16-44	21%	238
Men 45-64	26%	139
Women 45-64	33%	201
Men 65+	43%	142
Women 65+	35%	228
All	28%	1,085

Those in the most deprived areas were less likely to eat two or more portions of oily fish per week.

Table 4.39: Proportion Who Consume Two or More Portions of Oily Fish Per Week (Q27) by Deprivation and Socio Economic Measures

	2+ Portions of Oily Fish Per Week	Unweighted base (n)
Bottom 20% datazones	15%	555
Other datazones	29%	530
SIMD quintile		
1 (most deprived)	15%	555
2	14%	72
3	22%	81
4	34%	99
5 (least deprived)	32%	278

Those who received all household income from benefits were less likely to eat two or more portions of oily fish per week. However, those who felt isolated from family and friends were more likely to do this.

Table 4.40: Proportion Who Consume Two or More Portions of Oily Fish Per Week (Q27) by Factors Associated with Social Exclusion

	2+ Portions of Oily Fish Per Week	Unweighted base (n)
All income from benefits	8%	273
Feel isolated from family/friends	46%	80

Table 4.41 shows that for health and wellbeing measures, those less likely to eat two or more portions of oily fish per week were those exposed to second hand smoke, smokers and those who consume fewer than five portions of fruit/vegetables. Obese people and those with a high GHQ12 score were more likely to eat two or more portions of oily fish per week.

Table 4.41: Proportion Who Consume Two or More Portions of Oily Fish Per Week (Q27) by Health and Wellbeing Measures

	2+ Portions of Oily Fish Per Week	Unweighted base (n)		2+ Portions of Oily Fish Per Week	Unweighted base (n)
High GHQ12 score	33%	261	Obese	36%	172
Exposed to second hand smoke	16%	377	Consumes fewer than 5 portions of fruit/veg per day	23%	831
Current smoker	20%	324			

High Fat and Sugary Snacks

Just over a third (35%) of respondents exceeded the recommended daily limit of one high fat and sugary snack (e.g. cakes, pasties, chocolate, biscuits, crisps). Those aged 16-24 were more likely to exceed the recommended limit for high fat/sugary snacks.

Table 4.42: Proportion Who Exceeded Recommended Daily Limit of 1 Portion of High Fat/Sugary Snacks (Q26) by Age and Gender

	Two or More High Fat/Sugary Snacks Per Day	Unweighted base (n)
Age:		
16-24	47%	79
25-34	29%	127
35-44	25%	160
45-54	45%	176
55-64	28%	164
65-74	34%	187
75+	33%	184
All	35%	1,084

Those in the most deprived areas were more likely than those in other areas to consume two or more high fat/sugary snacks per day. However, those in the 4th SIMD quintile were as likely as those in the most deprived quintile to exceed this limit. This is shown in Table 4.43.

Table 4.43: Proportion Who Exceeded Recommended Daily Limit of 1 Portion of High Fat/Sugary Snacks (Q26) by Deprivation and Socio Economic Measures

	Two or More High Fat/Sugary Snacks Per Day	Unweighted base (n)
Bottom 20% datazones	50%	556
Other datazones	34%	528
SIMD quintile		
1 (most deprived)	50%	556
2	30%	72
3	30%	81
4	51%	99
5 (least deprived)	31%	276

Those who received all household income from benefits and those who did not feel in control of their lives were more likely to exceed the recommended daily limit for high fat/sugary snacks.

Table 4.44: Proportion Who Exceeded Recommended Daily Limit of 1 Portion of High Fat/Sugary Snacks (Q26) by Factors Associated with Social Exclusion

	Two or More High Fat/Sugary Snacks Per Day	Unweighted base (n)
All income from benefits	51%	273
Not in control of decisions affecting daily life, or only 'to some extent'	40%	364

Table 4.45 shows that those more likely to consume two or more high fat and sugary snacks per day were those exposed to second hand smoke and those who consume fewer than five portions of fruit/vegetables per day.

Those with a positive view of their general health or mental/emotional wellbeing were less likely to consume two or more portions of high fat/sugary snacks.

Table 4.45: Proportion Who Exceeded Recommended Daily Limit of 1 Portion of High Fat/Sugary Snacks (Q26) by Health and Wellbeing Measures

	Two or More High Fat/Sugary Snacks Per Day	Unweighted base (n)		Two or More High Fat/Sugary Snacks Per Day	Unweighted base (n)
Positive view of general health	33%	706	Exposed to second hand smoke	49%	376
Positive view of mental/emotional wellbeing	33%	884	Consumes fewer than 5 portions of fruit/veg per day	39%	831

4.6 Body Mass Index (BMI)

Respondents were asked to state their height and weight, from which their Body Mass Index (BMI) was calculated.

BMI classification points are defined as follows:

Underweight	BMI below 18.5
Ideal weight	BMI between 18.5 and 24.99
Overweight	BMI between 25 and 29.99
Obese	BMI between 30 and 39.99
Very obese	BMI 40 or over

However, due to a recognised tendency for people to over-report height and under-report weight, a revised cut off for obesity has been applied at 29.2. The tables in this section show both measures of obesity.

Altogether, half (52%) of respondents had a BMI of 25 or over, indicating that they are overweight or obese. Using the new definition obesity (BMI of 29.2), 19% of respondents were classified as obese.

Those aged 45-64 were the most likely to be obese. Men were more likely than women to be overweight (but the proportion who were obese was similar for both men and women). This is shown in Table 4.46.

Table 4.46: Body Mass Index (Q28/Q29) by Age and Gender

	Under-weight	Ideal	Over-weight	Obese	Very obese	Revised obese (29.2+)	Unweighted base (n)
Age:							
16-24	0%	79%	20%	0%	2%	2%	58
25-34	4%	57%	27%	12%	0%	17%	99
35-44	1%	46%	43%	9%	2%	10%	131
45-54	2%	25%	54%	15%	5%	34%	144
55-64	0%	32%	37%	27%	3%	33%	133
65-74	1%	46%	38%	15%	0%	17%	142
75+	1%	57%	35%	6%	0%	10%	119
Gender:							
Men	0%	42%	44%	11%	2%	19%	337
Women	2%	52%	30%	14%	2%	18%	490
Men 16-44	0%	60%	36%	2%	2%	4%	104
Women 16-44	3%	61%	25%	10%	1%	14%	184
Men 45-64	0%	20%	55%	21%	5%	41%	121
Women 45-64	2%	37%	37%	21%	3%	27%	156
Men 65+	0%	44%	44%	13%	0%	14%	111
Women 65+	3%	56%	29%	11%	0%	14%	150
All	1%	47%	37%	13%	2%	19%	827

Those with no qualifications were more likely to be obese, as shown in Table 4.47.

Table 4.47: Body Mass Index (Q28/Q29) by Deprivation and Socio Economic Measures

	Under-weight	Ideal	Over-weight	Obese	Very obese	Revised obese (29.2+)	Unweighted base (n)
At least one qualification	1%	49%	38%	10%	2%	17%	606
No qualifications	3%	38%	31%	28%	0%	33%	217

Those who exceeded the recommended weekly limit for alcohol consumption were more likely to be obese. Those who had a positive view of their physical wellbeing were less likely to be obese.

Table 4.48: Body Mass Index (Q28/Q42) by Health and Wellbeing Measures

	Under-weight	Ideal	Over-weight	Obese	Very obese	Revised obese (29.2+)	Unweighted base (n)
Positive view of physical wellbeing	1%	48%	38%	12%	1%	17%	671
Exceeds weekly alcohol limit	1%	41%	41%	15%	3%	26%	132

4.7 Unhealthy and Healthy Behaviour Indices

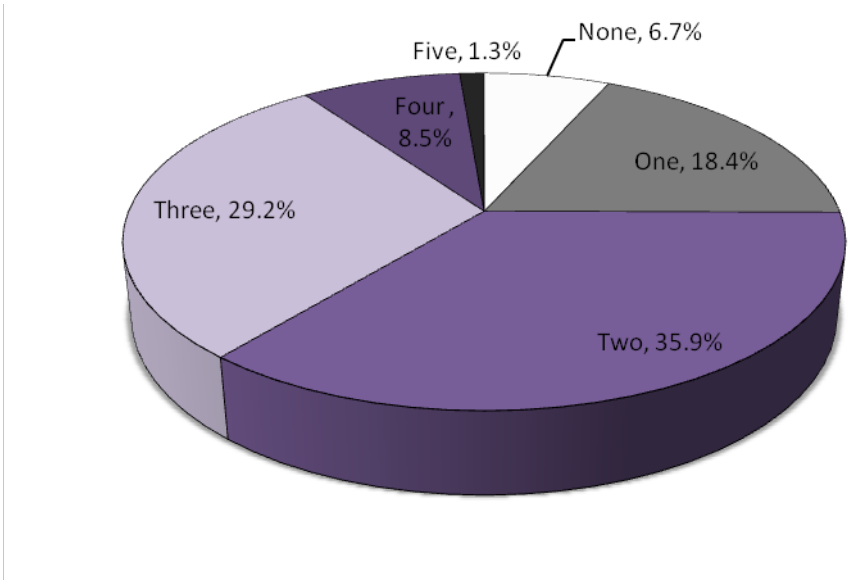
An Unhealthy Behaviour Index

This section examines the extent to which multiple 'unhealthy' behaviours are exhibited by the same people. An 'unhealthy' behaviour index has been derived from the following five unhealthy behaviours:

- Smoking;
- Having a BMI of 25 or over;
- Not meeting the recommended levels of physical activity;
- Not meeting the recommended level of fruit and vegetable consumption; and
- Binge drinking.

Figure 4.6 shows that most respondents (93%) exhibited at least one of these behaviours, but just 1% exhibited all five. The mean number of unhealthy behaviours was 2.18.

Figure 4.6: Number of Unhealthy Behaviours Exhibited
Unweighted N=826



Those aged under 35 tended to have the fewest number of unhealthy behaviours. Men tended to have more unhealthy behaviours than women (means of 2.45 and 1.91 respectively). The age/gender group with the highest mean number of unhealthy behaviours was men aged 45-64 (mean of 2.65 unhealthy behaviours). This is shown in Table 4.49 below.

Table 4.49: Mean Number of Unhealthy Behaviours by Age and Gender

	Mean No. of Unhealthy Behaviours	Unweighted base (n)
Age:		
16-24	1.96	58
25-34	1.94	98
35-44	2.23	131
45-54	2.47	144
55-64	2.28	133
65-74	1.99	142
75+	2.22	119
Men	2.45	337
Women	1.91	489
Men 16-44	2.35	104
Women 16-44	1.76	183
Men 45-64	2.65	121
Women 45-64	2.10	156
Men 65+	2.27	111
Women 65+	1.91	150
All	2.18	826

For demographic and socio economic measures, those who tended to exhibit more unhealthy behaviours were those in the most deprived areas and those with no qualifications.

Table 4.50: Mean Number of Unhealthy Behaviours by Deprivation and Socio Economic Measures

	Mean No. of Unhealthy Behaviours	Unweighted base (n)
Bottom 20% datazones	2.65	408
Other datazones	2.16	418
SIMD quintile		
1 (most deprived)	2.65	408
2	1.92	63
3	2.05	63
4	2.00	73
5 (least deprived)	2.30	219
At least one qualification	2.13	605
No qualifications	2.47	217

Those who received all household income from benefits and those who felt isolated from family and friends tended to exhibit more unhealthy behaviours.

Table 4.51: Mean Number of Unhealthy Behaviours by Deprivation and Socio Economic Measures by Factors Associated with Social Exclusion

	Mean No. of Unhealthy Behaviours	Unweighted base (n)
All income from benefits	2.72	185
Feel isolated from family/friends	2.43	51

A Healthy Behaviour Index

A 'healthy behaviour index' was also developed, which examined the extent to which respondents exhibited multiple healthy behaviours. The five healthy behaviours used in the index were:

- Not smoking;
- Having a BMI within the ideal range (18.5 to 24.99);
- Meeting the physical activity recommendations;
- Consuming five or more portions of fruit/vegetables per day; and
- Either not drinking or drinking within safe limits (i.e. not binging or drinking too much in a week).

Figure 4.7 shows that nearly all (99%) exhibited at least one healthy behaviour, and 6% of respondents exhibited all five. The mean number of healthy behaviours was 2.67.

Figure 4.7: Number of Healthy Behaviours Exhibited
Unweighted base=826

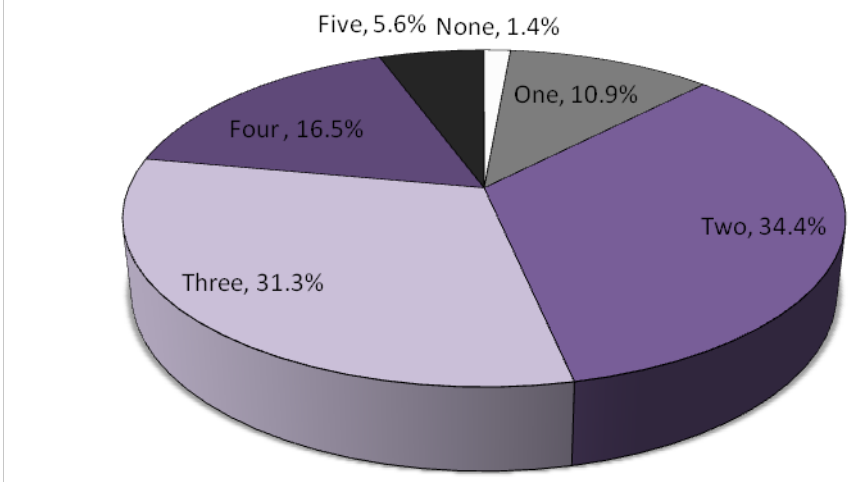


Table 4.52 shows that those with the highest mean number of healthy behaviours were those aged under 25. Women tended to exhibit more healthy behaviours than men.

Table 4.52: Mean Number of Healthy Behaviours by Age and Gender

	Mean No. of Healthy Behaviours	Unweighted base (n)
Age:		
16-24	2.93	58
25-34	2.88	98
35-44	2.65	131
45-54	2.41	144
55-64	2.58	133
65-74	2.76	142
75+	2.67	119
Men	2.46	337
Women	2.89	489
Men 16-44	2.58	104
Women 16-44	3.04	183
Men 45-64	2.30	121
Women 45-64	2.69	156
Men 65+	2.53	111
Women 65+	2.90	150
All	2.67	826

Those tending to exhibit fewer healthy behaviours were those in the most deprived areas and those with no qualifications. This is shown in Table 4.53.

Table 4.53: Mean Number of Healthy Behaviours by Deprivation and Socio Economic Measures

	Mean No. of Healthy Behaviours	Unweighted base (n)
Bottom 20% datazones	2.23	408
Other datazones	2.69	418
SIMD quintile		
1 (most deprived)	2.23	408
2	2.93	63
3	2.82	63
4	2.88	73
5 (least deprived)	2.55	219
At least one qualification	2.73	605
No qualifications	2.34	217

Those who received all household income from benefits tended to have fewer healthy behaviours.

Table 4.54: Mean Number of Healthy Behaviours by Factors Associated with Social Exclusion

	Mean No. of Healthy Behaviours	Unweighted base (n)
All income from benefits	2.13	185

5 Social Health

5.1 Chapter Summary

Table 5.1 summarises the indicators relating to social health.

Table 5.1: Indicators for Social Health

Indicator	% of sample	Unweighted base (n)
Feel isolated from family and friends (Q41)	9%	1,083
Feel I belong to the local area (Q40b)	81%	1,076
Feel valued as a member of the community (Q40d)	57%	1,066
People in my neighbourhood can influence decisions (Q40f)	59%	926
Identify with a religion (Q60)	64%	1,059
Treated offensively in last three months (Q61)	4%	1,072
Feel safe in own home (Q43c)	99%	1,084
Feel safe using public transport (Q43a)	95%	869
Feel safe walking alone even after dark (Q43b)	83%	1,012

One in eleven (9%) respondents felt isolated from family and friends. Those more likely to feel isolated from family and friends were those aged under 35, those in the least deprived areas, those who did not definitely feel in control of the decisions affecting their life, those with a high GHQ12 score and those who exceeded the recommended weekly alcohol limit.

Four in five (81%) respondents agreed that they belonged to the local area. Those less likely to feel that they belonged to the local area were those aged 25-34, those who felt isolated from family/friends, those who did not definitely feel in control of the decisions affecting their life, those with a high GHQ12 score, those who exceeded the recommended weekly limit for alcohol consumption and those who were exposed to second hand smoke.

Three in five (57%) respondents felt valued as members of the community. Those less likely to feel valued as members of the community were those aged under 25, men, those in the least deprived areas, those who felt isolated from family/friends, those who did not definitely feel in control of the decisions affecting their life, those with a high GHQ12 score, those exposed to second hand smoke, those with a limiting condition or illness and those who consumed fewer than five portions of fruit/vegetables per day.

Three in five (59%) respondents agreed that by working together local people could influence the decisions that affect their neighbourhood. Those less likely to agree with this were those aged under 25, those who felt isolated from family/friends, those who did not definitely feel in control of the decisions affecting their life, those with a limiting condition or illness, those exposed to second hand smoke, those with a high GHQ12 score, those who exceeded the recommended weekly limit for alcohol consumption and those who consumed fewer than five portions of fruit/vegetables per day.

Two in three (64%) identified with a religion. Those less likely to identify with a religion were those aged under 25, men, those in the most deprived areas, those exposed to second hand smoke, smokers, those who exceeded the recommended weekly limit for alcohol consumption, those with a positive view of their general health and those with a positive view of their physical wellbeing.

One in 28 (3.5%) felt they had been treated offensively in the last three months. Those who exhibited factors associated with social exclusion were more likely to feel they had been treated offensively.

Most (99%) respondents felt safe in their own home. Those less likely to feel safe in their home were those in the most deprived areas, those with no qualifications, those who felt isolated from family and friends and those who did not definitely feel in control of the decisions affecting their life.

More than nine in ten (94%) respondents felt safe using public transport in their local area. Those less likely to feel safe using public transport were those aged 75 or over, those with no qualifications, those who felt isolated from family/friends, those who did not definitely feel in control of decisions, those with a high GHQ12 score and those with a limiting condition or illness.

Four in five (83%) respondents felt safe walking alone in their local area even after dark. Those less likely to feel safe walking alone were older respondents, women, those in the most deprived areas, those with no qualifications, those who received all household income from benefits and those with a limiting condition or illness.

5.2 Social Connectedness

Isolation from Family and Friends

One in eleven (9%) said they ever felt isolated from family and friends.

Those aged under 35 were the most likely to say that they felt isolated from family and friends.

Table 5.2: Feel Isolated from Family and Friends (Q41) by Age and Gender

	Feel Isolated	Unweighted base (n)
Age:		
16-24	14%	79
25-34	14%	127
35-44	6%	160
45-54	10%	175
55-64	5%	164
65-74	5%	187
75+	6%	184
All	9%	1,083

Those in the most deprived areas (bottom 20% datazones) were less likely than those in other areas to say they felt isolated. Those in the least deprived SIMD quintile were the most likely to say they felt isolated.

Table 5.3: Feel Isolated from Family and Friends (Q41) by Deprivation and Socio Economic Measures

	Feel Isolated	Unweighted base (n)
Bottom 20% datazones	5%	554
Other datazones	9%	529
SIMD quintile		
1 (most deprived)	5%	554
2	0%	72
3	6%	81
4	1%	99
5 (least deprived)	14%	277

Feeling isolated from family and friends has been used throughout this report as a measure of social exclusion. Not feeling definitely in control of decisions was another measure of social exclusion and this was associated with a higher likelihood of feeling isolated from family and friends, as shown in Table 5.4.

Table 5.4: Feel Isolated from Family and Friends (Q41) by Factors Associated with Social Exclusion

	Feel Isolated	Unweighted base (n)
Not in control of decisions affecting daily life, or only 'to some extent'	17%	363

Those with positive views of their physical and mental wellbeing and quality of life were less likely to feel isolated from family and friends. Those more likely to feel isolated were those with a high GHQ12 score and those who exceeded the recommended weekly alcohol limit.

Table 5.5: Feel Isolated from Family and Friends (Q41) by Health and Wellbeing Measures

	Feel Isolated	Unweighted base (n)		Feel Isolated	Unweighted base (n)
Positive view of physical wellbeing	7%	846	High GHQ12 Score	19%	260
Positive view of mental/emotional wellbeing	7%	885	Exceeds weekly alcohol limit	16%	169
Positive view of quality of life	8%	920			

Sense of Belonging to the Community

Respondents were asked to indicate the extent to which they agreed or disagreed with the statement "I feel I belong to this local area". Four in five (81%) respondents agreed with this statement (31% strongly agreed and 50% agreed), 7% disagreed and 12% neither agreed nor disagreed.

Those aged 16-24 were the most likely to agree they belonged to the local area and those aged 25-34 were the least likely. This is shown in Table 5.6.

Table 5.6: Belong to the Local Area (Q40b) by Age and Gender

	Agree	Neither / Nor	Disagree	Unweighted base (n)
Age:				
16-24	93%	3%	5%	79
25-34	68%	21%	11%	125
35-44	79%	12%	9%	159
45-54	77%	13%	10%	175
55-64	83%	14%	3%	163
65-74	84%	12%	4%	184
75+	84%	11%	5%	183
All	81%	12%	7%	1,076

Those who felt isolated from family and friends and those who did not definitely feel in control of the decisions affecting their life were less likely to feel that they belonged to their local area.

Table 5.7: Belong to the Local Area (Q40b) by Factors Associated with Social Exclusion

	Agree	Neither / Nor	Disagree	Unweighted base (n)
Feel isolated from friends/family	57%	10%	34%	79
Not in control of decisions affecting daily life, or only 'to some extent'	76%	12%	11%	360

For health and wellbeing measures, those less likely to feel that they belonged to the local area were:

- Those with a high GHQ12 score;
- Those who exceed the recommended weekly limit for alcohol; and
- Those exposed to second hand smoke.

Table 5.8: Belong to the Local Area (Q40b) by Health and Wellbeing Measures

	Agree	Neither / Nor	Disagree	Unweighted base (n)
Positive view of physical wellbeing	83%	12%	5%	841
Positive view of quality of life	82%	11%	6%	913
High GHQ12 Score	72%	11%	17%	257
Exposed to second hand smoke	77%	11%	11%	374
Exceeds weekly alcohol limits	75%	14%	10%	168

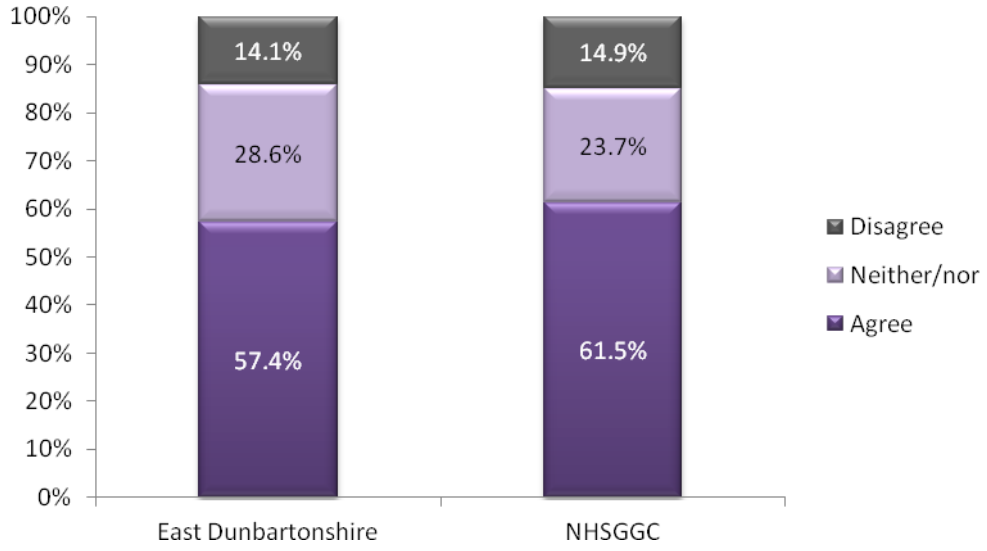
Feeling Valued as a Member of the Community

Respondents were asked to indicate the extent to which they agreed or disagreed with the statement "I feel valued as a member of my community". Just under three in five (57%) agreed with this statement (16% strongly agreed and 42% agreed); 14% disagreed and 29% neither agreed nor disagreed.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde area as a whole to agree that they felt valued as a member of their community (57% East Dunbartonshire; 61% NHSGGC).

