



Building Momentum for Change

Report of the Director of Public Health on Population Health in
NHS Greater Glasgow and Clyde 2013-2015

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Introduction: Personal Reflections

I am pleased to publish my fourth biennial report on the health of people living in Greater Glasgow and Clyde. This report is focused on poverty and health, recognising that human health is shaped by the many life circumstances, behaviours, environmental and cultural contexts that we encounter throughout our entire lives. Some of these factors are critical at particular points in the life course, with cumulative, additive and multiplicative impacts on subsequent health. Given the vital importance of these life course influences, we focus in Chapters 1-3 on the factors which powerfully shape future health at three key life stages of the early years, adolescence and older age and identify priorities for action in addressing these in a context of poverty and disadvantage.

The report then focuses on two specific population subgroups which merit individual chapters because these subgroups systematically face a greater risk of poverty and disadvantage, often as a result of life course factors. The two subgroups explored in depth within this report, in common with other disadvantaged sections of the population, experience vulnerability at many levels. Not only do they have substantially increased health need (such as mental health, adverse lifestyle and addictions issues, with all their attendant health impact), they also have less personal resilience, weaker social support networks and, all too often, poor experience of statutory services which can appear incoherent to the service user. Looked after and accommodated young people are a particularly vulnerable group, with many failing to reach their full potential and going on to experience major problems in later life. These issues play out in the second subgroup discussed in the report: the prison population, a substantial proportion of who have experienced the formal care system. Neither population subgroup has been included in detail in previous reports. In the past year, public health staff have undertaken work on needs assessment and planning for both subgroups.

The report concludes with a call for a collective movement for change based on the many recommendations and aspirations in the report and makes the case for a coherent response across the public systems.

Since taking up post in 2006, I have published a report on the health of the population of NHS Greater Glasgow and Clyde every two years. The first of these reports, “A Call to Debate: A Call to Action” (2007) presented information on health in west central Scotland around the themes from “Let Glasgow Flourish” (Hanlon et al 2006). These themes were:

- There are lessons to be learned from what is getting better
- Health inequalities are increasing
- Our least healthy communities are unlike our healthy communities in every way
- Significant changes are taking place in our population
- The obesity epidemic must be taken seriously
- Alcohol is an increasing problem
- Sustainability should be a more explicit consideration

Since then, two further reports have been published; “An unequal struggle for Health” in 2009 and “Keeping Health in Mind” in 2011. These reports provided more detail and progress on specific aspects of the original seven themes and then this current report explores the theme of inequalities in health in relation to poverty.

Many of the issues outlined in my previous reports remain public health challenges for Greater Glasgow and Clyde. One important example is alcohol-related harm. There is evidence of a reduction in alcohol related mortality in some age groups but the level of harm caused by overconsumption of alcohol to our population remains significant. There has been real progress in areas for action described in the three previous reports, including the use of alcohol brief interventions, influence on local licensing policies and national developments on access and price. However all

community planning partnerships must continue to progress the priorities for action on alcohol described in previous reports. I decided there was limited value in repeating these recommendations here but I refer readers to the previous reports. Tackling obesity is a similar issue in terms of continuing the need for action on priorities identified in previous reports.

The 2011 report “Keeping Health in Mind” focused on mental health. Again, there is a strong relationship with the issues in this report. In the current financial climate there is stress about money, work and debt. Stress has a particular impact on both pregnant women and parents. The effects on their children can be life-long. Michael Marmot’s report Fair Society, Healthy Lives suggests “To have any impact on health inequalities we need to address the social gradient in children’s access to positive early experiences.”

I have been struck by stories told by parents at events this year: at the Poverty Truth Commission, at a Poverty Alliance workshop in June 2013 and at a Glasgow Centre for Population Health seminar on lone parents in October 2013. The stories came from lone parents struggling through welfare reforms and finding employment; kinship carers talking about trying to give grandchildren a better life but struggling to make ends meet; and also from parents who have experienced and benefited from a positive parenting intervention. Stories can give circumstances a reality that statistics and graphs are unable to do. These stories of people’s lives, struggles and resilience were moving and informative.

Philip Pulman said “After nourishment, shelter and companionship, stories are the things we need most in the world.” Stories are important to families because reading them to children is nurturing and supports their language development. This is an important part of parenting. I remain committed to the implementation of the evidence-based parenting programme Triple P, despite some media and journal reports questioning progress. I have heard inspirational stories of parents and

practitioners benefiting from the programme. Parents who complete groups or one to one Triple P interventions are showing significant improvements to their own mental health and their child's behaviours. As part of the national early years' collaborative approach, we are utilising improvement science to support true engagement with families. We are ensuring that more staff have dedicated time to deliver parenting support. The topic of the first chapter of the report is early years.