Figure 5.1: Feel Valued as a Member of the Community (Q40d) - East Dunbartonshire and NHS Greater Glasgow & Clyde



Those aged under 25 were the least likely to feel they were valued as a member of the community. Also, women were more likely than men to feel valued as members of the community. This is shown in Table 5.9.

Table 5.9: Feel Valued as a Member of the Community (Q40d) by Age and Gender

	Agree	Neither / Nor	Disagree	Unweighted base (n)
Age:				
16-24	41%	29%	30%	78
25-34	53%	31%	15%	125
35-44	57%	34%	9%	157
45-54	65%	22%	13%	174
55-64	58%	33%	9%	162
65-74	66%	25%	9%	185
75+	58%	29%	13%	176
Gender:				
Men	54%	28%	18%	408
Women	60%	29%	11%	657
Men 16-44	45%	29%	26%	126
Women 16-44	56%	34%	10%	234
Men 45-64	59%	28%	13%	138
Women 45-64	65%	26%	10%	198
Men 65+	66%	26%	8%	140
Women 65+	59%	27%	14%	221
All	57%	29%	14%	1,066

Those in the least deprived areas were less likely than those in other areas to agree that they felt valued as members of their community.

Table 5.10: Feel Valued as a Member of the Community (Q40d) by Deprivation and Socio Economic Measures

	Agree	Neither / Nor	Disagree	Unweighted base (n)
SIMD quintile				
1 (most deprived)	60%	24%	16%	550
2	90%	6%	3%	71
3	61%	28%	11%	78
4	65%	31%	4%	99
5 (least deprived)	46%	34%	20%	268

Those who felt isolated from family and friends and those who did not definitely feel in control of the decisions affecting their life were less likely to feel valued as a member of their community.

Table 5.11: Feel Valued as a Member of the Community (Q40d) by Factors Associated with Social Exclusion

	Agree	Neither / Nor	Disagree	Unweighted base (n)
Feel isolated from friends/family	22%	22%	57%	78
Not in control of decisions affecting daily life, or only 'to some extent'	41%	38%	21%	356

Table 5.12 shows that those less likely to feel valued as a member of their community were:

- Those with a high GHQ12 score;
- Those exposed to second hand smoke;
- Those with a limiting condition or illness; and
- Those who consume fewer than five portions of fruit/vegetables per day.

Those with positive views of their physical or mental wellbeing or quality of life were more likely to feel valued as members of their community.

Table 5.12: Feel Valued as a Member of the Community (Q40d) by Health and Wellbeing Measures

	Agree	Neither / Nor	Disagree	Unweighted base (n)
Positive view of physical wellbeing	58%	29%	12%	832
Positive view of mental/emotional wellbeing	60%	28%	12%	872
Positive view of quality of life	59%	28%	13%	905
High GHQ12 Score	42%	31%	27%	255
Limiting condition/illness	51%	29%	20%	268
Exposed to second hand smoke	50%	36%	15%	369
Consumes fewer than 5 portions of fruit/veg per day	55%	29%	16%	318

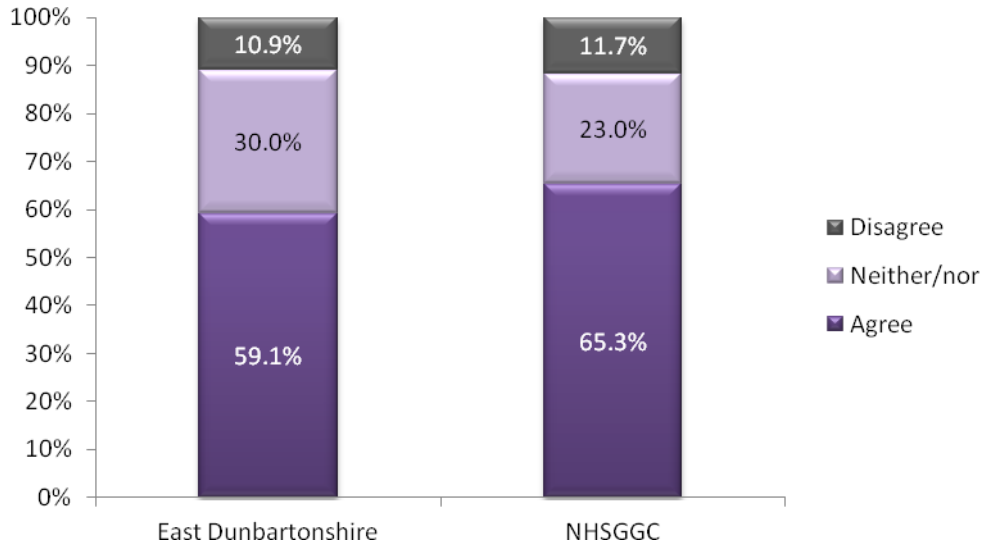
Influence in the Neighbourhood

Respondents were asked the extent to which they agreed or disagreed with the statement, "By working together people in my neighbourhood can influence decisions that affect my neighbourhood". In total, 59% agreed with this statement (10% strongly agreed and 49% agreed), while 11% disagreed and 30% neither agreed nor disagreed.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde area as a whole to agree that people in their neighbourhood could influence local decisions (59% East Dunbartonshire; 65% NHSGGC).

Figure 5.2: Can Influence Decisions that Affect Neighbourhood (Q40f) - East Dunbartonshire & NHS Greater Glasgow & Clyde



Those aged under 25 were the least likely to agree that people in their areas could influence local decisions, while those aged 75 and over were the most likely to agree with this. This is shown in Table 5.13.

Table 5.13: Can Influence Decisions that Affect Neighbourhood (Q40f) by Age and Gender

	Agree	Neither/ Nor	Disagree	Unweighted base (n)
Age:				
16-24	48%	51%	1%	55
25-34	58%	32%	9%	111
35-44	55%	32%	13%	137
45-54	65%	21%	14%	156
55-64	54%	35%	12%	151
65-74	61%	31%	8%	161
75+	71%	18%	11%	149
Men 16-44	58%	35%	7%	101
Women 16-44	51%	39%	10%	202
Men 45-64	55%	27%	17%	132
Women 45-64	65%	27%	8%	175
Men 65+	70%	19%	11%	126
Women 65+	61%	30%	9%	184
All	59%	30%	11%	926

Those who did not feel in control of the decisions affecting their life and particularly those who felt isolated from family and friends were less likely to agree that local people could influence local decisions.

Table 5.14: Can Influence Decisions that Affect Neighbourhood (Q40f) by Factors Associated with Social Exclusion

	Agree	Neither/ Nor	Disagree	Unweighted base (n)
Feel isolated from friends/family	27%	42%	31%	54
Not in control of decisions affecting daily life, or only 'to some extent'	51%	36%	13%	258

Table 5.15 shows that those less likely to agree that local people can influence local decisions were:

- Those with a limiting condition or illness;
- Those exposed to second hand smoke;
- Those with a high GHQ12 score;
- Those who exceed the recommended weekly limit for alcohol; and
- Those who consume fewer than five portions of fruit/vegetables per day.

Table 5.15: Can Influence Decisions that Affect Neighbourhood (Q40f) by Health and Wellbeing Measures

	Agree	Neither/ Nor	Disagree	Unweighted base (n)
Positive view of physical wellbeing	60%	30%	10%	744
Positive view of mental/emotional wellbeing	61%	29%	11%	786
High GHQ12 Score	51%	32%	18%	213
Limiting condition/illness	50%	34%	16%	215
Exposed to second hand smoke	50%	38%	12%	315
Exceeds weekly alcohol limit	54%	28%	18%	142
Consumes fewer than 5 portions of fruit/veg per day	57%	31%	12%	696

Religious Identity

Just under two in three (64%) respondents identified with a religion.

The likelihood of identifying with a religion increased with age, ranging from 45% of those aged under 25 to 87% of those aged 75 or over. Women were more likely than men to have a religious identity (69% of women compared to 58% of men).

Table 5.16: Religious Identity (Q60) by Age and Gender

	Have Religious Identity	Unweighted base (n)
Age:		
16-24	45%	79
25-34	47%	125
35-44	52%	153
45-54	64%	172
55-64	75%	160
65-74	81%	185
75+	87%	180
Men	58%	401
Women	69%	658
Men 16-44	42%	124
Women 16-44	55%	233
Men 45-64	66%	134
Women 45-64	71%	198
Men 65+	79%	140
Women 65+	86%	225
All	64%	1,059

Those in the most deprived areas were less likely to identify with a religion. This is shown in Table 5.17.

Table 5.17: Religious Identity (Q60) by Deprivation and Socio Economic Measures

	Have Religious Identity	Unweighted base (n)
Bottom 20% datazones	56%	551
Other datazones	64%	508
SIMD quintile		
1 (most deprived)	56%	551
2	60%	71
3	58%	81
4	67%	95
5 (least deprived)	66%	261

Table 5.18 shows that those less likely to identify with a religion were:

- Those exposed to second hand smoke;
- Smokers;
- Those who exceed the recommended weekly limit for alcohol;
- Those with a positive view of their general health; and
- Those with a positive view of their physical wellbeing.

Obese people and those with a limiting condition or illness were more likely to identify with a religion.

Table 5.18: Religious Identity (Q60) by Health and Wellbeing Measures

	Have Religious Identity	Unweighted base (n)		Have Religious Identity	Unweighted base (n)
Positive view of general health	59%	687	Current smoker	52%	319
Positive perception of physical health	62%	829	Exceeds weekly alcohol limit	54%	165
Limiting condition or illness	81%	269	Obese	77%	170
Exposed to second hand smoke	50%	369			

Experience of Being Treated Offensively

Respondents were asked whether they had been treated in a way that they felt was offensive during the last three months. In total 3.5% of respondents felt they had been treated offensively.

All three factors associated with social exclusion were associated with a higher likelihood of having been treated offensively in the last three months. In particular, 20% of those who felt isolated from family/friends felt they had been treated offensively.

Table 5.19: Experience of Being Treated Offensively in Last Three Months (Q61) by Factors Associated with Social Exclusion

	Treated Offensively	Unweighted base (n)
All income from benefits	11.0%	267
Feel isolated from family/friends	19.8%	73
Not in control of decisions affecting daily life, or only 'to some extent'	6.3%	352

Of all those who felt they had been treated offensively (unweighted n=40), the most common types of people/agencies who had treated respondents offensively were:

- Unknown person in a public place (33%);
- Known person in a public place (30%); and
- Close relative (4%).

5.3 Feelings of Safety

Feeling Safe in Own Home

Most people (99%) agreed that they felt safe in their own home (78% strongly agreed and 21% agreed), while less than 1% disagreed and 1% neither agreed nor disagreed.

Table 5.20: Feel Safe in Own Home (Q43c) by Deprivation and Socio Economic Measures

	Agree	Neither/ Nor	Disagree	Unweighted base (n)
Bottom 20% datazones	95%	2%	3%	555
Other datazones	99%	1%	0%	529
SIMD Quintile				
1 (Most deprived)	95%	2%	3%	555
2	100%	0%	0%	72
3	99%	1%	0%	81
4	100%	0%	0%	99
5 (Least deprived)	99%	1%	0%	277
At least one qualification	100%	<1%	0%	746
No qualifications	96%	3%	1%	329

Table 5.21 shows that those who felt isolated from family and friends and those who did not definitely feel in control of the decisions affecting their life were less likely to feel safe at home.

Table 5.21: Feel Safe in Own Home (Q43c) by Factors Associated with Social Exclusion

	Agree	Neither/ Nor	Disagree	Unweighted base (n)
Feel isolated from friends/family	94%	6%	0%	80
Not in control of decisions affecting daily life, or only 'to some extent'	98%	2%	<1%	364

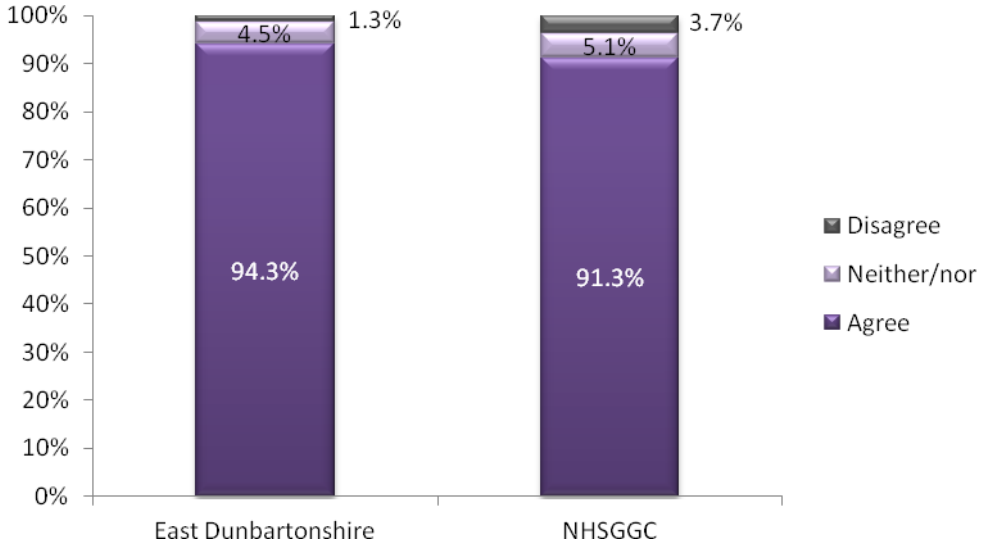
Feeling Safe Using Public Transport

Respondents were asked the extent to which they agreed or disagreed with the statement "I feel safe using public transport in this local area". More than nine in ten (94%) agreed with this (63% strongly agreed and 32% agreed), while 1% disagreed and 4% neither agreed nor disagreed.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were more likely than those in the NHS Greater Glasgow & Clyde area as a whole to feel safe using public transport in their area (94% East Dunbartonshire; 91% NHS Greater Glasgow & Clyde).

Figure 5.3: Feel Safe Using Public Transport (Q43a) - East Dunbartonshire and NHS Greater Glasgow & Clyde



Those aged 75 and over were the least likely to say that they felt safe using public transport in their local area.

Table 5.22: Feel Safe Using Public Transport (Q43a) by Age and Gender

	Agree	Neither / Nor	Disagree	Unweighted base (n)
Age:				
16-24	96%	3%	1%	74
25-34	94%	6%	0%	109
35-44	95%	5%	0%	140
45-54	96%	4%	0%	133
55-64	99%	1%	0%	139
65-74	93%	5%	2%	147
75+	84%	11%	5%	123
Men 16-44	96%	4%	0%	112
Women 16-44	94%	5%	1%	211
Men 45-64	99%	1%	0%	114
Women 45-64	95%	4%	1%	158
Men 65+	91%	9%	0%	99
Women 65+	88%	7%	5%	171
All	94%	4%	1%	869

Table 5.23 shows that those with no qualifications were less likely than those with qualifications to feel safe using local public transport.

Table 5.23: Feel Safe Using Public Transport (Q43a) by Deprivation and Socio Economic Measures

	Agree	Neither/ Nor	Disagree	Unweighted base (n)
At least one qualification	96%	4%	<1%	603
No qualifications	88%	7%	4%	260

Table 5.24 shows that those who felt isolated from family and friends and those who did not feel in control of the decisions affecting their life were less likely to feel safe on public transport.

Table 5.24: Feel Safe Using Public Transport (Q43a) by Factors Associated with Social Exclusion

	Agree	Neither/ Nor	Disagree	Unweighted base (n)
Feel isolated from friends/family	89%	6%	6%	69
Not in control of decisions affecting daily life, or only 'to some extent'	91%	6%	2%	286

Table 5.25 shows that for health and wellbeing measures, those less likely to feel safe using public transport were those with a high GHQ12 score and those with a limiting condition or illness.

Those more likely to feel safe using public transport were those with a positive view of their general health and physical wellbeing.

Table 5.25: Feel Safe Using Public Transport (Q43a) by Health and Wellbeing Measures

	Agree	Neither/ Nor	Disagree	Unweighted base (n)
Positive view of general health	95%	4%	1%	598
Positive view of physical wellbeing	95%	4%	1%	688
High GHQ12 Score	88%	9%	3%	214
Limiting condition/illness	89%	7%	4%	194

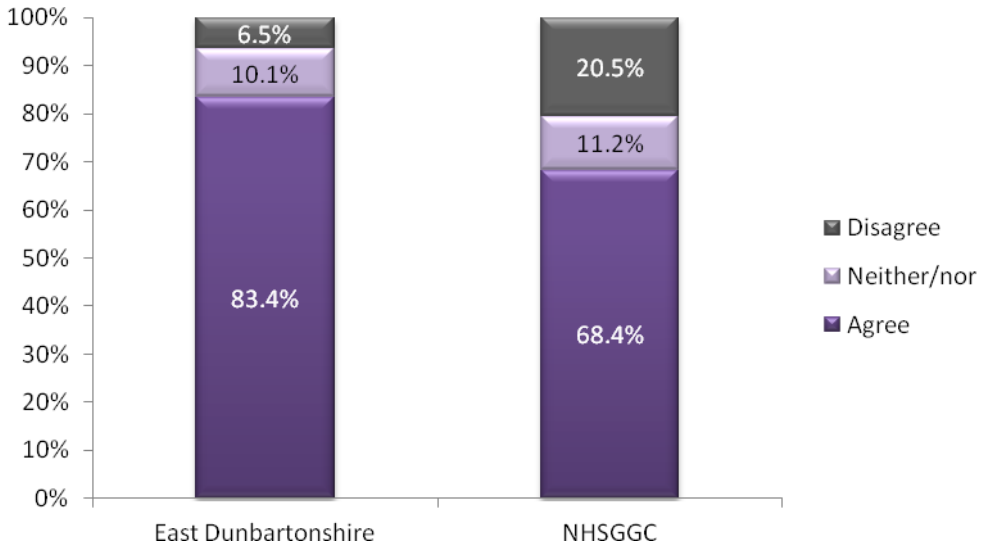
Feeling Safe Walking Alone in Local Area Even After Dark

Respondents were asked the extent to which they agreed or disagreed with the statement "I feel safe walking alone around this local area even after dark". In total 83% agreed with this statement (51% strongly agreed and 23% agreed), 7% disagreed and 10% neither agreed nor disagreed.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were more likely than those in the NHS Greater Glasgow & Clyde area as a whole to feel safe walking alone in their area even after dark (83% East Dunbartonshire; 68% NHS Greater Glasgow & Clyde).

Figure 5.4: Feel Safe Walking Alone Even After Dark (Q43b) - East Dunbartonshire & NHS Greater Glasgow & Clyde



Older respondents were less likely to feel safe walking alone in their neighbourhood after dark, and women were less likely than men to feel safe walking alone (94% of men compared to 73% of women felt safe). This is shown in Table 5.26.

Table 5.26: Feel Safe Walking Alone Even After Dark (Q43b) by Age and Gender

	Agree	Neither / Nor	Disagree	Unweighted base (n)
Age:				
16-24	88%	8%	4%	78
25-34	92%	5%	3%	126
35-44	82%	14%	4%	159
45-54	89%	5%	7%	173
55-64	86%	9%	5%	158
65-74	74%	14%	12%	173
75+	63%	25%	12%	139
Men	94%	4%	2%	395
Women	73%	16%	11%	616
Men 16-44	97%	2%	1%	128
Women 16-44	75%	18%	7%	235
Men 45-64	97%	2%	1%	136
Women 45-64	78%	11%	11%	195
Men 65+	79%	15%	5%	128
Women 65+	61%	21%	18%	184
All	83%	10%	7%	1,012

Table 5.27 shows that those in the most deprived areas were the least likely to feel safe walking alone in their area after dark while those in the least deprived areas were the most likely to feel safe. Also, those with no qualifications were less likely to feel safe walking alone after dark.

Table 5.27: Feel Safe Walking Alone Even After Dark (Q43b) by Deprivation and Socio Economic Measures

	Agree	Neither/ Nor	Disagree	Unweighted base (n)
Bottom 20% datazones	61%	11%	28%	530
Other datazones	84%	10%	6%	482
SIMD Quintile				
1 (Most deprived)	61%	11%	28%	530
2	69%	16%	16%	65
3	78%	13%	9%	70
4	84%	9%	7%	91
5 (Least deprived)	90%	8%	2%	256
At least one qualification	85%	10%	6%	714
No qualifications	77%	13%	11%	290

Those who received all household income from benefits were less likely to say that they felt safe when walking alone in the local area even after dark.

Table 5.28: Feel Safe Walking Alone Even After Dark (Q43b) by Factors Associated with Social Exclusion

	Agree	Neither/ Nor	Disagree	Unweighted base (n)
All income from benefits	51%	20%	29%	248

Those who exceeded the recommended weekly alcohol limit and those with a high GHQ12 score were more likely to feel safe walking alone after dark. Positive views of health, wellbeing and quality or life were also associated with a higher likelihood of feeling safe walking alone after dark.

Those with a limiting condition or illness were less likely to feel safe walking alone even after dark.