Stephen Fry said “no adolescent ever wants to be understood which is why they complain about being misunderstood all the time.” We need specific approaches for young people. It is not uncommon for teenagers and young adults to suffer from mental ill health and — as reported recently by Jacqueline Campbell (2013) — once smoking is excluded depression, stress and anxiety are the conditions most closely associated with physical ill health. Chapter 2 explores the transitions of adolescence. It makes ambitious recommendations for improving coordination and linkages between health services, the youth sector and local communities. Service responses should be locally relevant but there needs to be greater consistency across GGC.

Life expectancy in Scotland continues to improve but healthy life expectancy is pretty static: more people are living longer but with chronic disease. Multi morbidity requires a new model of care, taking account of the complex health, emotional and social problems which can make management so challenging, especially in socio-economically deprived areas. Our goal must be to enhance healthy life expectancy as described in Chapter 3 of this report. We can do this by reducing risk factors earlier in life, offering anticipatory care and supporting self-management. Partnering with patients in the management of long term conditions must become far more than rhetoric as it can improve both quality of care and also health care efficiency. It will require a fundamental shift in the power relationships in health, working alongside patients, their families and local communities.

As I reflect on my career in public health, it can seem as if we have identified the poor health of looked after children and young people for most of that time. While it is right to continue to highlight this issue, it is also important to describe the real, practical progress that partner agencies across Greater Glasgow and Clyde have made. There is evidence that structured, systemic family based programmes can reduce the risks for vulnerable children at home and improve the care they receive if the local authority takes the child into substitute care. These interventions meet the exacting standard of 'Blueprints', a US quality measure used by Federal Government. Examples include Functional Family Therapy and Multi Systemic Therapy both of which provide intensive interventions to improve young people's behaviour and functioning. These programmes are now being delivered by local authorities with NHS clinical support. Chapter 4 makes important recommendations about how to support these developments.

The health of prisoners is explored in Chapter 5. I was privileged to be part of the Commission on Women Offenders under the chairmanship of Dame Elish Angiolini last year. It gave me new insights into the needs and issues of women offenders in Scotland. The new Women's Justice Centre in Glasgow will attempt to meet the needs of women in a holistic and meaningful way and to learn from the excellent work already going on at the 218 Centre in Glasgow. I look forward to contributing to its development and I have been pleased at the progress made at a national level in implementing the recommendations of the commission.

Many of the issues about poverty and inequality discussed in this report can only be addressed in a fairer society. However, much can be done to improve health through the development of productive therapeutic relationships between professionals and patients or clients. It is vital that the NHS and other public sector agencies support front-line staff in dealing with the emotionally demanding aspects of working with people experiencing disadvantage and in building positive relationships with their patients.

At the Faculty of Public Health in Scotland annual conference this year, the public health community in Scotland were called to action on issues of social justice. Rich Mitchell of the University of Glasgow and Iona Heath (immediate past president of the Royal College of General Practitioners) were particularly inspirational. Rich encouraged the conference to consider actions to reduce the impact on health of social and economic inequality. Iona eloquently argued for public health advocacy about social justice. Both presentations used data from social attitudes surveys to make a strong case for influencing public attitudes about poverty and inequality in order to create a more equal and healthier Scotland. I hope this report helps that cause and I encourage all readers to join in this endeavour.

My excellent public health team — whose work is described in this report —work hard in partnership with many others to improve the health of the public. I am very grateful to them and to local community planning partnerships and senior management teams for their comments on and contributions to this report.

Linda de Caestecker

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NHS Greater Glasgow and Clyde

Chapter 1: Supporting our most disadvantaged families

Tackling child poverty is a public health priority. A recent analysis (Cribb et al 2013) showed that, across the UK, absolute and relative income related child poverty is projected to increase between 2010-11 and 2020-21. This would reverse the reduction seen between 2000-01 and 2010-11, and would mean an expected increase of 1.1 million children in the UK in relative income related poverty and 1.4 million in the number of children in poverty according to the absolute low income measure. This equates to around 50,000 more children in poverty in Scotland. The report concludes that the UK government needs to review its policies to meet their legally binding targets or develop objectives that are both desirable and achievable to reduce child poverty and mitigate the impact.

What is child poverty?

Poverty is about lack of income. Lister (2004) suggests “One danger of [Governments] downplaying income when defining poverty is that it can be used to justify a policy stance opposed to raising the incomes of those in poverty.” Children in poverty live in households that are in receipt of welfare benefits, living on low wages; have a lone or disabled parent or a parent with a long term limiting illness. Minority ethnic communities are disproportionately affected.

Poverty is also about social exclusion. Townsend (1979) enabled a deeper understanding of poverty by developing a multidimensional definition of child poverty which helps us to better understand the experience of poverty:

Individuals, families and groups in the population can be said to be in poverty when they lack the resources to obtain the types of diet, participate in the activities and have the living conditions and amenities which are customary, or are at least widely encouraged or approved, in the societies to which they belong. Their resources are so seriously below those commanded by the average individual or family that they are, in effect, excluded from ordinary living patterns, customs and activities.

Townsend's definition is important in a society defined by abundance rather than scarcity and where poverty is measured in relative terms rather than absolutes. If relative and absolute poverty persist then so will social exclusion and the consequent effects on children and families.

Poverty is emotive. Those better off in society are inclined to see people in poverty as victims of their own fate (The Fabian Society 2006). The Child Poverty Action Group (2009) lists ten reasons why we should be angry about the social injustice of child poverty:

- More than half of the children living in poverty have a parent in employment
- Current benefit and tax credits leave many children living below the poverty line
- The poorest families pay the most for key necessities
- The poorest families pay the highest proportion of their income in tax
- Poor children are more likely to experience unsafe environments
- More affluent and better educated people tend to get the best out of public services
- Poverty is a barrier to educational success
- Children in poverty go without the necessities most of us take for granted
- Poverty damages children's health
- Parents' aspirations for their children are high, but their life chances are low

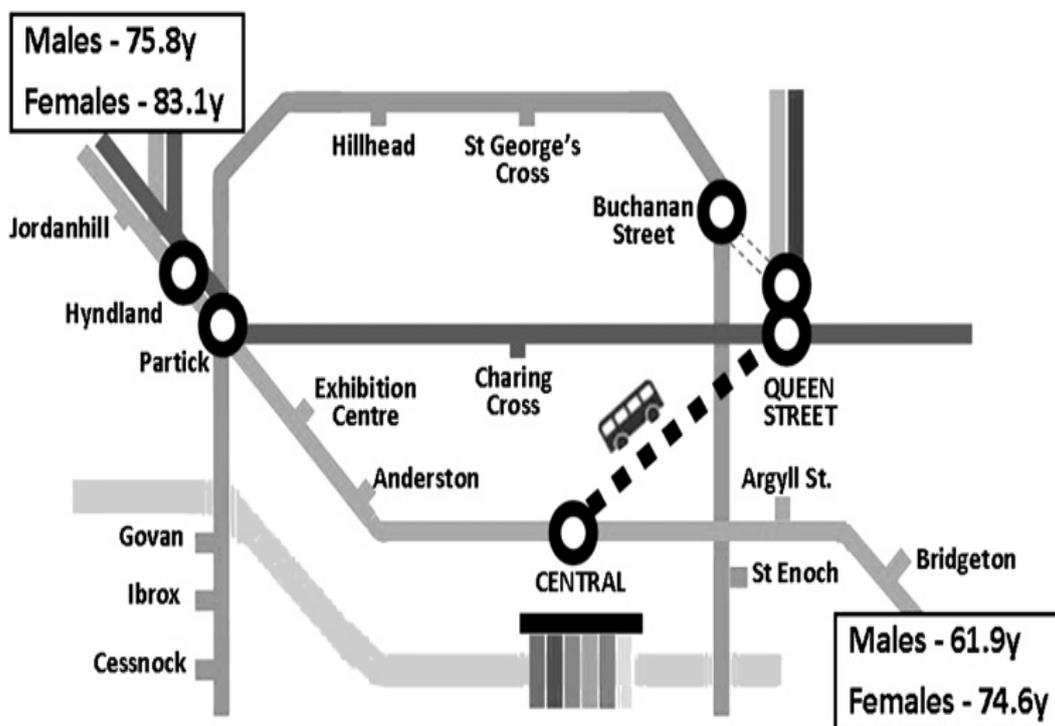
Why does poverty matter to health?

Understanding why poverty matters is critical to the effectiveness of anti poverty strategies. Material circumstances and relative income make a difference to health and social problems. Policy needs to address both.