Table 5.29: Feel Safe Walking Alone Even After Dark (Q43b) by Health and Wellbeing Measures

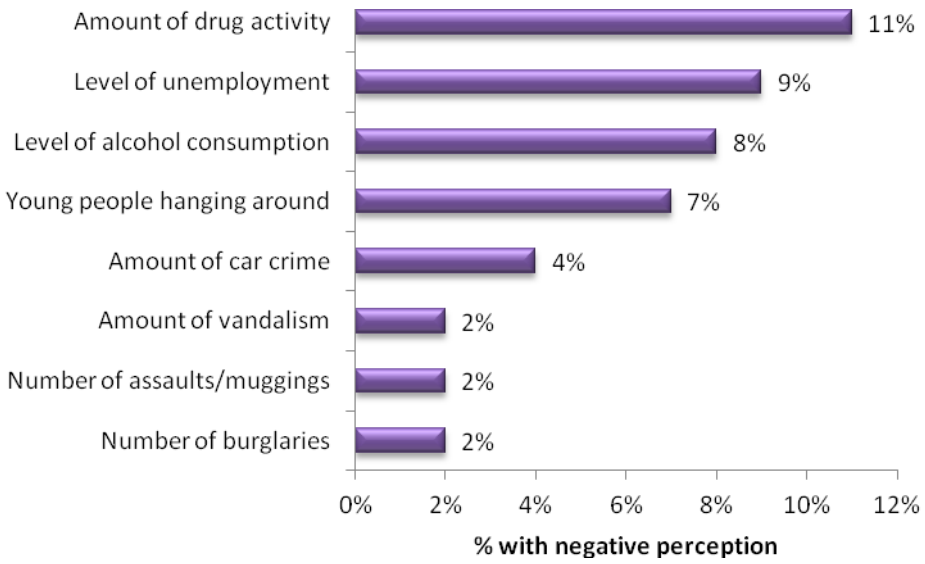
	Agree	Neither/ Nor	Disagree	Unweighted base (n)
Positive view of general health	85%	10%	4%	689
Positive view of physical wellbeing	84%	11%	6%	817
Positive view of mental/emotional wellbeing	84%	11%	6%	840
Positive view of quality of life	84%	10%	5%	876
High GHQ12 Score	87%	5%	8%	241
Limiting condition/illness	79%	8%	13%	226
Exceeds weekly alcohol limit	93%	5%	2%	168

5.4 Social Issues in the Local Area

Using the 'faces' scale (see Section 2.2 of this report for full explanation of the scale), respondent were asked to indicate how they felt about a range of perceived social problems. Faces 5 to 7 are classified as negative perceptions and indicate that respondents are concerned about these issues.

The social issues which most frequently caused concern were the amount of drug activity, the level of unemployment and the level of alcohol consumption.

Figure 5.5: Negative Perception of Social Issues in the Local Area (Q38a-h)



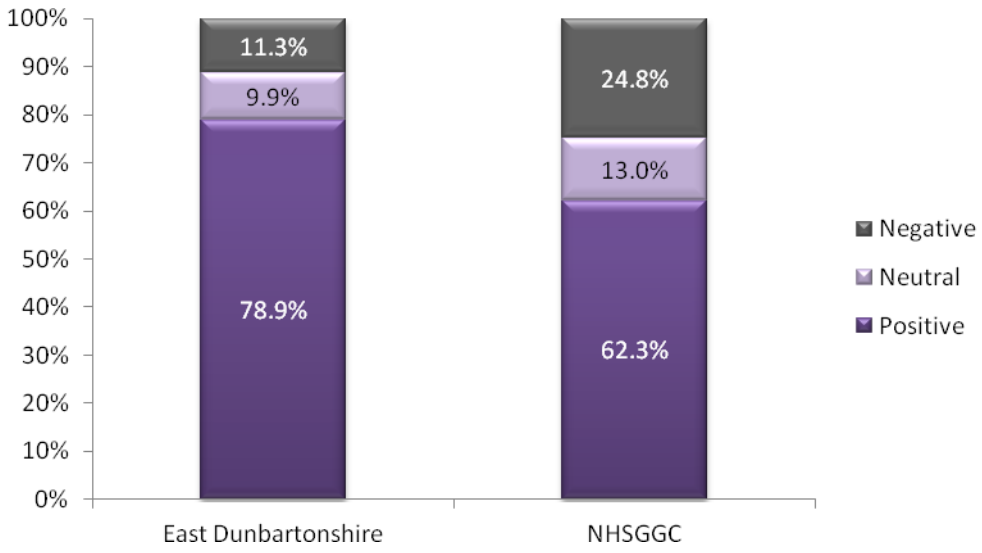
Amount of Drug Activity

One in nine (11%) respondents gave a negative perception of the amount of drug activity in their local area.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde area as a whole to have a negative perception of the amount of drug activity in their area (11% East Dunbartonshire; 25% NHS Greater Glasgow & Clyde).

Figure 5.6 Perception of Amount of Drug Activity (Q38e) - East Dunbartonshire & NHS Greater Glasgow & Clyde



Those aged under 25 were the most likely to be concerned about the amount of drug activity while those aged 75 and over were the least likely. This is shown in Table 5.30.

Table 5.30: Negative Perception of Amount of Drug Activity (Q38e) by Age and Gender

	Negative Perception	Unweighted base (n)
Age:		
16-24	18%	71
25-34	8%	108
35-44	12%	131
45-54	9%	142
55-64	9%	122
65-74	14%	115
75+	2%	66
All	11%	757

Those in the most deprived areas were much more likely than those in other areas to have a negative perception of the amount of drug activity in their area. Also, those with no qualifications were more likely to be concerned about drug activity.

Table 5.31: Negative Perception of Amount of Drug Activity (Q38e) by Deprivation and Socio Economic Measures

	Negative Perception	Unweighted base (n)
Bottom 20% datazones	59%	412
Other datazones	9%	345
SIMD quintile		
1 (most deprived)	59%	412
2	9%	47
3	22%	60
4	3%	60
5 (least deprived)	6%	178
At least one qualification	9%	560
No qualifications	25%	194

Those who received all household income from benefits were more likely to be concerned about drug activity in their area. However, those who did not feel in control of the decisions affecting their life were less likely to have a negative perception of the amount of drug activity.

Table 5.32: Negative Perception of Amount of Drug Activity (Q38e) by Factors Associated with Social Exclusion

	Negative Perception	Unweighted base (n)
All income from benefits	27%	187
Not in control of decisions affecting daily life, or only 'to some extent'	6%	238

Table 5.33 shows that for health and wellbeing measures, those more likely to be concerned about the amount of drug activity in their area were those exposed to second hand smoke, smokers and those who consumed fewer than five portions of fruit/vegetables per day.

Table 5.33: Negative Perception of Amount of Drug Activity (Q38e) by Health and Wellbeing Measures

	Negative Perception	Unweighted base (n)		Negative Perception	Unweighted base (n)
Positive view of mental/emotional wellbeing	10%	619	Current smoker	20%	252
Exposed to second hand smoke	21%	287	Consumes fewer than 5 portions of fruit/veg per day	14%	569

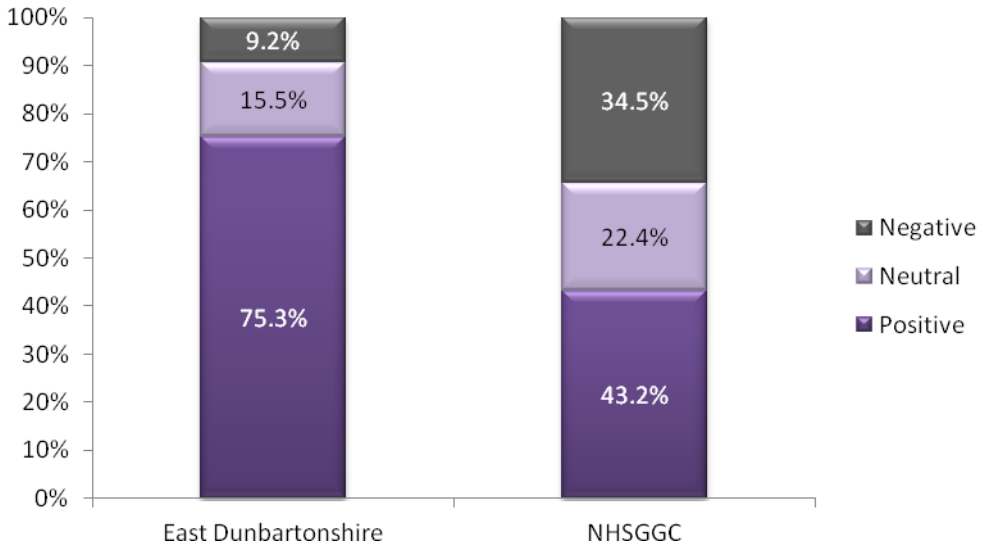
Level of Unemployment

One in eleven (9%) respondents had a negative perception of the level of unemployment in their area.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were much less likely than those in the NHS Greater Glasgow & Clyde area to have a negative perception of the level of unemployment in their area (9% East Dunbartonshire; 34% NHS Greater Glasgow & Clyde).

Figure 5.7: Perception of Level of Unemployment (Q38a) - East Dunbartonshire and NHS Greater Glasgow & Clyde



Those aged 25-34 and those aged 65-74 or over were the most likely to have a negative perception of the level of unemployment, as shown in Table 5.34.

Table 5.34: Negative Perception of Level of Unemployment (Q38a) by Age and Gender

	Negative Perception	Unweighted base (n)
Age:		
16-24	13%	65
25-34	18%	100
35-44	8%	134
45-54	5%	134
55-64	4%	124
65-74	17%	124
75+	4%	77
Men 16-44	12%	107
Women 16-44	12%	192
Men 45-64	3%	113
Women 45-64	6%	145
Men 65+	13%	96
Women 65+	10%	105
All	9%	761

Those in the most deprived areas were the most likely to have a negative perception of the level of unemployment while those in the least deprived areas were the least likely to have a negative perception. Those with no qualifications were more likely to have a negative perception of unemployment levels.

Table 5.35: Negative Perception of Level of Unemployment (Q38a) by Deprivation and Socio Economic Measures

	Negative Perception	Unweighted base (n)
Bottom 20% datazones	59%	419
Other datazones	7%	342
SIMD quintile		
1 (most deprived)	59%	419
2	24%	48
3	11%	50
4	11%	65
5 (least deprived)	<1%	179
At least one qualification	8%	566
No qualifications	20%	191

Those who received all household income from benefits were more likely to have a negative perception of the level of unemployment in their area. However, those who felt isolated from family and friends were less likely to have a negative perception of the level of unemployment.

Table 5.36: Negative Perception of Level of Unemployment (Q38a) by Factors Associated with Social Exclusion

	Negative Perception	Unweighted base (n)
All income from benefits	53%	186
Feel isolated from friends/family	2%	47

For health and wellbeing measures, those more likely to be concerned about levels of unemployment were:

- Smokers;
- Those exposed to second hand smoke; and
- Those who consume fewer than five portions of fruit/vegetables per day.

Those with positive views of their mental/emotional wellbeing or quality of life were less likely to be concerned about levels of unemployment.

Table 5.37: Negative Perception of Level of Unemployment (Q38a) by Health and Wellbeing Measures

	Negative Perception	Unweighted base (n)		Negative Perception	Unweighted base (n)
Positive view of mental/emotional wellbeing	8%		Current smoker	18%	
Positive view of quality of life	9%		Consumes fewer than 5 portions of fruit/veg per day	11%	
Exposed to second hand smoke	18%				

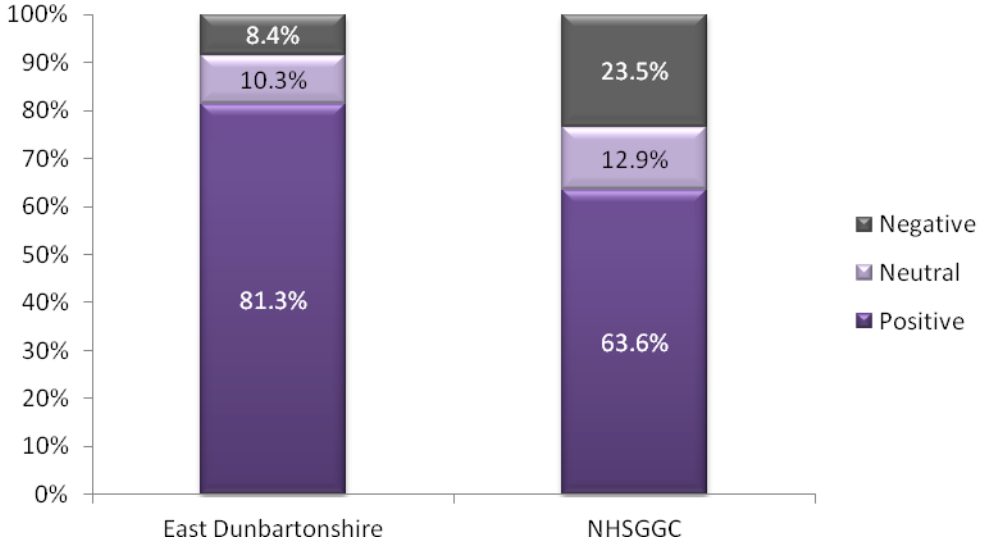
Level of Alcohol Consumption

One in 12 (8%) respondents gave a negative perception of the level of alcohol consumption in their area.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde area to be concerned about the amount of alcohol consumption in their area (8% East Dunbartonshire; 24% NHS Greater Glasgow & Clyde).

Figure 5.8: Perception of Level of Alcohol Consumption - East Dunbartonshire and NHS Greater Glasgow & Clyde



Those in the most deprived areas were much more likely than those in other areas to have a negative perception of the level of alcohol consumption in their area. Those with no qualifications were more likely to be concerned about alcohol consumption than those who had qualifications.

Table 5.38: Negative Perception of Level of Alcohol Consumption (Q38f) by Deprivation and Socio Economic Measures

	Negative Perception	Unweighted base (n)
Bottom 20% datazones	50%	449
Other datazones	6%	406
SIMD quintile		
1 (most deprived)	50%	449
2	9%	48
3	11%	70
4	3%	65
5 (least deprived)	6%	223
At least one qualification	7%	611
No qualifications	16%	239

Those who received all income from benefits were more likely to be concerned about the level of alcohol consumption in the local area.

Table 5.39: Negative Perception of Level of Alcohol Consumption (Q38f) by Factors Associated with Social Exclusion

	Negative Perception	Unweighted base (n)
All income from benefits	21%	206

Those with positive views of their physical wellbeing were less likely to be concerned about the level of alcohol consumption in their area. Smokers were more likely to be concerned about the level of alcohol consumption.

Table 5.40: Negative Perception of Level of Alcohol Consumption (Q38f) by Health and Wellbeing Measures

	Negative Perception	Unweighted base (n)		Negative Perception	Unweighted base (n)
Positive view of physical wellbeing	7%	665	Current smoker	14%	272

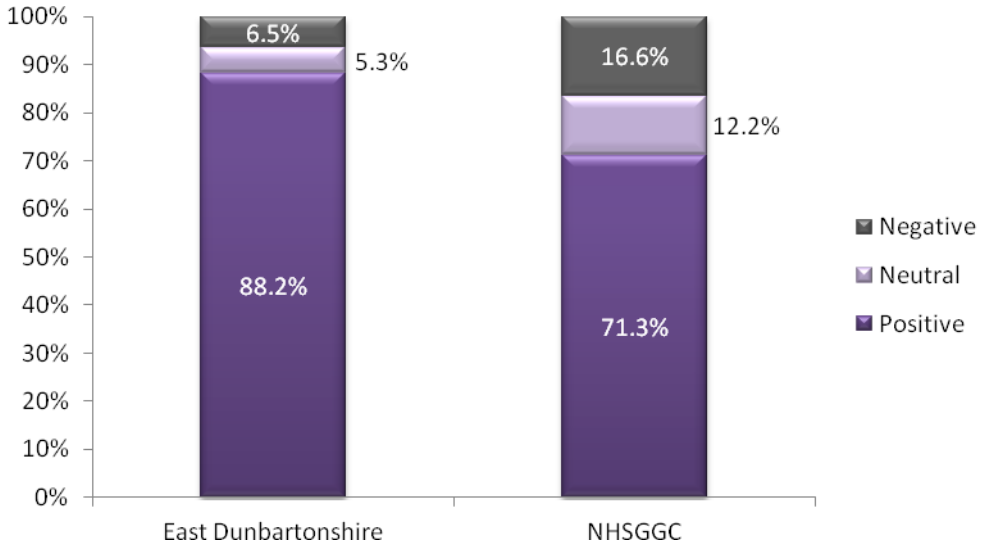
Young People Hanging Around

One in 14 (7%) respondents had a negative perception of young people hanging around in their local area.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde area as a whole to have a negative perception of young people hanging around in their area (7% East Dunbartonshire; 17% NHS Greater Glasgow & Clyde).

Figure 5.9: Perception of Young People Hanging Around (Q38g) - East Dunbartonshire and NHS Greater Glasgow & Clyde



Those aged 25-34 were the most likely to be concerned about this while those aged 65 or over were the least likely.

Table 5.41: Negative Perception of Young People Hanging Around (Q38g) by Age and Gender

	Negative Perception	Unweighted base (n)
Age:		
16-24	8%	78
25-34	14%	124
35-44	5%	157
45-54	7%	173
55-64	6%	158
65-74	3%	171
75+	3%	167
All	7%	1,034

Table 5.42 shows that for deprivation and socio economic measures those more likely to be concerned about young people hanging around were those in the most deprived areas and those with no qualifications.

Table 5.42: Negative Perception of Young People Hanging Around (Q38g) by Deprivation and Socio Economic Measures

	Negative Perception	Unweighted base (n)
Bottom 20% datazones	35%	542
Other datazones	5%	492
SIMD quintile		
1 (most deprived)	35%	542
2	3%	69
3	13%	79
4	0%	96
5 (least deprived)	5%	248
At least one qualification	6%	724
No qualifications	13%	301

Table 5.43 shows that those who received all household income from benefits were more likely to have a negative perception of young people hanging around in the local area.

Table 5.43: Negative Perception of Young People Hanging Around (Q38g) by Factors Associated with Social Exclusion

	Negative Perception	Unweighted base (n)
All income from benefits	14%	261

For health and wellbeing measures, those more likely to be concerned about young people hanging around in their local area were:

- Those exposed to second hand smoke;
- Smokers; and
- Those who consume fewer than 5 portions of fruit/veg per day.

Those who had positive views of their physical and mental wellbeing or quality of life were less likely to be concerned about young people hanging around.

Table 5.44: Negative Perception of Young People Hanging Around (Q38g) by Health and Wellbeing Measures

	Negative Perception	Unweighted base (n)		Negative Perception	Unweighted base (n)
Positive view of physical wellbeing	6%	819	Exposed to second hand smoke	15%	367
Positive view of mental/emotional wellbeing	5%	841	Current smoker	13%	316
Positive view of quality of life	6%	883	Consumes fewer than 5 portions of fruit/veg per day	8%	800

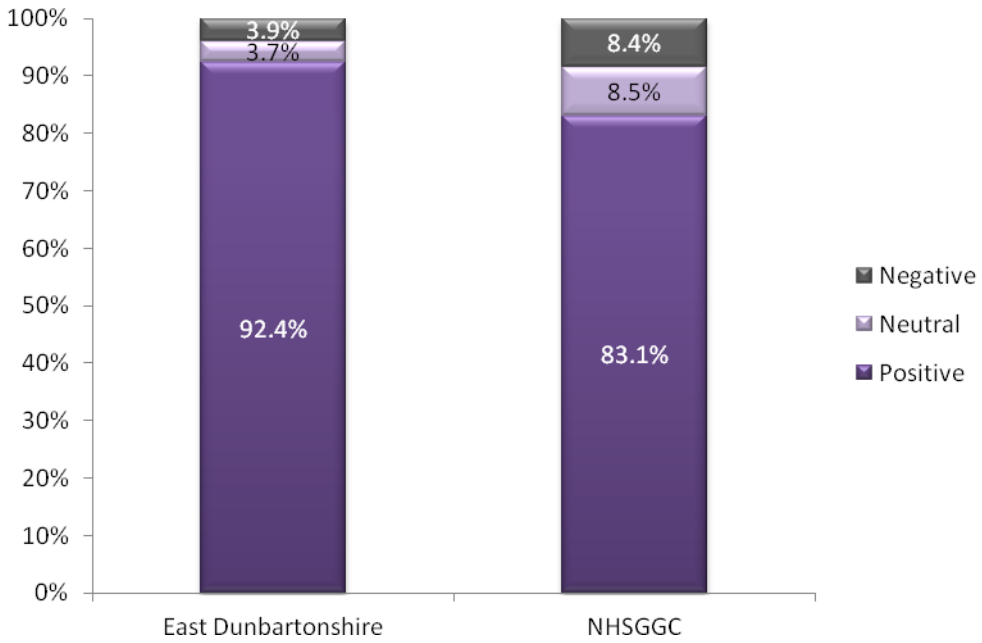
Amount of Car Crime

One in 25 (4%) respondents gave a negative perception of the amount of car crime in their area.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde area as a whole to have a negative perception of car crime in their area (4% East Dunbartonshire; 8% NHS Greater Glasgow & Clyde).

Figure 5.10: Perception of Amount of Car Crime - East Dunbartonshire and NHS Greater Glasgow & Clyde



Those aged under 35 were the most likely to have a negative perception of the amount of car crime in their area. This is shown in Table 5.45.

Table 5.45: Negative Perception of Amount of Car Crime (Q38h) by Age and Gender

	Negative Perception	Unweighted base (n)
Age:		
16-24	9%	61
25-34	7%	104
35-44	3%	123
45-54	1%	148
55-64	3%	124
65-74	3%	128
75+	3%	81
Men 16-44	5%	102
Women 16-44	7%	186
Men 45-64	2%	115
Women 45-64	1%	157
Men 65+	4%	90
Women 65+	2%	119
All	4%	773

Those in the most deprived areas were more likely to have a negative perception of the amount of car crime in their area. This is shown in Table 5.46.

Table 5.46: Negative Perception of Amount of Car Crime (Q38h) by Deprivation and Socio Economic Measures

	Negative Perception	Unweighted base (n)
Bottom 20% datazones	23%	373
Other datazones	3%	400
SIMD quintile		
1 (most deprived)	23%	373
2	2%	57
3	1%	60
4	0%	83
5 (least deprived)	5%	200

Those exposed to second hand smoke most or some of the time were more likely to have a negative perception of car crime in their area.

Table 5.47: Negative Perception of Amount of Car Crime (Q38h) by Health and Wellbeing Measures

	Negative Perception	Unweighted base (n)
Exposed to second hand smoke	9%	263

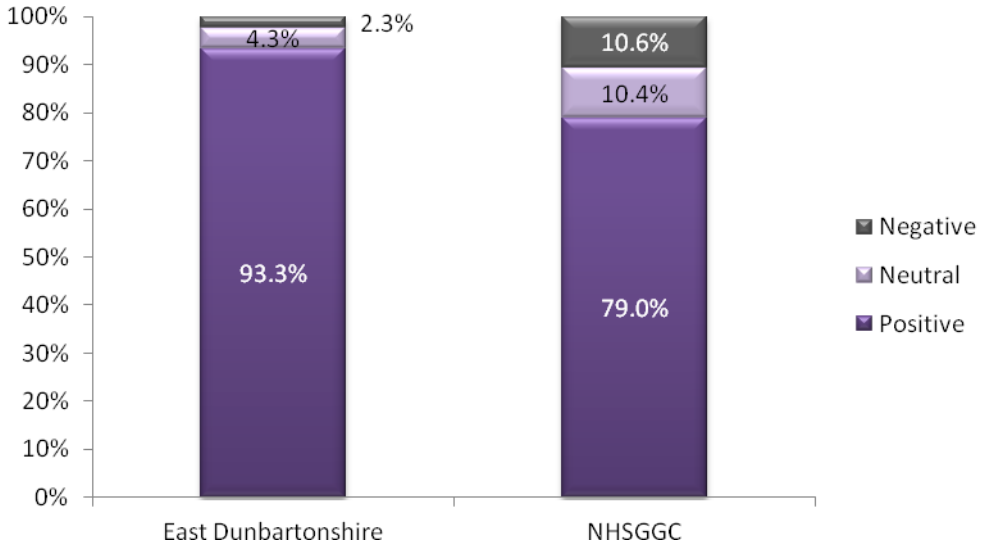
Amount of Vandalism

Two percent of respondents gave a negative perception of the amount of vandalism in their area.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde area as a whole to have a negative perception of vandalism in their area (2% East Dunbartonshire; 11% NHS Greater Glasgow & Clyde).

Figure 5.11: Perception of Amount of Vandalism (Q38g) - East Dunbartonshire and NHS Greater Glasgow & Clyde



Those in the most deprived areas were more likely to have a negative perception of the amount of vandalism in their area. This is shown in Table 5.48.

Table 5.48: Negative Perception of Amount of Vandalism (Q38g) by Deprivation and Socio Economic Measures

	Negative Perception	Unweighted base (n)
Bottom 20% datazones	19%	509
Other datazones	2%	477
SIMD quintile		
1 (most deprived)	19%	509
2	2%	67
3	5%	78
4	0%	93
5 (least deprived)	1%	239

Those who were exposed to second hand smoke most or some of the time were more likely to have a negative perception of vandalism in their area.

Table 5.49: Negative Perception of Amount of Vandalism (Q38g) by Health and Wellbeing Measures

	Negative Perception	Unweighted base (n)
Exposed to second hand smoke	5%	356

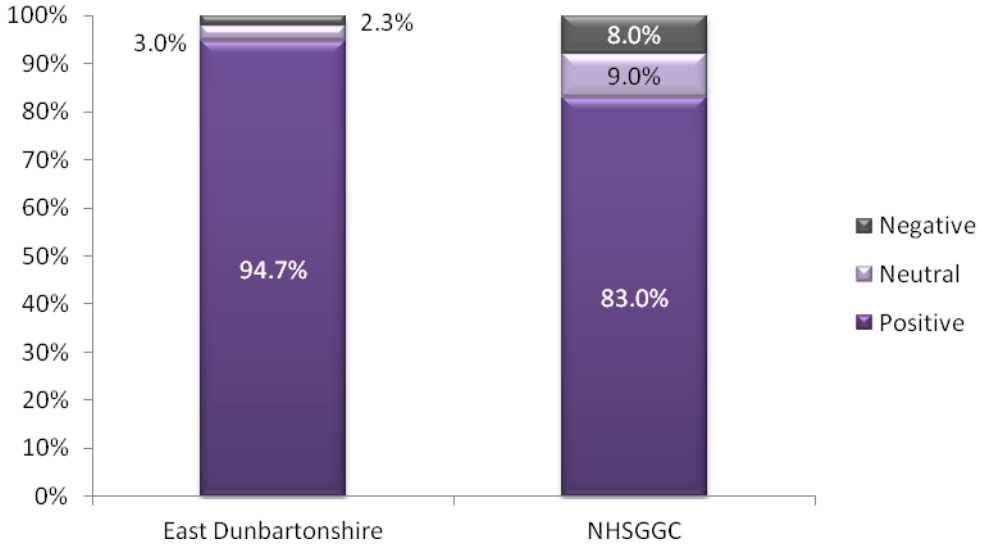
Number of Assaults/Muggings

Two percent of respondents had a negative perception of the number of assaults/muggings in their area.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde area as a whole to have a negative perception of the number of assaults/muggings in their area (2% East Dunbartonshire; 8% NHSGGC).

Figure 5.12: Perception of Number of Assaults/Muggings (Q38d) - East Dunbartonshire and NHS Greater Glasgow & Clyde



Those in the most deprived areas were the most likely to have negative perception in the number of assaults/muggings in their local area. This is shown in Table 5.50.

Table 5.50: Negative Perception of Number of Assaults/Muggings (Q38d) by Deprivation and Socio Economic Measures

	Negative Perception	Unweighted base (n)
Bottom 20% datazones	15%	478
Other datazones	2%	458
SIMD quintile		
1 (most deprived)	15%	478
2	2%	63
3	1%	76
4	0%	90
5 (least deprived)	2%	229

Those who felt isolated from family and friends were more likely to have a negative perception of the number of assaults/muggings in their area.

Table 5.51: Negative Perception of Number of Assaults/Muggings (Q38d) by Factors Associated with Social Exclusion

	Negative Perception	Unweighted base (n)
Feel isolated from friends/family	10%	57

Smokers and those exposed to second hand smoke were more likely to have a negative perception of the number of assaults/muggings in their area.

Table 5.52: Negative Perception of Number of Assaults/Muggings (Q38d) by Health and Wellbeing Measures

	Negative Perception	Unweighted base (n)		Negative Perception	Unweighted base (n)
Positive view of physical wellbeing	2%	749	Current smoker	5%	284
Exposed to second hand smoke	4%	331			

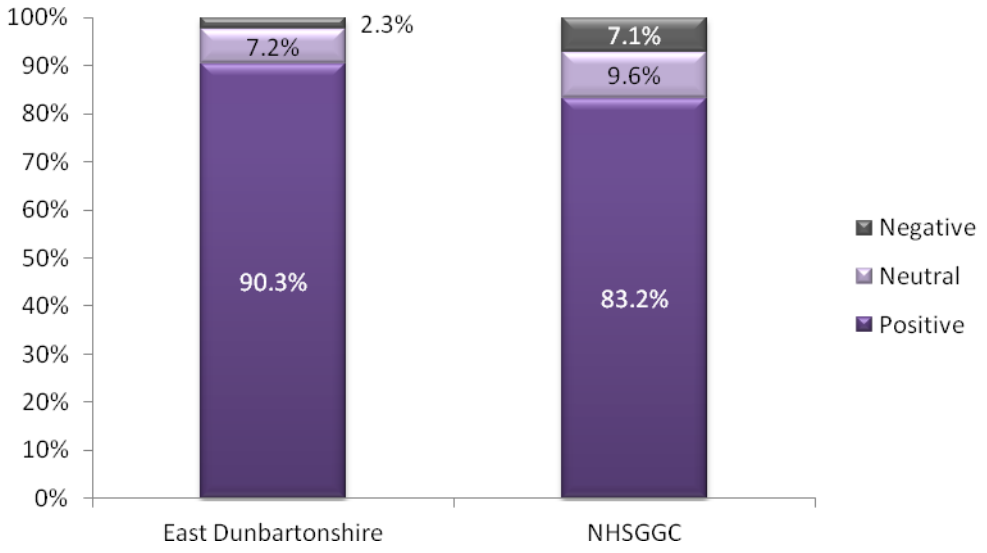
Number of Burglaries

Two percent of respondents expressed a negative perception of the number of burglaries in their area.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde area as a whole to have a negative perception of the number of burglaries in their area (2% East Dunbartonshire; 7% NHSGGC).

Figure 5.13: Perception of Number of Burglaries (Q38b) - East Dunbartonshire and NHS Greater Glasgow & Clyde



Those in the most deprived areas were more likely to be concerned about the number of burglaries in their area.

Table 5.53: Negative Perception of Number of Burglaries (Q38b) by Deprivation and Socio Economic Measures

	Negative Perception	Unweighted base (n)
Bottom 20% datazones	17%	478
Other datazones	2%	456
SIMD quintile		
1 (most deprived)	17%	478
2	2%	60
3	1%	76
4	1%	91
5 (least deprived)	2%	229

Those who felt isolated from family and friends were more likely to have a negative perception of burglaries in their area.

Table 5.54: Negative Perception of Number of Burglaries (Q38b) by Factors Associated with Social Exclusion

	Negative Perception	Unweighted base (n)
Feel isolated from friends/family	9%	57

Smokers and those exposed to second hand smoke were more likely to have a negative perception of burglaries in their area.

Table 5.55: Negative Perception of Number of Burglaries (Q38b) by Health and Wellbeing Measures

	Negative Perception	Unweighted base (n)		Negative Perception	Unweighted base (n)
Positive view of physical wellbeing	2%	736	Exposed to second hand smoke	6%	332
Positive view of mental/emotional wellbeing	2%	769	Current smoker	7%	288

5.5 Environmental Issues in the Local Area

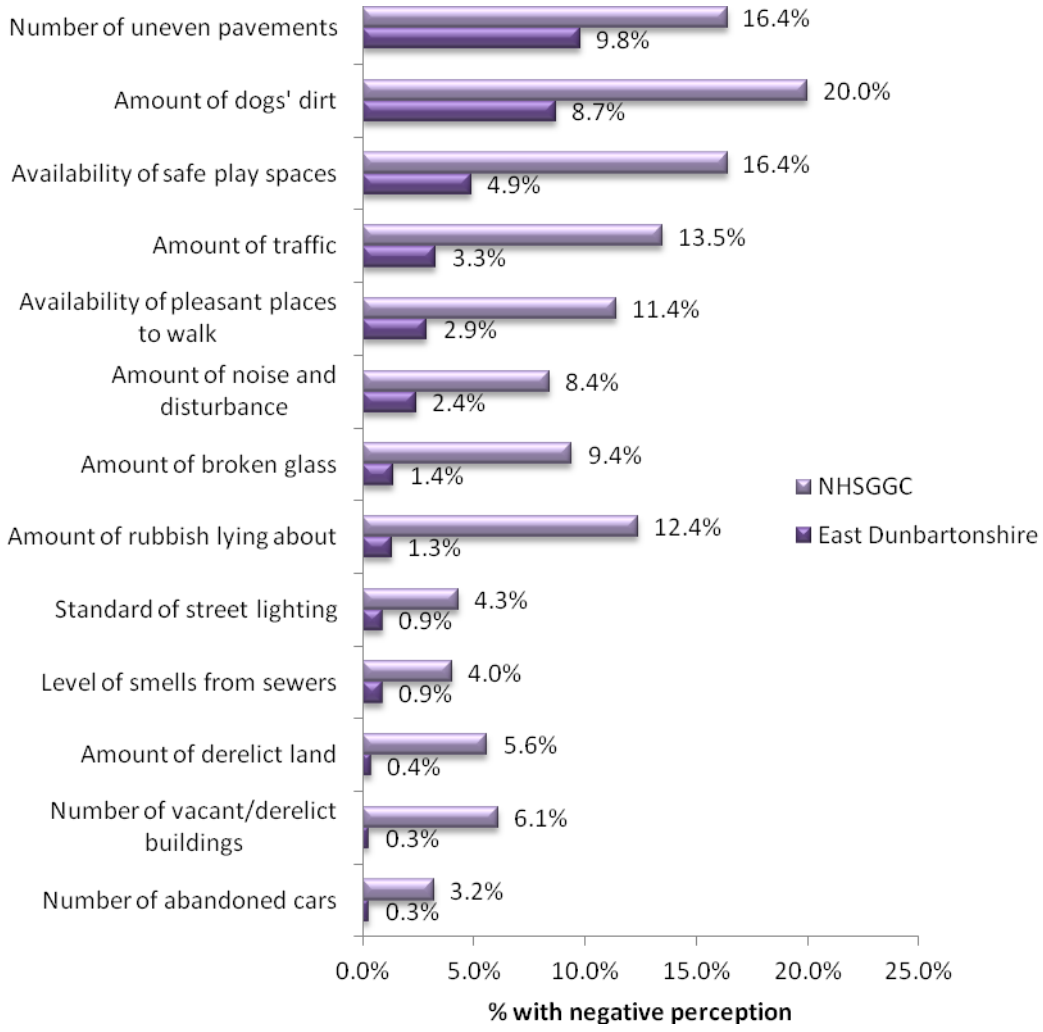
Again using the 'faces' scale (see Section 2.2 of this report for full explanation of the scale), respondent were asked to indicate how they felt about a range of perceived environmental problems. Faces 5 to 7 are classified as negative perceptions and indicate that respondents are concerned about these issues.

The environmental issues which most frequently caused concern were the number of uneven pavements (10%) and the amount of dogs dirt (9%).

Comparison with NHS Greater Glasgow & Clyde

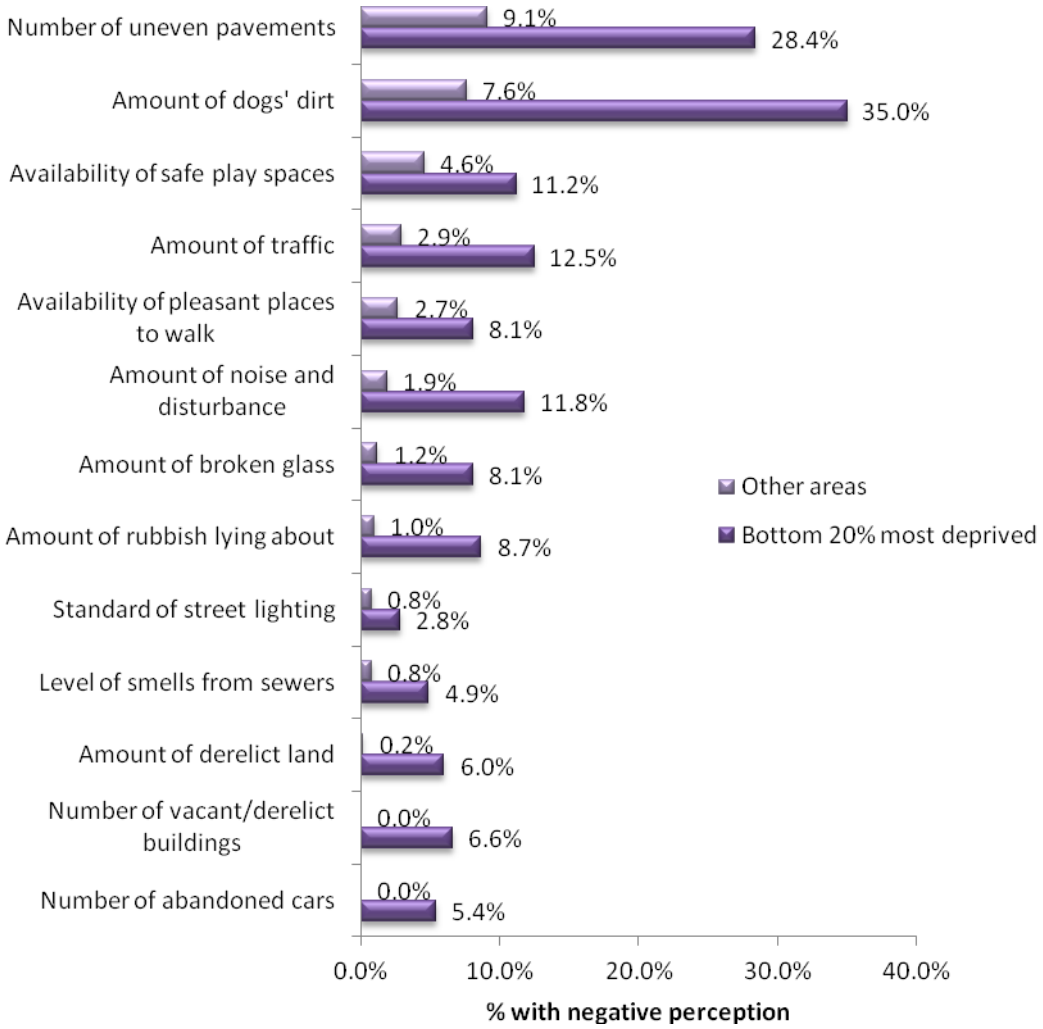
For all environmental issues, those in East Dunbartonshire were less likely to express a negative perception than those in the NHS Greater Glasgow & Clyde area as a whole, as shown in Figure 5.14.

Figure 5.14: Negative Perception of Environmental Issues in the Local Area (Q39a-m) - East Dunbartonshire and NHS Greater Glasgow & Clyde



For every environmental issue, those in the most deprived areas were more likely than those in other areas to have a negative perception. This is shown in Figure 5.15.

Figure 5.15: Negative Perception of Environmental Issues in the Local Area (Q39a-m) - Bottom 20% Most Deprived Areas and Other Areas

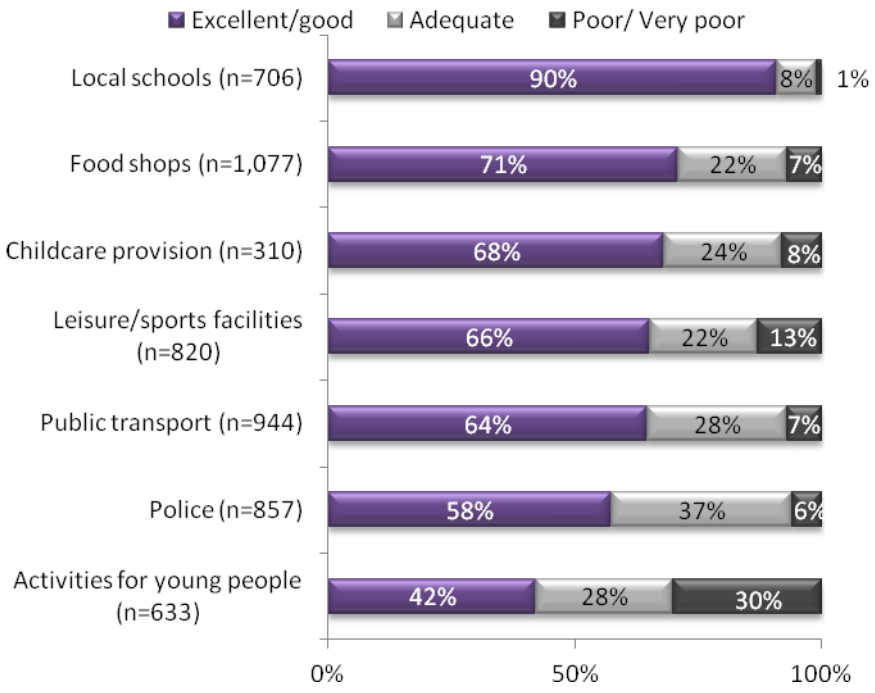


5.6 Perceived Quality of Services in the Area

Respondents were given a list of seven local services and asked to rate each (excellent, good, adequate, poor or very poor). Figure 5.16 shows the responses to each type of service. The number of respondents answering 'don't know' varied for different types of service reflecting the level of use. 'Don't know' responses have been excluded from analysis, and Figure 5.16 shows the number of respondents who gave a rating response for each service.

The services for which the largest proportion of respondents gave a positive rating were local schools and public transport. Activities for young people had the fewest proportion of respondents giving a positive rating.

Figure 5.16: Perceived Quality of Local Services



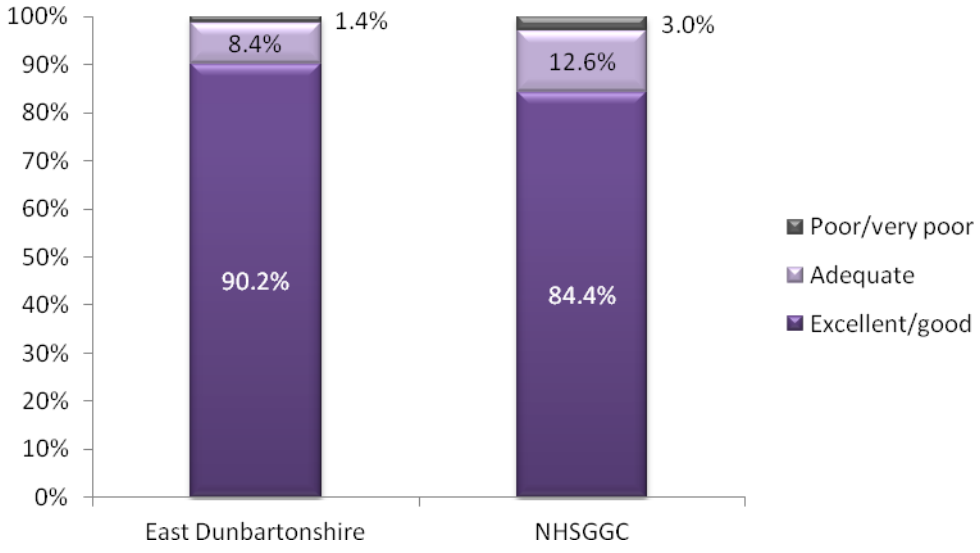
Local Schools

Nine in ten (90%) respondents rated local schools positively, with a further 8% saying they were adequate and 1% saying they were poor.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were more likely than those in the NHS Greater Glasgow & Clyde area as a whole to rate local schools positively (90% East Dunbartonshire; 84% NHSGGC).

Figure 5.17: Perceived Quality of Local Schools (Q42b) - East Dunbartonshire and NHS Greater Glasgow & Clyde



Those in the youngest and oldest age groups were less likely to rate local schools positively. Women were more likely than men to rate local schools positively.

Table 5.56: Perceived Quality of Local Schools (Q42b) by Age and Gender

	Excellent / Good	Adequate	Poor / Very Poor	Unweighted base (n)
Age:				
16-24	83%	17%	0%	65
25-34	93%	7%	0%	94
35-44	94%	3%	2%	128
45-54	89%	9%	2%	135
55-64	92%	6%	2%	102
65-74	93%	7%	0%	104
75+	85%	9%	6%	76
Men	87%	10%	2%	245
Women	93%	7%	<1%	461
All	90%	8%	1%	706

Those who felt isolated from family and friends were less likely to rate local schools positively.

Table 5.57: Perceived Quality of Local Schools (Q42b) by Factors Associated with Social Exclusion

	Excellent / Good	Adequate	Poor / Very Poor	Unweighted base (n)
Feel isolated from friends/family	80%	20%	0%	45

For health and wellbeing measures, those less likely to rate local schools positively were:

- Those with a limiting condition or illness;
- Those with a high GHQ12 score; and
- Those who consumed fewer than five portions of fruit/vegetables per day.

Those with positive views of their health and mental/emotional wellbeing were more likely to have positive views of local schools.

Table 5.58: Perceived Quality of Local Schools (Q42b) by Health and Wellbeing Measures

	Excellent / Good	Adequate	Poor / Very Poor	Unweighted base (n)
Positive view of general health	91%	7%	1%	511
Positive view of mental/emotional wellbeing	91%	7%	2%	603
High GHQ12 score	86%	10%	3%	167
Limiting condition/illness	83%	16%	1%	139
Consumes fewer than 5 portions of fruit/veg per day	88%	11%	2%	536

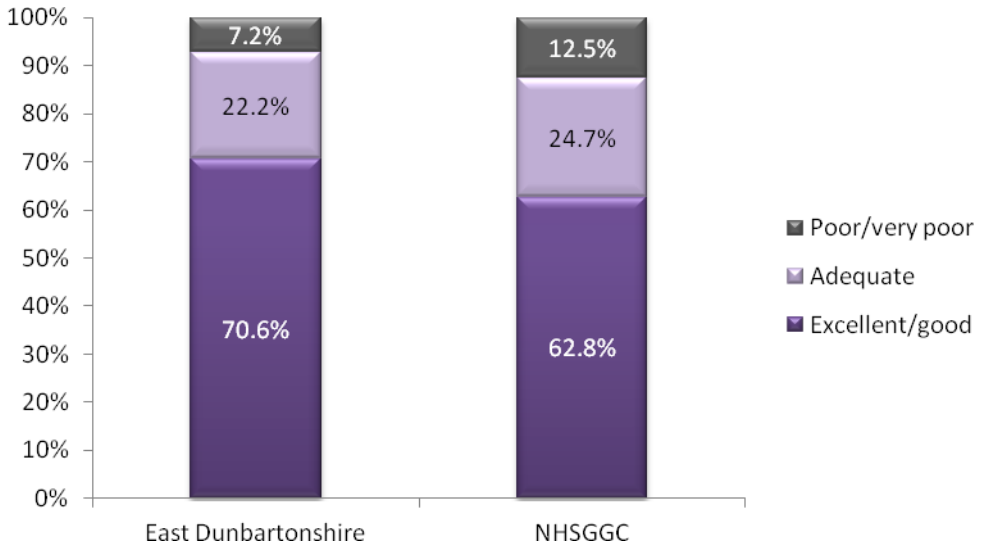
Food Shops

Seven in ten (71%) respondents had a positive view of local food shops while 22% said they were adequate and 7% said they were poor.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were more likely than those in the NHS Greater Glasgow & Clyde area as a whole to have a positive view of local food shops (71% East Dunbartonshire; 63% NHS Greater Glasgow & Clyde).

Figure 5.18: Perceived Quality of Food Shops (Q42a) - East Dunbartonshire and NHS Greater Glasgow & Clyde



Those in the most deprived areas were less likely than those in other areas to rate local food shops positively. However, those in the 4th SIMD quintile were the least likely to rate local food shops positively. This is shown in Table 5.59.

Table 5.59: Perceived Quality of Food Shops (Q42a) by Deprivation and Socio Economic Measures

	Excellent / Good	Adequate	Poor / Very Poor	Unweighted base (n)
Bottom 20% datazones	61%	26%	13%	550
Other datazones	71%	22%	7%	527
SIMD quintile				
1 (most deprived)	61%	26%	13%	550
2	92%	5%	3%	72
3	56%	31%	13%	81
4	49%	46%	6%	98
5 (least deprived)	77%	16%	7%	276

Those who received all household income from benefits were less likely to rate local food shops positively.

Table 5.60: Perceived Quality of Food Shops (Q42a) by Factors Associated with Social Exclusion

	Excellent / Good	Adequate	Poor / Very Poor	Unweighted base (n)
All income from benefits	59%	32%	10%	269

Those who consumed fewer than five portions of fruit/vegetables per day were less likely to rate local food shops positively. Those who had a positive view of their general health were more likely to have a positive view of local food shops.

Table 5.61: Perceived Quality of Food Shops (Q42a) by Health and Wellbeing Measures

	Excellent / Good	Adequate	Poor / Very Poor	Unweighted base (n)
Positive view of general health	73%	21%	6%	704
Consumes fewer than 5 portions of fruit/veg per day	67%	24%	9%	825

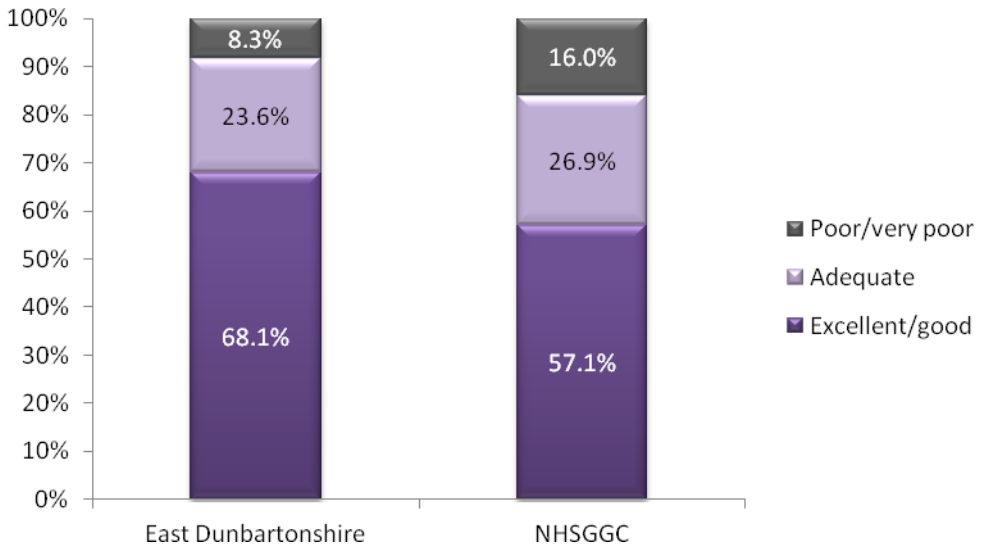
Childcare Provision

Two in three (68%) of respondents rated local childcare provision positively while 24% said it was adequate and 8% said it was poor.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were more likely than those in the NHS Greater Glasgow & Clyde area as a whole to rate local childcare provision positively (68% East Dunbartonshire; 57% NHS Greater Glasgow & Clyde).

Figure 5.19: Perceived Quality of Childcare Provision (Q42f) - East Dunbartonshire and NHS Greater Glasgow & Clyde



Women were more likely than men to have a positive perception of local childcare, as shown in Table 5.62.

Table 5.62: Perceived Quality of Childcare (Q42f) by Age and Gender

	Excellent / Good	Adequate	Poor / Very Poor	Unweighted base (n)
Men	60%	29%	11%	80
Women	73%	20%	6%	230
Men 16-44	67%	25%	8%	44
Women 16-44	74%	22%	4%	161
Men 45-64	48%	36%	17%	26
Women 45-64	78%	12%	10%	54
Men 65+	67%	22%	11%	10
Women 65+	42%	50%	8%	15
All	68%	24%	8%	310

Table 5.63 shows that all three factors associated with social exclusion were associated with a lower likelihood of rating local childcare provision positively.

Table 5.64: Perceived Quality of Childcare Provision (Q42f) by Factors Associated with Social Exclusion

	Excellent / Good	Adequate	Poor / Very Poor	Unweighted base (n)
All income from benefits	27%	60%	13%	75
Feel isolated from friends/family	45%	55%	0%	16
Not in control of decisions affecting daily life, or only 'to some extent'	59%	31%	10%	85

Table 5.65 shows that those less likely to rate local childcare provision positively were:

- Smokers;
- Obese people;
- Those exposed to second hand smoke; and
- Those with a high GHQ12 score.

Those who exceeded the recommended weekly limit for alcohol consumption and those with positive views of their health and physical wellbeing were more likely to have positive views of childcare provision in their area.

Table 5.65: Perceived Quality of Childcare Provision (Q42f) by Health and Wellbeing Measures

	Excellent / Good	Adequate	Poor / Very Poor	Unweighted base (n)
Positive view of general health	69%	22%	9%	244
Positive view of physical wellbeing	73%	20%	7%	255
High GHQ12 score	54%	33%	13%	73
Exposed to second hand smoke	52%	42%	6%	130
Current smoker	43%	48%	9%	110
Obese	49%	21%	30%	223

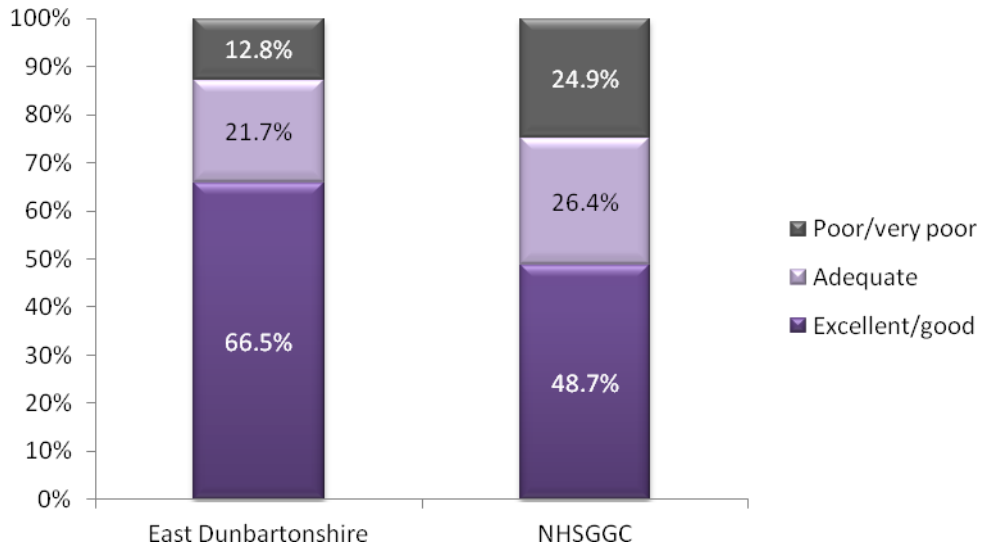
Leisure / Sports Facilities

Two thirds (66%) of respondents gave a positive rating of local leisure/sports facilities while 22% said they were adequate and 13% said they were poor.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were more likely than those in the NHS Greater Glasgow & Clyde area as a whole to rate local leisure/sports facilities positively (66% East Dunbartonshire; 49% NHSGGC).

Figure 5.20: Perceived Quality of Leisure / Sports Facilities (Q42e) - East Dunbartonshire and NHS Greater Glasgow & Clyde



Those aged 75 or over were the most likely to give a positive rating of local leisure/sports facilities and those aged under 25 were the most likely to give a negative rating.

Table 5.66: Perceived Quality of Leisure/Sports Facilities (Q42e) by Age and Gender

	Excellent/ Good	Adequate	Poor/ Very Poor	Unweighted base (n)
Age:				
16-24	68%	11%	21%	75
25-34	70%	22%	8%	116
35-44	63%	26%	11%	150
45-54	56%	26%	18%	157
55-64	69%	23%	8%	125
65-74	67%	21%	11%	111
75+	74%	20%	6%	84
Men 16-44	68%	16%	16%	112
Women 16-44	66%	24%	11%	229
Men 45-64	60%	30%	10%	111
Women 45-64	63%	20%	17%	171
Men 65+	68%	23%	9%	85
Women 65+	73%	18%	9%	110
All	66%	22%	13%	820

Those in the most deprived areas were less likely to rate local leisure/sports facilities positively.

Table 5.67: Perceived Quality of Leisure/Sports Facilities (Q42e) by Deprivation and Socio Economic Measures

	Excellent/ Good	Adequate	Poor/ Very Poor	Unweighted base (n)
Bottom 20% datazones	39%	30%	31%	394
Other datazones	67%	21%	12%	426
SIMD quintile				
1 (most deprived)	39%	30%	31%	394
2	56%	42%	2%	51
3	58%	25%	17%	61
4	74%	9%	17%	76
5 (least deprived)	68%	20%	12%	238

Table 5.68 shows that all three factors associated with social exclusion were associated with a lower likelihood of rating local leisure/sports facilities positively.

Table 5.68: Perceived Quality of Leisure/Sports Facilities (Q42e) by Factors Associated with Social Exclusion

	Excellent/ Good	Adequate	Poor/ Very Poor	Unweighted base (n)
All income from benefits	41%	43%	15%	155
Feel isolated from friends/family	44%	27%	29%	60
Not in control of decisions affecting daily life, or only 'to some extent'	59%	29%	12%	283

For health and wellbeing measures, those less likely to rate local leisure/sports facilities positively were:

- Smokers;
- Those exposed to second hand smoke;
- Obese people; and
- Those who consume fewer than 5 portions of fruit/vegetables per day.

Table 5.69: Perceived Quality of Leisure/Sports Facilities (Q42e) by Health and Wellbeing Measures

	Excellent/ Good	Adequate	Poor/ Very Poor	Unweighted base (n)
Positive view of general health	67%	22%	11%	587
Positive view of physical wellbeing	68%	21%	11%	653
Exposed to second hand smoke	54%	31%	15%	299
Current smoker	47%	32%	20%	248
Obese	54%	33%	14%	136
Consumes fewer than 5 portions of fruit/veg per day	64%	20%	15%	617

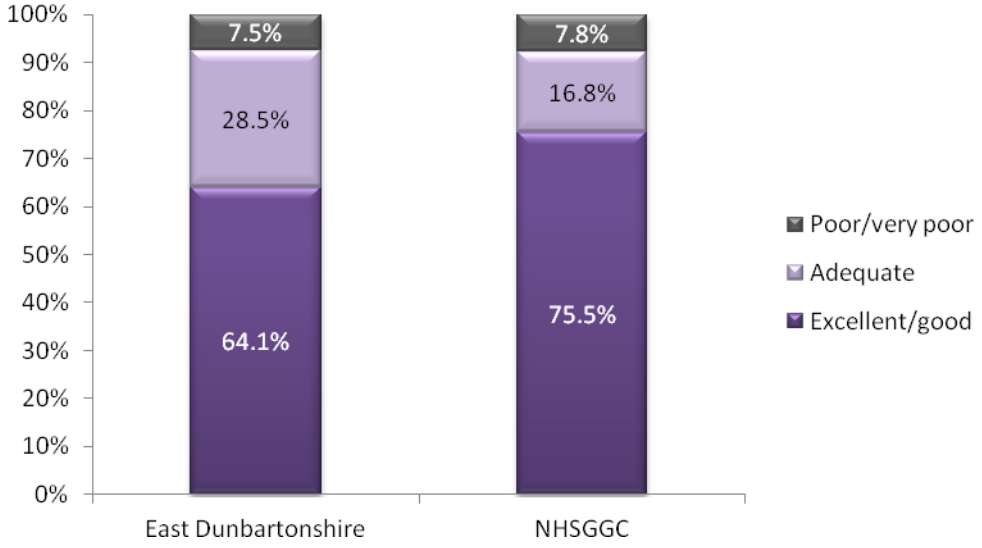
Public Transport

Two in three (64%) respondents rated public transport positively, while 28% said it was adequate and 7% considered it poor.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde area as a whole to rate local public transport positively (64% East Dunbartonshire; 75% NHSGGC).

Figure 5.21: Perceived Quality of Public Transport (Q42c) - East Dunbartonshire and NHS Greater Glasgow & Clyde



Those aged 25-34 were the most likely to rate public transport positively and those aged 65-74 were the least likely.

Table 5.70: Perceived Quality of Public Transport (Q42c) by Age

	Excellent / Good	Adequate	Poor / Very Poor	Unweighted base (n)
Age:				
16-24	63%	32%	6%	77
25-34	73%	18%	10%	115
35-44	64%	28%	8%	143
45-54	60%	36%	4%	158
55-64	66%	27%	7%	147
65-74	57%	26%	16%	163
75+	68%	27%	5%	138
All	64%	28%	7%	944

Those in the fourth SIMD quintile were the least likely to rate local public transport positively, as shown in Table 5.71.

Table 5.71: Perceived Quality of Public Transport (Q42c) by Deprivation and Socio Economic Measures

	Excellent / Good	Adequate	Poor / Very Poor	Unweighted base (n)
SIMD quintile				
1 (most deprived)	64%	19%	17%	496
2	85%	13%	2%	63
3	69%	20%	11%	73
4	48%	41%	12%	79
5 (least deprived)	63%	32%	6%	233

Table 5.72 shows that those who felt isolated were less likely to rate public transport positively.

Table 5.72: Perceived Quality of Public Transport (Q42c) by Factors Associated with Social Exclusion

	Excellent / Good	Adequate	Poor / Very Poor	Unweighted base (n)
Feel isolated from friends/family	35%	52%	14%	69

For health and wellbeing measures, those less likely to have a positive view of local public transport were:

- Those with a limiting condition or illness;
- Smokers;
- Those who consume fewer than five portions of fruit/vegetables per day; and
- Those with a positive view of their mental/emotional wellbeing.

Those with a positive view of their physical wellbeing were more likely to rate local public transport positively.

Table 5.73: Perceived Quality of Public Transport (Q42c) by Health and Wellbeing Measures

	Excellent / Good	Adequate	Poor / Very Poor	Unweighted base (n)
Positive view of physical wellbeing	67%	26%	7%	746
Positive view of mental/emotional wellbeing	63%	30%	6%	768
Limiting condition/illness	54%	34%	12%	216
Current smoker	57%	31%	11%	340
Consumes fewer than 5 portions of fruit/veg per day	61%	31%	8%	726

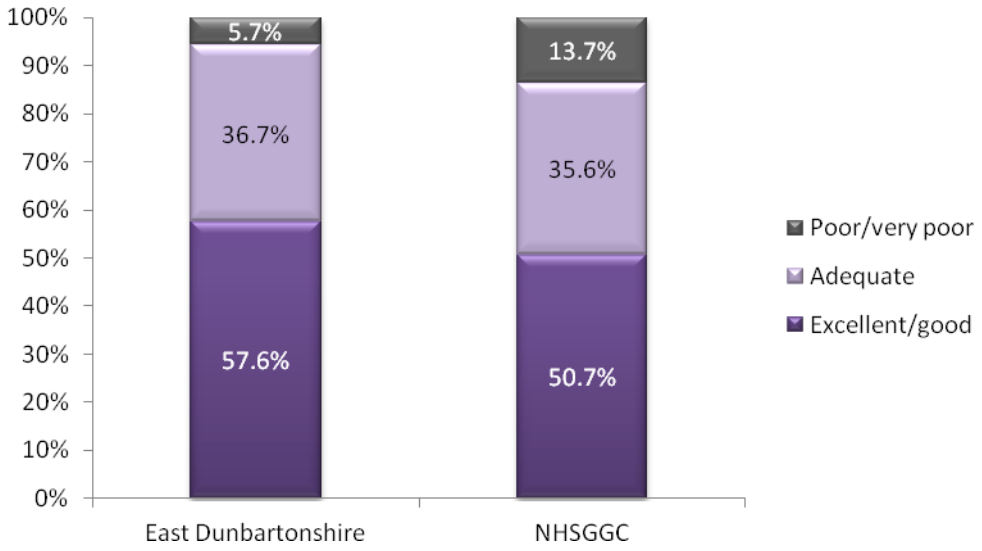
Police

Three in five (58%) respondents rated the local police service positively while 37% said it was adequate and 6% said it was poor.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were more likely than those in the NHS Greater Glasgow & Clyde area as a whole to rate the police positively (58% East Dunbartonshire; 51% NHSGGC).

Figure 5.22: Perceived Quality of Police - East Dunbartonshire and NHS Greater Glasgow & Clyde



Those aged 45-54 were the least likely to rate the police positively and those aged 25-34 were the most likely.

Table 5.74: Perceived Quality of Police (Q42g) by Age and Gender

	Excellent / Good	Adequate	Poor / Very Poor	Unweighted base (n)
Age:				
16-24	64%	36%	0%	57
25-34	70%	25%	5%	109
35-44	61%	32%	7%	142
45-54	40%	52%	8%	155
55-64	64%	33%	3%	131
65-74	54%	39%	7%	139
75+	61%	31%	8%	120
Men 16-44	68%	29%	3%	99
Women 16-44	61%	33%	6%	209
Men 45-64	49%	43%	8%	110
Women 45-64	51%	46%	4%	176
Men 65+	64%	27%	9%	104
Women 65+	52%	42%	6%	155
All	58%	37%	6%	857

Those with no qualifications were less likely to rate their local police service positively. However, those in the least deprived areas were the least likely to rate the police positively. This is shown in Table 5.75.

Table 5.75: Perceived Quality of Police (Q42g) by Deprivation and Socio Economic Measures

	Excellent / Good	Adequate	Poor / Very Poor	Unweighted base (n)
Bottom 20% datazones	66%	27%	7%	440
Other datazones	57%	37%	6%	417
SIMD quintile				
1 (most deprived)	66%	27%	7%	440
2	69%	29%	2%	65
3	54%	35%	11%	74
4	72%	22%	5%	87
5 (least deprived)	49%	46%	5%	191
At least one qualification	59%	36%	5%	621
No qualifications	48%	42%	10%	229

Those who felt isolated from family and friends and those who did not definitely feel in control of the decisions affecting their life were less likely to rate the police positively.

Table 5.76: Perceived Quality of Police (Q42g) by Factors Associated with Social Exclusion

	Excellent / Good	Adequate	Poor / Very Poor	Unweighted base (n)
Feel isolated from friends/family	36%	62%	2%	51
Not in control of decisions affecting daily life, or only 'to some extent'	49%	44%	6%	280

For health and wellbeing measures, those less likely to rate the local police positively were:

- Those with a limiting condition/illness;
- Smokers;
- Those exposed second hand smoke;
- Obese people; and
- Those with a high GHQ12 score.

Table 5.77: Perceived Quality of Police (Q42g) by Health and Wellbeing Measures

	Excellent / Good	Adequate	Poor / Very Poor	Unweighted base (n)
Positive view of physical wellbeing	61%	36%	4%	672
Positive view of mental/emotional wellbeing	59%	35%	5%	709
High GHQ12 score	49%	43%	7%	199
Limiting condition/illness	43%	48%	9%	211
Exposed to second hand smoke	45%	46%	9%	305
Current smoker	43%	48%	9%	259
Obese	47%	49%	4%	148

Activities for Young People

Two in five (42%) respondents rated the quality of activities for young people locally positively, 28% said they were adequate and 30% said they were poor.

Those aged 75 or over were the most likely to rate activities for young people positively and those aged under 25 were the least likely. Men were more likely than women to give this a positive rating.

Table 5.78: Perceived Quality of Activities for Young People (Q42d) by Age and Gender

	Excellent / Good	Adequate	Poor / Very Poor	Unweighted base (n)
Age:				
16-24	36%	20%	44%	70
25-34	53%	23%	24%	98
35-44	42%	32%	26%	131
45-54	41%	26%	34%	140
55-64	35%	36%	29%	91
65-74	50%	35%	15%	65
75+	63%	20%	17%	36
Gender:				
Men	44%	23%	33%	231
Women	40%	32%	28%	402
Men 16-44	43%	17%	40%	93
Women 16-44	42%	32%	26%	206
Men 45-64	45%	27%	28%	92
Women 45-64	32%	32%	36%	139
Men 65+	44%	36%	21%	45
Women 65+	68%	21%	11%	56
All	42%	28%	30%	633

Those in the most deprived areas and those with no qualifications were less likely to rate activities for young people positively.

Table 5.79: Perceived Quality of Activities for Young People (Q42d) by Deprivation and Socio Economic Measures

	Excellent / Good	Adequate	Poor / Very Poor	Unweighted base (n)
Bottom 20% datazones	22%	18%	60%	328
Other datazones	43%	28%	29%	305
SIMD quintile				
1 (most deprived)	22%	18%	60%	328
2	46%	51%	2%	44
3	37%	11%	53%	43
4	35%	29%	37%	59
5 (least deprived)	47%	28%	25%	159
At least one qualification	45%	27%	28%	500
No qualifications	22%	36%	42%	126

Table 5.80 shows that all three factors associated with social exclusion were associated with a lower likelihood of rating local activities for young people positively.

Table 5.80: Perceived Quality of Activities for Young People (Q42d) by Factors Associated with Social Exclusion

	Excellent / Good	Adequate	Poor / Very Poor	Unweighted base (n)
All income from benefits	14%	46%	41%	126
Feel isolated from friends/family	25%	26%	49%	38
Not in control of decisions affecting daily life, or only 'to some extent'	35%	37%	27%	196

For health and wellbeing measures, those less likely to rate local activities for young people positively were:

- Those exposed to second hand smoke;
- Smokers; and
- Those who consume fewer than five portions of fruit/vegetables per day.

Those with a high GHQ12 score were more likely to rate the quality of activities for young people positively.

Table 5.81: Perceived Quality of Activities for Young People (Q42d) by Health and Wellbeing Measures

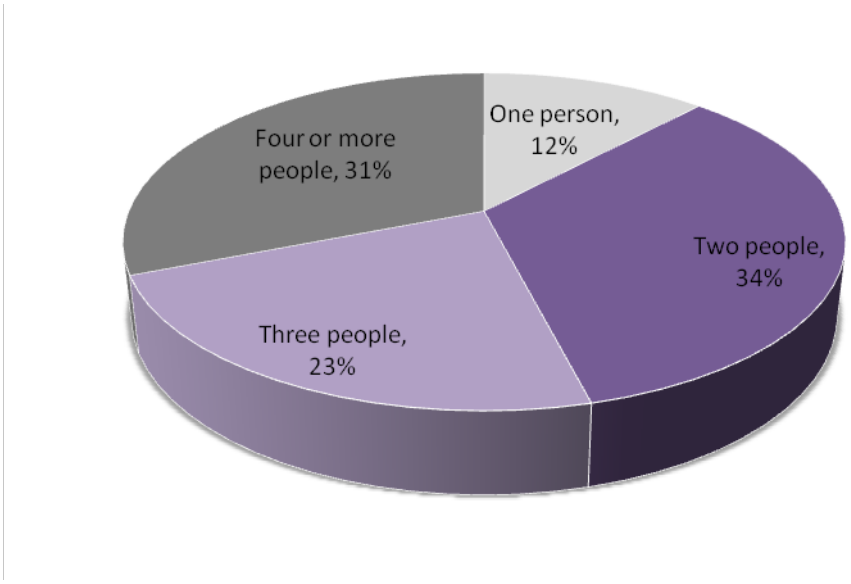
	Excellent / Good	Adequate	Poor / Very Poor	Unweighted base (n)
High GHQ12 score	52%	21%	27%	162
Exposed to second hand smoke	26%	32%	42%	254
Current smoker	31%	28%	42%	211
Consumes fewer than 5 portions of fruit/veg per day	39%	25%	36%	486

5.7 Individual Circumstances

Household Size

Twelve percent of respondents lived alone. Figure 5.23 shows the breakdown of household size in East Dunbartonshire.

Figure 5.23: Household Size
(Base: 1,079)



Ethnicity

Respondents were asked their ethnicity. The vast majority (99%) identified themselves as White. The small number of minority ethnic groups prohibits detailed analysis of ethnicity.

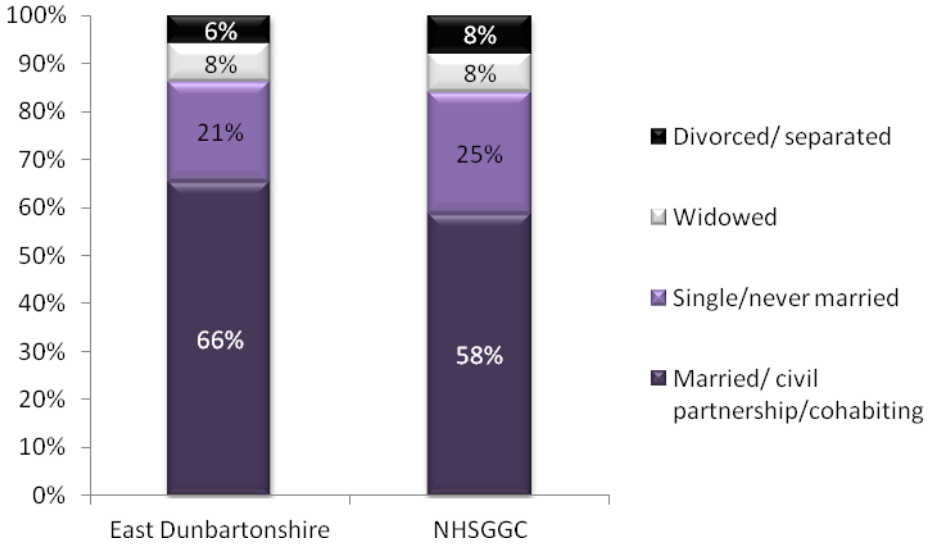
Marital Status

Two in three (66%) of respondents were married, in civil partnership or living with their partner.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were more likely than those in the NHS Greater Glasgow & Clyde area as a whole to be married or living with a partner (66% East Dunbartonshire; 58% NHSGGC). This is shown in Figure 5.24.

Figure 5.24: Marital Status - East Dunbartonshire and NHS Greater Glasgow & Clyde



The age group most likely to describe themselves as married or cohabiting was 55-64 year olds, of whom 84% were married, in a civil partnership or living with their partner. Half (47%) of those aged 75 or over were widowed.

Those in the bottom 20% most deprived areas were less likely than those in other areas to be married, in a civil partnership or living with their partner (46% in the bottom 20% areas and 66% in other areas were married/in a civil partnership/cohabiting).

Caring Responsibilities

One in 16 (6%) respondents said that they were responsible for caring for someone on a day to day basis (excluding regular childcare). Those who cared for others were asked how many hours a day they spent caring. Two in three (64%) said they spent 24 hours per day caring. The mean number of hours per day spent caring was 17.7.

Those aged 55-64 were the most likely to have caring responsibilities (10% in this age group had caring responsibilities), and women (9%) were more likely to have caring responsibilities than men (3%).

Table 5.82: Caring Responsibilities (Q55) by Age and Gender

	Caring responsibilities	Unweighted base (n)
Age:		
16-24	1%	79
25-34	3%	127
35-44	9%	160
45-54	6%	176
55-64	10%	164
65-74	7%	187
75+	8%	184
Men	3%	414
Women	9%	670
Men 16-44	3%	128
Women 16-44	6%	238
Men 45-64	1%	139
Women 45-64	13%	201
Men 65+	7%	143
Women 65+	8%	228
All	6%	1,084

Educational Qualifications

One in six (16%) had no educational qualifications.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were more likely than those in the NHS Greater Glasgow & Clyde area as a whole to have any qualifications (84% East Dunbartonshire; 80% NHSGGC).

The likelihood of having no qualifications increased with age, ranging from 1% of those aged 16-24 to 41% of those aged 75 or over. Women were more likely than men to have no qualifications (22% and 10% respectively).

More than a third (36%) of those in the bottom 20% most deprived areas had no qualifications compared to 15% of those in other areas.

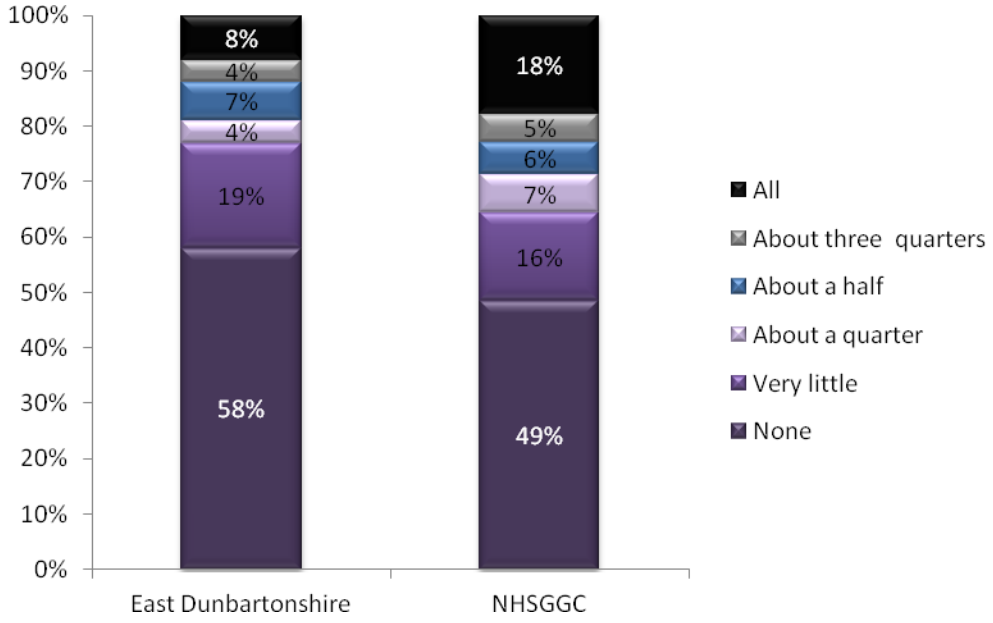
Proportion of Household Income from State Benefits

Two in five (42%) of respondents said that at least some of their household income came from state benefits, and 8% said that all their household income came from state benefits.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde area as a whole to receive income from benefits (42% East Dunbartonshire; 51% NHSGGC). This is shown in Figure 5.25.

Figure 5.25: Proportion of Household Income from State Benefits - East Dunbartonshire and NHS Greater Glasgow & Clyde



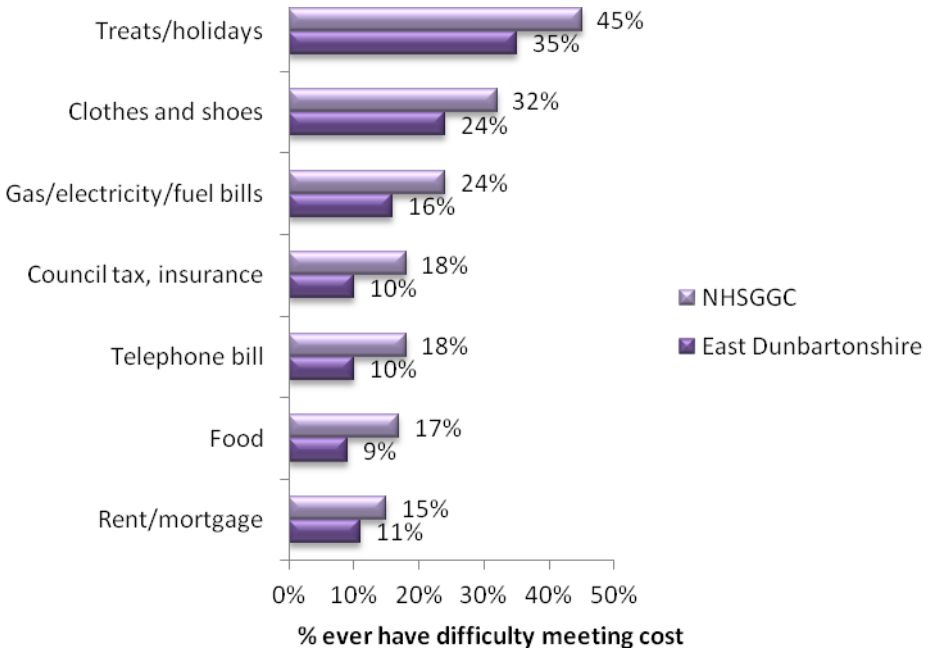
More than a third (36%) of those in the bottom 20% most deprived areas received all household income from benefits compared with 7% of those in other areas. In the least deprived quintile less than 1% received all household income from benefits.

A quarter (24%) of those with no qualifications received all household income from benefits compared to 5% of those with qualifications.

Difficulty Meeting the Cost of Specific Expenses

Figure 5.26 shows the proportion of respondents who said they ever had difficulty meeting specific expenses. For each type of expense, those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde area as a whole to ever have difficulty meeting the cost.

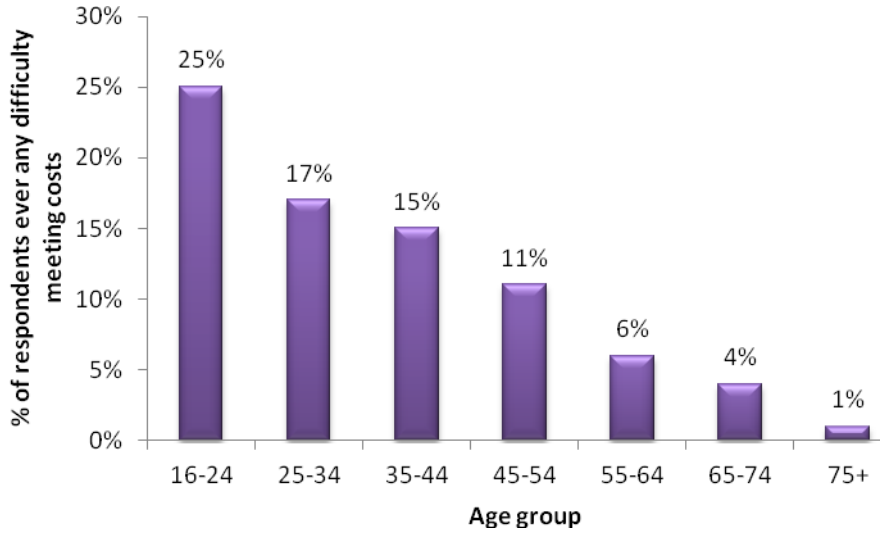
Figure 5.26: Difficulty Meeting the Costs of Specific Expenses (Q51) - East Dunbartonshire and NHS Greater Glasgow & Clyde



All together,11% said that they ever had difficulty meeting the costs rent/mortgage, fuel bills, telephone bills, council tax/insurance, food or clothes/shoes. This compares to 15% of those in the NHS Greater Glasgow & Clyde area as a whole.

Those aged under 25 were the most likely to have difficulty meeting these costs and those aged 75 or over were the least likely.

Figure 5.27: Difficulty Meeting the Costs of Rent/Mortgage, Fuel Bills, Telephone Bills, Council Tax/Insurance, Food or Clothes Shoes (Q51) by Age



More than one in five (22%) of those in the bottom 20% most deprived areas ever had difficulty meeting these expenses compared to 11% of those in other areas.

Difficulty Finding Unexpected Sums

One in 20 (5%) said that they would have a problem meeting an unexpected expense of £20; 19% said they would have a problem meeting an unexpected expense of £100 and 45% would had a problem finding £1,000 for an unexpected expense.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde to have a problem finding unexpected sums of £20, £100 or £1,000, as shown in Figure 5.28.

Figure 5.28: Would have a Problem Meeting Unexpected Expenses of £20, £100 and £1,000 - East Dunbartonshire and NHS Greater Glasgow & Clyde

Those in the bottom 20% most deprived areas were more likely to have difficulty finding money for unexpected expenses. In these areas, 18% would a have a problem finding £20, 58% would have a problem finding £100 and 85% would have a problem finding £1,000.

Economic Activity

Two thirds (65%) of respondents lived in households where the main wage earner was economically active (in or looking for work).

Sexual Orientation

The vast majority (99%) of respondents described their sexual orientation as heterosexual.

6 Social Capital

6.1 Chapter Summary

Table 6.1 summarises the indicator data for social capital.

Table 6.1: Indicators for Social Capital

Indicator	% of sample	Unweighted base (n)
Positive perception of local area as a place to live (Q36)	96%	1,079
Positive perception of local area as a place to bring up children (Q37)	95%	791
Positive perception of reciprocity (Q40a)	81%	1,066
Positive perception of trust (Q40e)	77%	1,060
Value local friendships (Q40c)	74%	1,075
Positive perception of social support (Q40g)	84%	1,058

In total 96% of respondents had a positive perception of their local area as a place to live and 95% had a positive perception of their local area as a place to bring up children. Those less likely to have positive views of their area as a place to live or to bring up children were those aged 45-54, those in the most deprived areas, those with no qualifications, those who exhibited factors associated with social exclusion, those with a high GHQ12 score, smokers and those exposed to second hand smoke.

Four in five (81%) had a positive view of reciprocity in their area and 77% had a positive view of trust in their area. Those less likely to have positive views of reciprocity or trust were men, those in the most and least deprived areas, those who felt isolated, those who did not definitely feel in control of their lives, those with a high GHQ12 score and those who exceeded the recommended weekly limit for alcohol consumption.

Three in four (74%) respondents valued local friendships. Those less likely to value local friendships were those aged 65 or over, those in the most and least deprived areas, those with no qualifications, those who felt isolated, those who did not definitely feel in control of their life, those with a high GHQ12 score and those who consume fewer than five portions of fruit/vegetables per day.

More than four in five (84%) had a positive view of social support in their area. Those less likely to have a positive view of social support were those in the most and least deprived areas, those with no qualifications, those who exhibited factors associated with social exclusion, those with a high GHQ12 score, those who exceed the recommended weekly limit for alcohol, obese people, smokers and those exposed to second hand smoke.

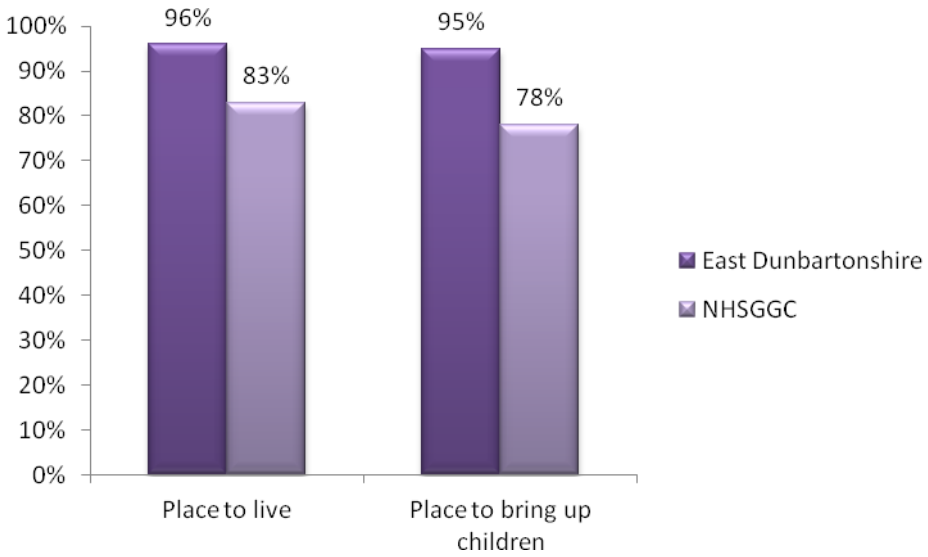
6.2 View of Local Area

Respondents were presented with the seven 'faces' scale (see Section 2.2 of this report for full explanation of the scale) and asked to indicate how they felt about their area a) as a place to live; and b) as a place to bring up children. Those choosing any of the three 'smiley' faces (1-3) were categorised as having a positive perception. Overall, 96% had a positive view of their area as a place to live and 95% had a positive view of the area as a place to bring up children.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were more likely than those in the NHS Greater Glasgow & Clyde area as a whole to have a positive view of their area as a place to live or to bring up children. This is shown in Figure 6.1.

Figure 6.1: Positive Perception of Area as a Place to Live (Q36) and as a Place to Bring Up Children (Q37) - East Dunbartonshire and NHS Greater Glasgow & Clyde



Those aged 45-54 were the least likely to have a positive view of their area as a place to live or to bring up children. Men were more likely than women to have a positive view of their area as a place to live,

Table 6.2: Positive Perception of Area as a Place to Live (Q36) and as a Place to Bring Up Children (Q37) by Age and Gender

	Place to Live	Place to Bring Up Children	Unweighted base (n)
Age:			
16-24	96%	92%	79
25-34	98%	94%	127
35-44	97%	99%	160
45-54	91%	89%	175
55-64	98%	99%	163
65-74	95%	99%	186
75+	98%	96%	181
Men	97%	-	412
Women	95%	-	667
Men 16-44	98%	-	128
Women 16-44	95%	-	238
Men 45-64	97%	-	138
Women 45-64	92%	-	200
Men 65+	98%	-	142
Women 65+	96%	-	225
All	96%	95%	1,079

Those in the most deprived areas and those with no qualifications were less likely to have positive views of their area as a place to live or to bring up children.

Table 6.3: Positive Perception of Area as a Place to Live (Q36) and as a Place to Bring Up Children (Q37) by Deprivation and Socio Economic Measures

	Place to Live	Place to Bring Up Children	Unweighted base (n)
Bottom 20% datazones	72%	72%	554
Other datazones	97%	96%	525
SIMD quintile			
1 (most deprived)	72%	72%	554
2	98%	100%	71
3	95%	87%	80
4	96%	92%	99
5 (least deprived)	98%	99%	275
At least one qualification	97%	96%	743
No qualifications	89%	88%	328

All three factors associated with social exclusion were associated with a lower likelihood of expressing a positive view of the local area as a place to live or to bring up children.

Table 6.4: Positive Perception of Area as a Place to Live (Q36) and as a Place to Bring Up Children (Q37) by Factors Associated with Social Exclusion

	Place to Live	Place to Bring Up Children	Unweighted base (n)
All income from benefits	84%	84%	271
Feel isolated from friends/family	86%	88%	77
Not in control of decisions affecting daily life, or only 'to some extent'	93%	92%	360

Table 6.5 shows that for health and wellbeing measures those less likely to have positive views of their area as a place to live or to bring up children were:

- Those with a high GHQ12 score;
- Smokers; and
- Those exposed to second hand smoke.

Those with positive views of their mental/emotional wellbeing or quality of life were more likely to have positive views of their local area as a place to live and to bring up children.

Table 6.5: Positive Perception of Area as a Place to Live (Q36) and as a Place to Bring Up Children (Q37) by Health and Wellbeing Measures

	Place to Live	Place to Bring Up Children	Unweighted base (n)
Positive view of mental/emotional wellbeing	97%	95%	881
Positive view of quality of life	97%	95%	917
High GHQ12 Score	91%	91%	259
Exposed to second hand smoke	91%	87%	376
Current smoker	91%	88%	324

6.3 Reciprocity and Trust

Respondents were asked to indicate the extent to which they agree or disagree with the following statements:

"This is a neighbourhood where neighbours look out for each other", and
"Generally speaking, you can trust people in my local area".

Those agreeing with the first statement were categorised as having a positive view of reciprocity, and those agreeing with the second were categorised as having a positive view of trust. Overall, 81% were positive about reciprocity and 79% were positive about trust.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were more likely than those in the NHS Greater Glasgow & Clyde area as a whole to have a positive view of reciprocity (81% East Dunbartonshire; 77% NHSGGC).

Those aged 45-54 were the least likely to have a positive view of reciprocity. Overall women were more likely than men to have positive views of reciprocity and trust.

Table 6.6: Positive Perception of Reciprocity (Q40a) and Trust (Q40e) by Age and Gender

	Reciprocity	Unweighted base (n)	Trust	Unweighted base (n)
Age:				
16-24	83%	76	-	-
25-34	85%	121	-	-
35-44	77%	157	-	-
45-54	73%	174	-	-
55-64	90%	164	-	-
65-74	80%	183	-	-
75+	85%	182	-	-
Men	77%	409	75%	407
Women	85%	656	83%	652
Men 16-44	74%	125	-	-
Women 16-44	88%	229	-	-
Men 45-64	76%	138	-	-
Women 45-64	85%	200	-	-
Men 65+	85%	142	-	-
Women 65+	80%	223	-	-
All	81%	1,066	77%	1,060

Those in the most deprived areas were less likely to have positive perceptions of reciprocity and trust. However, those in the least deprived areas were also less likely to have positive views of reciprocity and trust. Also, those with no qualifications were less likely to have positive perceptions of trust.

Table 6.7: Positive Perception of Reciprocity (Q40a) and Trust (Q40e) by Deprivation and Socio Economic Measures

	Reciprocity	Unweighted base (n)	Trust	Unweighted base (n)
Bottom 20% datazones	75%	546	72%	542
Other datazones	81%	520	79%	518
SIMD quintile				
1 (most deprived)	75%	546	72%	542
2	97%	71	97%	71
3	80%	80	85%	80
4	91%	99	85%	99
5 (least deprived)	76%	270	72%	268
At least one qualification	83%	738	80%	734
No qualifications	74%	319	73%	317

Table 6.8 shows that those who did not feel in control of the decisions affecting their life and particularly those who felt isolated from family/friends were less likely to have a positive perception of reciprocity or trust.

Table 6.8: Positive Perception of Reciprocity (Q40a) and Trust (Q40e) by Factors Associated with Social Exclusion

	Reciprocity	Unweighted base (n)	Trust	Unweighted base (n)
Feel isolated from friends/family	37%	71	45%	71
Not in control of decisions affecting daily life, or only 'to some extent'	73%	353	75%	351

Table 6.9 shows that for health and wellbeing measures, those less likely to have a positive perception of both reciprocity or trust were those with a high GHQ12 score and those who exceeded the recommended weekly limit for alcohol consumption. Also, smokers, those exposed to second hand smoke and those who consumed fewer than five portions of fruit/vegetables per day were less likely to have a positive view of reciprocity.

Table 6.9: Positive Perception of Reciprocity (Q40a) and Trust (Q40e) by Health and Wellbeing Measures

	Reciprocity	Unweighted base (n)	Trust	Unweighted base (n)
Positive view of physical wellbeing	82%	833	81%	829
Positive view of mental/ emotional wellbeing	83%	877	-	-
Positive view of quality of life	82%	909	80%	905
High GHQ12 Score	73%	253	69%	251
Exposed to second hand smoke	72%	369	-	-
Current smoker	71%	317	-	-
Exceeds weekly alcohol limit	75%	168	71%	166
Consumes fewer than 5 portions of fruit/veg per day	79%	814	-	-

6.4 Local Friendships

Respondents were asked to indicate the extent to which they agree or disagree with the statement: "*The friendships and associations I have with other people in my local area mean a lot to me*". Overall, 74% agreed with this statement.

Comparison with NHS Greater Glasgow & Clyde

Those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde area as a whole to value local friendships (74% East Dunbartonshire; 78% NHSGGC).

Those aged 65 and over were the least likely to value local friendships, while those aged under 25 were the most likely to do so. This is shown in Table 6.10.

Table 6.10: Proportion Value Local Friendships (Q40c) by Age and Gender

	Value Local Friendships	Unweighted base (n)
Age:		
16-24	87%	78
25-34	73%	124
35-44	71%	159
45-54	72%	175
55-64	79%	163
65-74	68%	186
75+	69%	181
All	74%	1,075

Those in the least and most deprived areas were less likely to value local friendships. Those with qualifications were more likely than those without qualifications to value local friendships.

Table 6.11: Proportion Value Local Friendships (Q40c) by Deprivation and Socio Economic Measures

	Value Local Friendships	Unweighted base (n)
SIMD quintile		
1 (most deprived)	69%	552
2	97%	71
3	83%	80
4	84%	99
5 (least deprived)	64%	273
At least one qualification	77%	740
No qualifications	60%	326

Those who did not definitely feel in control of their lives and particularly those who felt isolated were less likely to value local friendships.

Table 6.12: Proportion Value Local Friendships (Q40c) by Factors Associated with Social Exclusion

	Value Local Friendships	Unweighted base (n)
Feel isolated from family/friends	38%	78
Not in control of decisions affecting daily life, or only 'to some extent'	62%	361

Table 6.13 shows that those less likely to value local friendships were those with a high GHQ12 score and those who consumed fewer than five portions of fruit/vegetables per day. Those with positive views of their physical wellbeing, mental/emotional wellbeing and quality of life were more likely to value local friendships.

Table 6.13: Proportion Value Local Friendships (Q40c) by Health and Wellbeing Measures

	Value Local Friend-ships	Unweighted base (n)		Value Local Friend-ships	Unweighted base (n)
Positive view of physical wellbeing	77%	839	High GHQ12 score	62%	256
Positive view of mental/emotional wellbeing	76%	881	Consumes fewer than 5 portions of fruit/vegetables per day	72%	823
Positive view of quality of life	76%	912			

6.5 Social Support

Respondents were asked to indicate the extent to which they agree or disagree with the statement: "*If I have a problem, there is always someone to help me*". Those agreeing with this statement were categorised as having a positive view of social support. According to this definition, 84% overall were positive about social support.

Those in the most deprived areas were less likely than others to have a positive view of social support. However, those in the least deprived areas were also less likely to have a positive view of social support. Those without qualifications were less likely than those with qualifications to have a positive view of social support.

Table 6.14: Positive View of Social Support (Q40g) by Deprivation and Socio Economic Measures

	Positive View	Unweighted base (n)
Bottom 20% datazones	75%	547
Other datazones	85%	511
SIMD quintile		
1 (most deprived)	75%	547
2	97%	71
3	85%	80
4	93%	99
5 (least deprived)	79%	261
At least one qualification	86%	735
No qualifications	75%	314

Table 6.15 shows that all three factors associated with social exclusion were associated with a lower likelihood of expressing a positive view of social support.

Table 6.15: Positive View of Social Support (Q40g) by Factors Associated with Social Exclusion

	Positive View	Unweighted base (n)
All income from benefits	74%	264
Feel isolated from family/friends	61%	74
Not in control of decisions affecting daily life, or only 'to some extent'	74%	350

Table 6.16 shows that for health and wellbeing measures those less likely to have a positive view of social support were:

- Those with a high GHQ12 score;
- Those exceeding the recommended weekly limit for alcohol consumption;
- Obese people
- Smokers; and
- Those exposed to second hand smoke; and

Table 6.16: Positive View of Social Support (Q40g) by Health and Wellbeing Measures

	Positive View	Unweighted base (n)		Positive View	Unweighted base (n)
Positive view of physical wellbeing	86%	831	Exposed to second hand smoke	75%	366
Positive view of mental/emotional wellbeing	86%	871	Current smoker	75%	313
Positive view of quality of life	86%	904	Exceeds weekly alcohol limit	72%	163
High GHQ12 score	72%	248	Obese	74%	169

7 Summary of Comparisons with NHS Greater Glasgow & Clyde

7.1 Indicators Showing More Favourable Findings

Compared to those in the NHS Greater Glasgow & Clyde area as a whole, those in East Dunbartonshire were:

- More likely to have a positive perception of their physical wellbeing;
- More likely to have a positive perception of their mental/emotional wellbeing;
- More likely to have a positive perception of their happiness;
- More likely to have a positive perception of their quality of life;
- More likely to have any of their natural teeth;
- More likely to have visited the dentist within the last six months;
- More likely to say it was easy to get an appointment to see their GP;
- More likely to say it was easy to get an appointment at the hospital;
- Less likely to say it was difficult to get a GP consultation within 48 hours when needed;
- Less likely to be exposed to second hand smoke most or some of the time;
- Less likely to be a smoker;
- (Among smokers) more likely to intend to stop smoking;
- Less likely to exceed the recommended weekly limit for alcohol consumption;
- Less likely to have been a binge drinker in the previous week;
- More likely to participate in walking for leisure, athletics and golf;
- More likely to feel safe using local public transport;
- More likely to feel safe walking alone in their area even after dark;
- Less likely to have negative perceptions of the following issues in their area:
    - Drug activity;
    - Level of unemployment;
    - Young people hanging around;
    - Amount of car crime;
    - Amount of vandalism;
    - Number of assaults/muggings;
    - Number of burglaries.
- Less likely to have negative perceptions of the following environmental issues in their area:
    - Number of uneven pavements;
    - Amount of dogs' dirt
    - Availability of safe play spaces;
    - Amount of traffic;
    - Availability of pleasant places to walk;
    - Amount of noise and disturbance;
    - Amount of broken glass;
    - Amount of rubbish lying about;
    - Standard of street lighting;
    - Level of smells from sewers;
    - Amount of derelict land;
    - Number of vacant/derelict buildings;
    - Number of abandoned cars.
- More likely to have a positive perception of the following local services:
    - Quality of schools;
    - Food shops;
    - Childcare provision;
    - Leisure/sports facilities;
    - Police
- More likely to be married/cohabiting;
- More likely to have qualifications;

- Less likely to receive any income from benefits;
- Less likely to have difficulty meeting any type of cost/expense;
- Less likely to have a problem finding sums of £10, £100 or £1,000 to meet unexpected expenses;
- More likely to have a positive perception of their area as a place to live;
- More likely to have a positive perception of their area as a place to bring up children; and
- More likely to have a positive view of reciprocity in their area.

7.2 Indicators Showing Less Favourable Findings

Compared to those in the NHS Greater Glasgow & Clyde area as a whole, those in East Dunbartonshire were:

- Less likely to definitely feel in control of the decisions affecting their life;
- More likely to have a high GHQ12 score;
- More likely to have been to a hospital outpatient in the last year;
- Less likely to feel that they were encouraged to participate in decisions affecting their health or treatment;
- Less likely to feel that they had a say in how health services are delivered;
- Less likely to find it easy to travel to hospital for an appointment;
- Less likely to find it easy to access health services in an emergency;
- More likely to drink alcohol weekly;
- Less likely to have had two or more alcohol-free days in the previous week;
- Less likely to meet the target for physical activity;
- Less likely to have participated in water based sports or dance;
- Less likely to use active travel methods;
- Less likely to meet the target of consuming five or more portions of fruit/vegetables per day;
- Less likely to feel valued as a member of their community;
- Less likely to agree that people in their neighbourhood can influence local decisions;
- Less likely to have a positive perception of local public transport; and
- Less likely to value local friendships.

7.3 Other Significant Differences

Compared to those in the NHS Greater Glasgow & Clyde area as a whole, those in East Dunbartonshire were:

- Less likely to have visited staff at their GP surgery such as physiotherapists, chiropodists, dieticians, occupational therapists or clinical psychologists in the last year;
- Less likely to have used a pharmacist for health advice in the last year; and
- Less likely to have contacted NHS24 in the last year.

8 Trend Data

In this chapter, results from all indicator questions that represent a statistically significant change between 2011 and 2008, 2011 and 2005 or 2011 and 2002 are shown.

The formula used to test for significant change is a hypothesis test for two proportions. The 'null hypothesis' is that there is no change since 2002, since 2005 or since 2008. The following formula yields a 'test statistic' (z):

$$z = \frac{\hat{p}_1 - \hat{p}_2}{\sqrt{\hat{p}_p(1-\hat{p}_p)}\sqrt{\left(\frac{1}{n_1}\right)+\left(\frac{1}{n_2}\right)}}$$	p_1 = proportion observed in 2011 p_2 = proportion observed in 2002/2005/2008 n_1 = sample size in 2011 n_2 = sample size in 2002/2005/2008
$$\hat{p}_p = \frac{x_1 + x_2}{n_1 + n_2} = \frac{n_1 p_1 + n_2 p_2}{n_1 + n_2}$$	

If the value of z falls outside of the range (-1.96 to 1.96), we reject the null hypothesis and conclude that there has been significant change since 2002 (at the 95% confidence level).

For those results that show significant change, we have also calculated a confidence interval for the difference between any two sets of results.

$$\left(\hat{p}_1 - \hat{p}_2\right) \pm 1.96\sqrt{\frac{\hat{p}_1\left(1-\hat{p}_1\right)}{n_1} + \frac{\hat{p}_2\left(1-\hat{p}_2\right)}{n_2}}$$

For example, the confidence interval for the first result shown in Table 8.1 is (-9.1 to -0.5). This means that we can be 95% confident that, had we interviewed the entire population of East Dunbartonshire in the surveys, the actual difference between the two sets of results would be between -9.1 and -0.5 percentage points.

The tables show the results, and also show p values. Where p is less than 0.05, the change is considered to be significant. P values are reported as one of three levels of significance: <0.05, <0.01 and <0.001. A p value of <0.05 means that we can be 95% confident that a 'real' change has taken place. A p value of <0.01 means that we can be 99% confident, and a p value of <0.001 means that we can be 99.9% confident.

Only significant changes over time have been mentioned in the text. Where a change is not significant, the size of the change is not shown in the table, and no p value is shown.

It should be noted that the formulae used in this chapter only strictly apply to simple random samples, whereas this survey uses a complex multi-stage sample design. For this reason, results of tests should be interpreted with caution, particularly if the result is on the margins of statistical significance.

8.1 People's Perceptions of their Health and Illness

Between 2005 and 2011 there was a drop in the proportion of respondents who had a positive perception of their physical wellbeing.

Table 8.1: Positive Perceptions of Physical Wellbeing
Base: All

	East Dunbartonshire
2002	85.1%
2005	86.8%
2008	82.4%
2011	82.0%
Change (2005-2011)	-4.8%
P	<0.05
Confidence Interval	-9.1 to -0.5

There was no significant change in the proportion of respondents in East Dunbartonshire who had a positive perception of their mental/emotional wellbeing.

Table 8.2: Positive Perceptions of Mental or Emotional Wellbeing
Base: All

	East Dunbartonshire
2002	89.0%
2005	89.1%
2008	86.2%
2011	88.3%
Change	n/a
P	n/a
Confidence Interval	n/a

Between 2005 and 2011 there was a considerable drop in the proportion of respondents who definitely felt in control of the decisions affecting their life.

Table 8.3: Feeling Definitely in Control of Decisions Affecting Daily Life
Base: All

	East Dunbartonshire
2002	90.1%
2005	84.0%
2008	64.9%
2011	61.8%
Change (2005-2011)	-22.2%
P	<0.001
Confidence Interval	-27.1 to -17.3

There was a rise between 2008 and 2011 in the proportion of respondents who had a positive perception of their overall quality of life.

Table 8.4: Positive Perception of Overall Quality of Life
Base: All

	East Dunbartonshire
2002	92.4%
2005	89.3%
2008	87.6%
2011	92.8%
Change (2008-2011)	+5.2%
P	<0.001
Confidence Interval	+3.0 to +7.4

There was no significant change in the proportion of respondents who had a long term illness or condition affecting their daily life.

Table 8.5: Illness/Condition Affecting Daily Life
Base: All

	East Dunbartonshire
2002	13.8%
2005	18.3%
2008	20.5%
2011	17.9%
Change	n/a
P	n/a
Confidence Interval	n/a

There was a rise between 2002 and 2011 in the proportion who were receiving treatment for at least one condition.

Table 8.6: Receiving Treatment for One or More Condition
Base: All

	East Dunbartonshire
2002	34.8%
2005	39.9%
2008	43.1%
2011	41.5%
Change (2002-2011)	+6.7%
P	<0.05
Confidence Interval	+0.4 to +13.0

Between 2008 and 2011 there was a rise in the proportion of respondents who had any natural teeth.

Table 8.7: Proportion with Some/All of their Own Teeth
Base: All

	East Dunbartonshire
2002	88.1%
2005	85.4%
2008	87.7%
2011	90.3%
Change (2008-2011)	+2.6%
P	<0.05
Confidence Interval	+0.3 to +4.9

There was no significant change in the proportion of respondents who brushed their teeth twice or more per day.

Table 8.8: Proportion Brushing Teeth at Least Twice a Day
Base: Those with at least some of their own teeth

	East Dunbartonshire
2002	80.9%
2005	77.6%
2008	81.3%
2011	78.3%
Change	n/a
P	n/a
Confidence Interval	n/a

8.2 The Use of Health Services

Between 2008 and 2011 there was a drop in the proportion who had seen a GP in the last year.

Table 8.9: Proportion Seen a GP in the Last Year
Base: All

	East Dunbartonshire
2002	80.1%
2005	76.2%
2008	79.1%
2011	75.9%
Change (2008-2011)	-3.2%
P	<0.05
Confidence Interval	-6.4 to -0.0

There was no significant change in the proportion who had been to Accident & Emergency in the last year.

Table 8.10: Proportion Been to A&E in the Last Year
Base: All

	East Dunbartonshire
2002	11.4%
2005	10.7%
2008	13.6%
2011	12.8%
Change	n/a
P	n/a
Confidence Interval	n/a

There was a rise between 2002 and 2011 in the proportion of respondents who had been to a hospital outpatient in the previous year.

Table 8.11: Proportion Been to Hospital as an Outpatient to see a Doctor in the Last Year
Base: All

	East Dunbartonshire
2002	17.7%
2005	24.2%
2008	25.4%
2011	27.8%
Change (2002-2011)	+10.1%
P	<0.001
Confidence Interval	+4.9 to +15.3

There was no significant change in the proportion who had visited the dentist in the previous six months.

Table 8.12: Been to a Dentist in the Last Six Months
Base: All

	East Dunbartonshire
2002	64.4%
2005	60.4%
2008	62.1%
2011	63.7%
Change	n/a
P	n/a
Confidence Interval	n/a

8.3 Health Behaviours

The proportion of respondents who were current smokers fell between 2008 and 2011.

Table 8.13: Proportion Currently Smoking (On Some or Every Day)
Base: All

	East Dunbartonshire
2002	16.4%
2005	24.0%
2008	22.6%
2011	16.8%
Change (2008-2011)	-5.8%
P	<0.001
Confidence Interval	-8.8 to -2.8

There was a drop between 2008 and 2011 in the proportion who were exposed to second hand smoke some or all of the time.

Table 8.14: Proportion Exposed to Smoke (Some or All the Time)
Base: All

	East Dunbartonshire
2002	37.0%
2005	45.5%
2008	28.9%
2011	25.3%
Change (2008-2011)	-3.6%
P	<0.05
Confidence Interval	-6.9 to -0.3

There was no significant change in the proportion who exceeded the recommended weekly limit for alcohol consumption.

Table 8.15: Proportion Exceeding Recommended Alcohol Limit in Preceding Week (Based on old estimates of units)
Base: All

	East Dunbartonshire
2002	10.1%
2005	14.1%
2008	12.4%
2011	12.8%
Change	n/a
P	n/a
Confidence Interval	n/a

There was a drop between 2008 and 2011 in the proportion who met the target of taking 30 minutes or more of moderate physical activity on five or more days per week.

Table 8.16: Proportion Meeting the Physical Activity Target of 30 Minutes of Moderate Physical Activity on Five or More Days Per Week
Base: **All Greater Glasgow & Clyde**

	Total Sample
2002	46.3%
2005	43.6%
2008	53.2%
2011	41.6%
Change (2008-2011)	-11.6%
P	<0.001
Confidence Interval	-15.3 to -7.9

Between 2008 and 2011 there was a drop in the proportion of respondents who met the target of consuming five or more portions of fruit/vegetables per day.

Table 8.17: Proportion Meeting the Fruit and Vegetable Consumption Target
Base: All

	East Dunbartonshire
2002	40.0%
2005	34.4%
2008	41.3%
2011	29.5%
Change (2008-2011)	-11.8%
P	<0.001
Confidence Interval	-15.3 to -8.3

There was no significant change in the proportion who ate two or more portions of oily fish per week.

Table 8.18: Proportion Eating Two or More Portions of Oily Fish Per Week
Base: All

	East Dunbartonshire
2002	25.6%
2005	33.4%
2008	28.5%
2011	28.3%
Change	n/a
P	n/a
Confidence Interval	n/a

Between 2005 and 2011 there was a rise in the proportion who exceeded the recommended limit of one high fat/sugary snack per day.

Table 8.19: Proportion Eating More than the Recommended Amount of High Fat and Sugary Snacks
Base: All

	East Dunbartonshire
2002	29.1%
2005	25.8%
2008	36.1%
2011	34.9%
Change (2005-2011)	+9.1%
P	<0.01
Confidence Interval	+3.7 to +14.5

Between 2008 and 2011 there was a rise in the proportion of respondents who were overweight (BMI of 25 or more). Between 2002 and 2011 there was a rise in the proportion of respondents who were obese (BMI of 30 or more) and a rise in the proportion who were extremely obese (BMI of 35 or more).

Table 8.20: Body Mass Index
Base: All

	East Dunbartonshire
BMI of 25 or over	
2002	43.8%
2005	40.9%
2008	42.8%
2011	51.8%
Change (2008-2011)	+9.0%
P	<0.001
Confidence Interval	+5.2 to +12.8
BMI indicting obese/extremely obese	
2002	9.9%
2005	14.9%
2008	13.1%
2011	14.6%
Change (2002-2011)	+4.7%
P	<0.05
Confidence Interval	+0.6 to +8.8

8.4 Social Health

Between 2008 and 2011 there was a drop in the proportion of respondents who felt isolated from family/friends.

Table 8.21: Proportion Isolated from Family and Friends
Base: All

	East Dunbartonshire
2002	7.4%
2005	9.5%
2008	14.5%
2011	8.8%
Change (2008-2011)	-5.7%
P	<0.001
Confidence Interval	-8.0 to -3.4

There was a rise between 2008 and 2011 in the proportion who felt they belonged to the local area.

Table 8.22: Proportion Feeling they Belong to Local Area
Base: All

	East Dunbartonshire
2002	86.6%
2005	78.6%
2008	77.3%
2011	80.9%
Change (2008-2011)	+3.6%
P	<0.05
Confidence Interval	+0.6 to +6.6

There was a drop between 2002 and 2011 in the proportion who felt valued as members of their community.

Table 8.23: Proportion Feeling Valued as Member of their Community
Base: All

	East Dunbartonshire
2002	66.6%
2005	59.1%
2008	55.8%
2011	57.4%
Change (2002-2011)	-9.2%
P	<0.01
Confidence Interval	-15.5 to -2.9

There was a considerable drop between 2008 and 2011 in the proportion who felt that local people could influence local decisions.

Table 8.24: Proportion Feeling Local People Can Influence Decisions
Base: All

	East Dunbartonshire
2002	77.4%
2005	62.2%
2008	80.7%
2011	59.2%
Change (2008-2011)	-21.5%
P	<0.001
Confidence Interval	-24.9 to -18.1

There was a rise between 2008 and 2011 in the proportion who felt safe in their own home, felt safe using local public transport and felt safe walking alone in their area even after dark.

Table 8.25: Proportion Feeling Safe in Their Own Home
Base: All

	East Dunbartonshire
2002	98.9%
2005	93.9%
2008	97.7%
2011	99.0%
Change (2008-2011)	+1.3%
P	<0.05
Confidence Interval	+0.4 to +2.2

Table 8.26: Proportion Feeling Safe Using Public Transport
Base: All

	East Dunbartonshire
2002	89.7%
2005	76.9%
2008	88.3%
2011	94.3%
Change (2008-2011)	+6.0%
P	<0.001
Confidence Interval	+4.0 to +8.0

Table 8.27: Proportion Feeling Safe Walking Alone After Dark
Base: All

	East Dunbartonshire
2002	80.2%
2005	66.4%
2008	71.9%
2011	83.4%
Change (2008-2011)	+11.5%
P	<0.001
Confidence Interval	+8.5 to +14.5

8.5 Individual Circumstances

The proportion who were married or living as married fell between 2005 and 2011.

Table 8.28: Proportion Cohabiting / Married etc
Base: All

	East Dunbartonshire
2002	70.0%
2005	71.5%
2008	64.7%
2011	65.7%
Change (2005-2011)	-5.8%
P	<0.05
Confidence Interval	-11.4 to -0.2

There was a drop between 2005 and 2011 in the proportion who lived in households with children aged under 14.

Table 8.29: Proportion with Children Under 14
Base: All

	East Dunbartonshire
2002	41.0%
2005	34.4%
2008	25.0%
2011	23.7%
Change (2005-2011)	-10.7%
P	<0.001
Confidence Interval	-16.3 to -5.1

There was a drop between 2005 and 2011 in the proportion who were the only adult in a household with children aged under 14.

Table 8.30: Proportion who Are Lone Parents of Children Under 14
Base: All

	East Dunbartonshire
2002	3.4%
2005	6.7%
2008	1.9%
2011	2.3%
Change (2005-2011)	-4.4%
P	<0.001
Confidence Interval	-7.2 to -1.6

Between 2008 and 2011 there was a rise in the proportion of respondents who had no qualifications.

Table 8.31: Proportion with No Qualifications
Base: All

	East Dunbartonshire
2002	13.8%
2005	24.8%
2008	7.7%
2011	15.9%
Change (2008-2011)	+8.2%
P	<0.001
Confidence Interval	+5.7 to +10.7

There was a drop between 2008 and 2011 in the proportion of respondents who received all household income from state benefits.

Table 8.32: Proportion with all Income from State Benefits
Base: All

	East Dunbartonshire
2002	14.4%
2005	12.6%
2008	11.5%
2011	6.9%
Change (2008-2011)	-4.6%
P	<0.001
Confidence Interval	-6.7 to -2.5

There was a rise between 2008 and 2011 in the proportion of respondents who had a positive perception of their household income.

Table 8.33: Proportion with a Positive Perception of Household Income
Base: All

	East Dunbartonshire
2002	74.2%
2005	86.3%
2008	75.7%
2011	86.1%
Change (2008-2011)	+10.4%
P	<0.001
Confidence Interval	+7.5 to +13.3

There was a drop between 2008 and 2011 in the proportion who said they would have difficulty finding unexpected expenses of £100 or £1,000.

Table 8.34: Proportion Having Difficulties Finding Unexpected Expenses

	East Dunbartonshire
Difficulty finding £20	
2002	0.2%
2005	0.6%
2008	1.8%
2011	1.4%
Change	n/a
P	n/a
Confidence Interval	n/a
Difficulty finding £100	
2002	3.9%
2005	2.5%
2008	10.2%
2011	5.6%
Change (2008-2011)	-4.6%
P	<0.001
Confidence Interval	-6.6 to -2.6
Difficulty finding £1,000	
2002	18.6%
2005	26.4%
2008	35.3%
2011	23.7%
Change (2008-2011)	-11.6%
P	<0.001
Confidence Interval	-15.0 to -8.2

Between 2005 and 2011 there was a fall in the proportion of respondents who said the main wage earner in their household was employed full time.

Table 8.35: Proportion of Main Wage Earners Employed Full Time
Base: All

	East Dunbartonshire
2002	69.3%
2005	70.9%
2008	61.4%
2011	57.9%
Change (2005-2011)	-13.0%
P	<0.001
Confidence Interval	-18.7 to -7.3

There was a rise between 2002 and 2011 in the proportion of respondents who lived in households where no adult was employed.

Table 8.36: Proportion of Respondents in Households with No Adults in Employment
Base: All

	East Dunbartonshire
2002	23.3%
2005	29.3%
2008	31.5%
2011	30.9%
Change (2002-2011)	+7.6%
P	<0.05
Confidence Interval	+1.9 to +13.3

8.6 Social Capital

Between 2008 and 2011 there was a rise in the proportion of respondents who had a positive perception of their area as a place to live.

Table 8.37: Proportion with a Positive Perception of Local Area as a Place to Live
Base: All

	East Dunbartonshire
2002	90.4%
2005	93.4%
2008	93.7%
2011	95.9%
Change (2008-2011)	+2.2%
P	<0.05
Confidence Interval	+0.6 to +3.8

Between 2002 and 2011 there was a rise in the proportion who had a positive perception of their area as a place to bring up children.

Table 8.38: Proportion with Positive Perception of Local Area as a Place to Bring Up Children
Base: All

	East Dunbartonshire
2002	90.0%
2005	91.8%
2008	93.3%
2011	94.7%
Change (2002-2011)	+4.7%
P	<0.01
Confidence Interval	+0.9 to +8.5

There was a rise between 2008 and 2011 in the proportion who had a positive perception of reciprocity in their area.

Table 8.39: Proportion with Positive Perception of Reciprocity
Base: All

	East Dunbartonshire
2002	83.8%
2005	74.8%
2008	76.9%
2011	81.1%
Change (2008-2011)	+4.2%
P	<0.01
Confidence Interval	+1.2 to +7.2

There was a drop between 2008 and 2011 in the proportion who had a positive perception of trust in their area.

Table 8.40: Proportion with Positive Perception of Trust
Base: All

	East Dunbartonshire
2002	87.5%
2005	81.3%
2008	82.0%
2011	78.8%
Change (2008-2011)	-3.2%
P	<0.05
Confidence Interval	-6.2 to -0.2

Between 2002 and 2011 there was a drop in the proportion of respondents who valued local friendships.

Table 8.41: Proportion Valuing Local Friendships
Base: All

	East Dunbartonshire
2002	85.1%
2005	72.3%
2008	72.3%
2011	74.2%
Change (2002-2011)	-10.9%
P	<0.001
Confidence Interval	-15.8 to -6.0

There was a rise between 2008 and 2011 in the proportion of respondents who had a positive perception of social support.

Table 8.42: Proportion with a Positive Perception of Social Support
Base: All

	East Dunbartonshire
2002	84.1%
2005	78.5%
2008	75.1%
2011	84.2%
Change (2008-2011)	+9.1%
P	<0.001
Confidence Interval	+6.1 to +12.1

APPENDIX A: SURVEY METHODOLOGY & RESPONSE

Authorship

This appendix has been prepared by Progressive, who were responsible for the survey fieldwork.

Sampling

It was necessary to adopt a sampling system which would be:

- representative of the population of the Board's area as a whole in terms of age, sex, geographical distribution and index of deprivation;
- comparable with the system used in previous years, to allow results to be compared across all surveys;
- replicable, so that future surveys can track indicators over time.

The sample was stratified by local authority, sample type (main, boost, enhanced boost and by SIMD). The target sample was 6145.

To achieve this, 618 clusters were sampled in proportion to the population in each local authority, with a view to achieving an average of 10 random interviews per cluster.

The sampling itself was conducted and sourced by NHS Greater Glasgow and Clyde in agreement with Progressive and took the following approach. Allan Boyd, Senior Information Analyst, NHS GGC took on the key role of sourcing and designing the sample approach based on the approach taken in previous surveys.

Sample was based on:

- A Postcode Address File generated sample of 12,560 for the NHS GGC area split into constituent CH(C)P areas including addresses from Glasgow City, East Dunbartonshire, East Renfrewshire, Renfrewshire, Inverclyde, West Dunbartonshire, South and North Lanarkshire
- Postcode definitions were supplied by NHS GGC
- Each sample point was defined by an output area (data zone) and sample points were randomly generated.

The sample was split into several parts (see Table A1)

- a main sample of 2,400 interviews
- enhanced boost samples of 1,291 for Glasgow City South sector and 900 for East Dunbartonshire CH(C)P
- basic boosted sample of 1,554 for East Renfrewshire, Renfrewshire, Inverclyde and West Dunbartonshire CH(C)P areas
- there were no boosts required for Glasgow City North East, North West nor North and South Lanarkshire
- The main sample was representative of NHS GGC population in terms of CHCP and SIMD (15% most deprived areas) within each CHCP (definitions were supplied by NHS GGC)
- The basic boost samples were evenly spread across the CH(C)P areas

Table A1: Sample breakdown

Areas	Main Sample		Basic Boost	Enhanced Boosts				Total
	15%	Others	All	15%	Others	20%	Others	
NE Glasgow	190	174						**364**
NW Glasgow	135	261						**397**
South Glasgow	166	280		429	318			**1193**
South West Glasgow				302	242			**544**
East Dunbartonshire	6	205				509	391	**1111**
East Renfrewshire	6	166	424					**596**
Renfrewshire	60	282	256					**598**
Inverclyde	56	106	432					**595**
West Dunbartonshire	45	106	442					**593**
South Lanarkshire	31	85						**116**
North Lanarkshire	0	39						**39**
Total	**695**	**1705**	**1554**	**731**	**560**	**509**	**391**	**6145**
South Sample inc SW boost	**166**	**280**		**731**	**560**	**0**	**0**	**1737**
Total Sample inc SW boost	**695**	**1705**	**1554**	**731**	**560**	**509**	**391**	**6145**

NOTE: the figures above were estimates used prior to the actual sample being provided and hence the figures above are slightly different to those in Tables 2 (splitting the interviews by waves and by sample points).

The Glasgow South enhanced boost sample was multi-level; the South boost required over sampling in the 15% most deprived areas and within this there had to be enough interviews obtained from the former South West CHCP to allow analysis at 15% and other areas levels (see Table A1).

The East Dunbartonshire enhanced boost sample was also required for the 20% most deprived SIMD areas and other areas with substantial over sampling in the 20% most deprived areas.

The required outputs from the selected sampling agency (UK Changes) were:

- Full address (4 fields)
- Postcode
- Output area
- Local Authority name
- CH(C)P code (inc 3 sectors within new Glasgow City CHCP and a flag to identify those from the old South West CHCP)
- Datazone
- SIMD score
- SIMD rank
- PAFMOC (household number per dwelling)

Fieldwork

In terms of rolling out the fieldwork Progressive and NHS GGC decided that it would be beneficial for the randomness of the sampling for the project if the sample points could be distributed across the survey period in a random fashion (as compared to doing it by local authority or by CH(C)P, for example). This was felt to be the optimum approach that would ensure that each sample point was randomly allocated to a wave and as such that there was no bias in the results that could be related to when or where the interviews were conducted. This approach was taken to ensure that, for example, if there was a locally based issue in relation to health or crime (a sharp rise in crime or a murder, for example) that interviews for that area would not be conducted all at the same time but would be spread over the four waves. It was agreed that this suggested design made sense and was agreed as a way forward for all of the selected sample points. This also meant that the changing weather (and the possible impacts this might have on health and well being) would not have a locational impact as a result of sampling.

The four waves of the fieldwork and the random selection of sampling points was carried out using the approach noted below:

1. A single sample file was set up from the sample worksheets provided by UK Changes (these were split by CH(C)P area)
2. A unique ID was added for each address in the combined sample
3. A 'tag' was added to each of the 618 sample points so we knew which sample type each sample point had been sourced from
4. Using the rand() function in Excel each sample point (of which there were 618) was allocated a random number and these were then sorted numerically and then split into
    a. Wave 1 (approx. 25% of the total number of required interviews) – to be conducted August to mid September
    b. Wave 2 (approx. 33% of the total number of required interviews) – to be conducted mid September to mid October
    c. Wave 3 (approx. 33% of the total number of required interviews) – to be conducted mid October to mid November
    d. Wave 4 (approx. 9% of the total number of required interviews) – to be conducted mid November to mid December
5. The wave sample point selections were then checked using pivot tables in Microsoft Excel to detail the number of sample points per wave by CH(C)P and Local Authority

These tables are replicated below and were used as a guide to ensure that targets were met during the four waves of the fieldwork.

Table A2: Final interviewing numbers per CHP per wave

CHP	August-mid Sept Wave 1	Mid Sept-mid Oct Wave 2	Mid Oct-mid Nov Wave 3	Mid Nov-mid Dec Wave 4	Grand Total
East Dunbartonshire CHP	222	317	397	159	**1095**
East Renfrewshire CHCP	148	172	220	51	**591**
Glasgow North East	71	129	139	21	**360**
Glasgow North West	95	99	147	74	**415**
Glasgow South	440	539	504	232	**1715**
Inverclyde CHCP	170	202	146	64	**582**
North Lanarkshire CHP	10	20	0	11	**41**
Renfrewshire CHP	162	169	231	20	**582**
South Lanarkshire CHP	30	19	76	10	**135**
West Dunbartonshire CHCP	161	247	138	42	**588**
Grand Total	**1509**	**1913**	**1998**	**684**	**6104**

Questionnaire Design and Pilot

The survey questionnaire was based on the questionnaire used in 2008, but had been revised by NHS GGC to ensure that the questionnaire fitted with current policy and thinking. For example, the questionnaire had been shortened and several new questions had been added. There was also some minor updating of key demographic and characteristic questions and these were mostly relating to the harmonisation questions that had been issued by the Scottish Government.

Once a draft questionnaire had been agreed, a pilot survey was conducted. Three interviewers conducted ten interviews each and interviews were carried out to the following quotas:

Pilot Quota Sheet

Total	**10/interviewer**	
Male	Min 4	
Female	Min 4	
16 – 35	Min 3	
36 – 55	Min 3	
55+	Min 3	
AB	Min 2	
C1	Min 2	
C2	Min 2	
CE	Min 2	

Respondent:	Occupation/ industry sector (+ as much job detail to allow you to SEG) of CIE in household.	SEG:
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

The pilot ensured that:

- the questionnaire structure flowed easily, thereby maintaining the interest of the respondent over the duration of the interview which was not considered to be onerous;
- the routing of questions was complete;

- the questions were understood by a range of respondents. It was recognised that the questions had to be coherent and meaningful to people of different levels of ability.

Following the pilot, a few minor changes were made to the questionnaire, but question wording largely remained as it was in 2008 for the vast majority of the questions asked. Near the end of the questionnaire design process the Scottish Government issued a set of guidance notes on key harmonisation and comparison questions and some of these changes were discussed and in the end were included in the final draft of the working questionnaire. The changes were not major and tended to cover socio-demographic questions only.

One important point of note is that guidance from the Market Research Society also pointed to a requirement to include some extra options for respondents, allowing them the opportunity not to answer questions – again this was also a critical aspect of utilising CAPI

interviewing for the project where the flow and full completion of the surveys requires that respondents can actually answer a question in a way that they would want – in many cases this included the inclusion of 'don't know', 'not applicable' or 'prefer not to say' responses. Again, these are highlighted when comparing the 2008 survey questionnaire with the 2011 final survey questionnaire – these options were often not visually included in show cards used (a normal and standard approach) but were included in the CAPI script if respondents could not provide an informed response to a question asked.

Fieldwork

A team of 21 interviewers attended a briefing session which was conducted by Progressive executive staff and the fieldwork supervisor and which was attended by NHS GGC staff. The briefing session involved full instructions in the conduct of the survey interview and these were based on the notes used during the pilot making changes and amendments where necessary. Written instructions were given to all interviewers. Additional fieldwork staff were briefed separately as the full team used could not attend the two half days sessions that were organised – these were conducted by fieldwork supervisors and executive staff from Progressive.

Interviewers were assigned a number of sample points. A list of 20 random addresses was issued per cluster, with interviewers being instructed to obtain at least 10 interviews from each sample point issued. Their instructions were to make at least four calls at an address at different times of the day and on different days of the week before classifying the address as a non-response. A contact sheet was completed by the interviewer for each address and this outcome was logged so that response rates could be fully monitored throughout the four waves of the fieldwork period. The same codes were used as had been used in previous surveys to ensure consistency in coding of, in particular, reasons for non-response.

Respondents were randomly selected within households using the 'next birthday rule'. The person aged 16 or over who would next have a birthday was chosen for interview. In cases where the next birthday was not known, a Kish grid was used to make a random selection. The kish grid was also used where an address included multiple households.

Each sampled address was sent an advance letter from NHS GGC explaining the purpose of the survey and requesting involvement. As a result of this letter, a number of residents (approx 3%) contacted NHS GGC and Progressive to 'opt out' of the survey. These addresses were removed from the lists given to interviewers and these households were not contacted further by Progressive.

Each interviewer was also provided with a 'letter of authorisation' to show on the doorstep. Interviewers were also instructed to carry their MRS photo-identity card at all times and to display this to all potential respondents.

Response

Fieldwork began on August 8th 2011, and the target was to have four waves of interviews conducted between August and December 2011. The four waves were designed to ensure that each wave had a random selection of the available sampling points (a total of 618 sample points were developed through the sampling approach). To ensure that the selection of the sample points was random these were selected using a random number generator in Microsoft Excel and then placed in order – this ensures that each wave has a random selection of sample points and as such, the timing of the interviews was not focused in any one CHCP/geographic location.

The table overleaf shows the outcome of attempted contacts:

Table A3: Outcome of Attempts to Interview

Outcomes	2011 n	2011 % of in-scope	2011 % of all contacts
In-scope (interview possible)			
Interview obtained	6104	68.8%	48.6%
Office refusal (telephone/letter)	385	4.34%	3.07%
Number of people in household information refused	62	0.70%	0.49%
No household contact after 4+ calls	954	10.75%	7.60%
Household contact achieved but contact with selected person not achieved after 5+ visits	304	3.43%	2.42%
Personal refusal by selected person	961	10.83%	7.65%
Proxy refusal on behalf of selected person	42	0.47%	0.33%
Broken appointment, no recontact	8	0.09%	0.06%
Ill at home during survey period	4	0.05%	0.03%
Away/in hospital during survey period	19	0.21%	0.15%
Selected person has dementia	9	0.10%	0.07%
English not first language. Consent to use an interpretor was not achieved	23	0.26%	0.18%
Incomplete interview	0	0.00%	0.00%
Total in-scope	***8875***	***100.0%***	***70.66%***
Out of scope (no interview possible)			
Insufficient address	0		0.00%
Not traced	55		0.44%
Not yet built / not yet ready for occupation	0		0.00%
Derelict/demolished	133		1.06%
Empty/vacant	115		0.92%
Business/industrial only (not private)	56		0.45%
Institution only	7		0.06%
Other: Buzzer entry – no access (59); Gated entry – no access (23); Sample achieved (11); Security dogs (7); Parish church (1)	101		0.80%
Total out-of-scope	***467***		**3.72%**
Unresolved attempts (cluster quotas were achieved so the address was untried) – treated as 'out of scope'	3218		
Total contacts	**12560**		

Thus the response rate for the project was 68.8%

Data Coding and Input

A specially devised data entry programme was set up to allow data to be entered directly onto computer through the CAPI machine, as such there was no direct data inputting as this was part of the actual survey instrument. The CAPI programme included route, range and logic checks based on the final questionnaire.

APPENDIX B: DATA WEIGHTING

Introduction

Data were weighted to ensure that they were as representative as possible of the adult population in the NHSGGC area. This appendix describes the weighting processes.

Household Size Weighting

In this survey, households were selected at random and therefore had equal probability of selection. However within the household the probability of an individual's selection is not necessarily equal to that of others, since it is inversely proportional to the number of people available to be selected. For example, in a single-person household the probability of selection is exactly 1, whereas in a four-person household the probability of selection is 1/4. The logic of this implies that the respondent from the single-person household represents one person (him/herself) while the respondent from the four-person household is in fact representing four people. It is normal to allow for this bias by 'weighting' the sample to give the respondent from the four-person household four times the 'weight' of the respondent from the one-person household. It is usual to calculate this weighting in such a way that the sum of the weights matches the sample size.

The formula for calculating the household size weight was:

$$Wf = F \times \frac{T}{A}$$

Where:

- *Wf* is the household size weighting factor for a respondent living in a household size F.
- *F* is the household size
- *T* is the total number of respondents
- *A* is the total number of adults in all households where a successful interview took place.

Weighting by Age/Gender/Bottom 15%/CH(C)P

Firstly the household size weighting was applied to the dataset. This produced the new 'actual' counts to which we applied the age/sex/bottom15%[3]/CH(C)P weighting frame to produce the final weighting factors. This ensured that the weighted data would reflect the overall Greater Glasgow and Clyde population in terms of age, gender, bottom 15%/other areas and CH(C)P areas. The formula for this stage of the weighting process was:

$$Wi = \frac{ci}{C} \times \frac{T}{ti}$$

Where:

W_i is the individual weighting factor for a respondent in age/gender/bottom15% versus other areas/CH(C)P area group i

c_i is the known population in age/gender/bottom15% versus other areas/CH(C)P area group i

[3] Bottom 20% in the case of East Dunbartonshire

C is the total adult population in the NHS Greater Glasgow and Clyde area

T is the total number of interviews

t_i is the number of interviews (weighted by the household size weighting factor) for age/gender/bottom15% versus other areas/CH(C)P area group i

APPENDIX C: INDEPENDENT VARIABLES

The table below lists the independent variables used for the analysis in this report, showing for each the number of categories and how these categories were formed.

Independent Variable	Number of categories	Categories
Gender	2	Men; Women
Age	7	16-24; 25-34; 35-44; 45-54; 55-64; 65-74; 75+
Age/Gender	6	Men 16-44; Women 16-44; Men 45-64; Women 45-64; Men 65+; Women 65+
Bottom 20% vs the rest	2	20% most deprived datazones; Other datazones
SIMD quintile	5	1 (most deprived quintile), 2, 3, 4, 5 (least deprived quintile)
Educational Qualifications	2	No qualifications; At least one qualification
All income from benefits	2	All household income from benefits; Not all household income from benefits
Whether isolated from family and friends	2	Does ever feel isolated from family/ friends; Does not ever feel isolated from family/friends
Whether have control over decision affecting daily life	2	'Definitely' feel in control of decisions; Only feels in control of decisions 'to some extent' or not at all
Self assessed: general health	2	Q1='very good' or 'good; Q1='fair' 'bad' or 'very bad'
Self assessed: physical health	2	Positive perception (Q35b); Neutral or negative perception (Q35b)
Self assessed: mental health	2	Positive perception (Q35c); Neutral or negative perception (Q35c)
Quality of life	2	Positive perception (Q35a); Neutral or negative perception (Q35a)
GHQ12	2	High GHQ12 score (4+); Low GHQ12 score (less than 4)
Limiting illness/condition	2	Has long term condition (yes at Q3); Does not have long term condition (no at Q3)
Exposed to second Hand Smoke	2	In places with other smokers 'most of the time' or 'some of the time'; 'Seldom' or 'never' in places where others smoke
Current smoking	2	Current smoker; Not current smoker
Exceeds weekly alcohol limits (based on new units - See Appendix D)	2	Exceeds weekly (gender-specific) alcohol limits; Does not exceed weekly (gender specific) alcohol limits
Obese	2	Not obese (BMI of under 29.2); Obese (29.2 or over)
Fruit and veg consumption	2	Consumes 5+ portions of fruit/veg per day; Consumes fewer than 5 portions of fruit/veg per day

Appendix D: ASSUMPTIONS OF NUMBER OF UNITS OF ALCOHOL IN EACH TYPE OF DRINK (2005 and 2008/2011)

The table below shows the assumed number of units of alcohol in each type of drink that were used for the calculation of unit consumption in 2005, and the new assumptions that have been applied in 2008 and 2011

	Unit Assumption Used for Analysis 2005	Unit assumption used for analysis 2008 and 2011
Normal strength beer - pints	2.30	2.80
Normal strength beer - cans	1.80	2.20
Normal strength beer bottles	1.00	1.70
Strong beer - pints	2.80	3.40
Strong beer - cans	2.25	2.60
Strong beer - bottles	1.80	2.00
Extra strong beer - pints	5.00	5.10
Extra strong beer - cans	4.00	4.00
Extra strong beer - bottles	3.00	3.00
Single measures spirits	1.00	1.00
Single measure martini/sherry/buckfast etc	1.00	1.00
Small glass wine	1.00	1.75
Large glass wine	2.00	3.50
1/2 bottle wine	4.50	5.25
Full bottle wine	8.75	10.50
Small bottle of alcopops	1.50	1.40
Large bottle of alcopops	n/a	5.45

APPENDIX E: ANNOTATED SURVEY QUESTIONNAIRE

The survey questionnaire is presented here. Where relevant, questions show:

- The number of respondents who answered the question (with "don't know", refused and missing responses removed). These are **unweighted** and shown as "(n=)" after the question;

- The percentage of respondents who gave each response. These are **weighted**.

In some cases, the mean response rather than the percentage giving individual responses is given. These are also weighted.