The biggest challenge for Greater Glasgow and Clyde is the variation in health, particularly related to the effects of disadvantage. Using the Strathclyde Passenger Transport map (Figure 1:1) we can see that men living in the affluent west end of Glasgow, for example, can expect to live to 75. It is estimated that 87% of 15 year old boys in Eastwood and Bearsden, will reach their 65th birthday. In the east end of the city, however, life expectancy for men drops by almost two decades. Just 53% of 15 year old boys in Bridgeton and Dennistoun are estimated to reach their 65th birthday. Reducing the extent of income inequality can lead to improvement in health of all groups in the population. In addition to reducing life expectancy, poverty is associated with higher levels of infant mortality and stillbirth (Healthcare Improvement Scotland 2010). Smoking in pregnancy and in the postnatal period is the major modifiable risk factor underpinning the inequality (Allen et al 2009).

Figure 1.1: Glasgow - The Inequality Gap

(Source: GCPH community health and wellbeing profiles (various))



Life expectancy data refers to 2001-5 and was extracted from the GCPH community health and well-being profiles. Adapted from the SPT travel map by Gerry McCartney.

Early years' experiences are crucial for health throughout life. As Michael Marmot says in his report Fair Society, Healthy Lives (Marmot Review, 2010)

The foundations for virtually every aspect of human development - physical intellectual and emotional – are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being

Child poverty in Greater Glasgow and Clyde

In 2011, there were 270,542 children and young people (0-19) in NHS Greater Glasgow and Clyde (NHSGGC) (making up 22.2% of the population). The total number of children living in NHSGGC under 5 years old in 2011 was just over 67,000. The population of 0-15 year olds is projected to increase by 4% across NHSGGC across the period 2010-2020. This compares with a 5% rise across Scotland for the same period. However, there will be marked variations in change across local areas, with Glasgow City seeing a rise of 11% and East Dunbartonshire seeing a fall of 12% across the same period (National Records of Scotland, 2012). By 2030, it is projected that NHSGGC will have a 1% fall in the 0-15 population based on the 2010 level.

It is estimated that 30.4% of people in NHSGGC live in the 15% most deprived data zones (SIMD) the range is from 3.1% in East Dunbartonshire to over 50% in North and East Glasgow. Figure 1.2 shows that in Glasgow City 33% of children are estimated to live in relative poverty. In some of our neighbourhoods, such as Glasgow North East, 43% of children are living in relative poverty (see Figure 1.3).

Figure 1.2: Percentage of children living in relative poverty NHSGGC 2013 by Local Authority. (Source: End Child Poverty (2013))

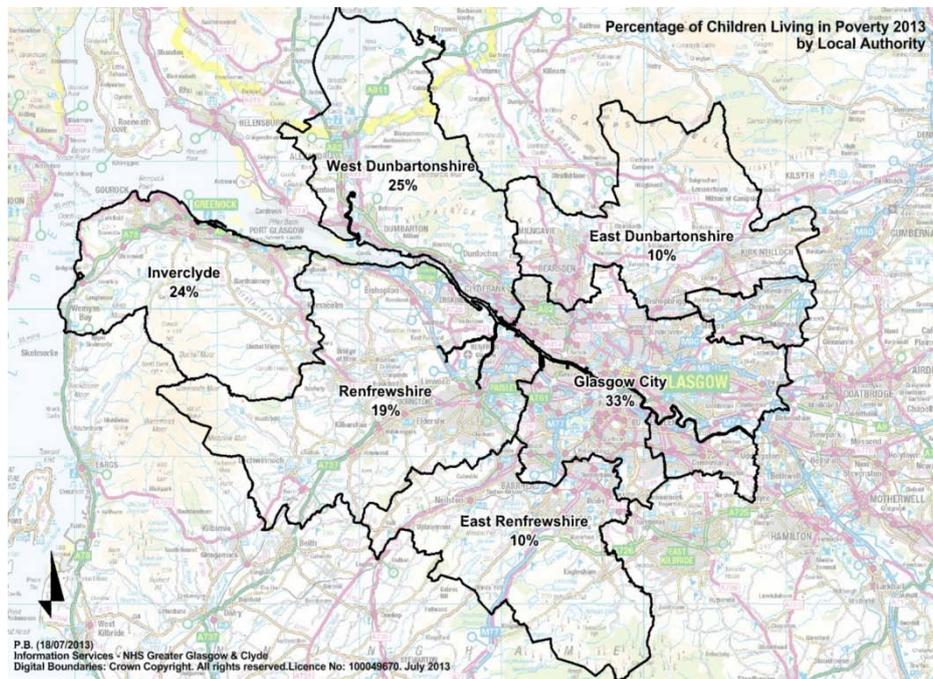
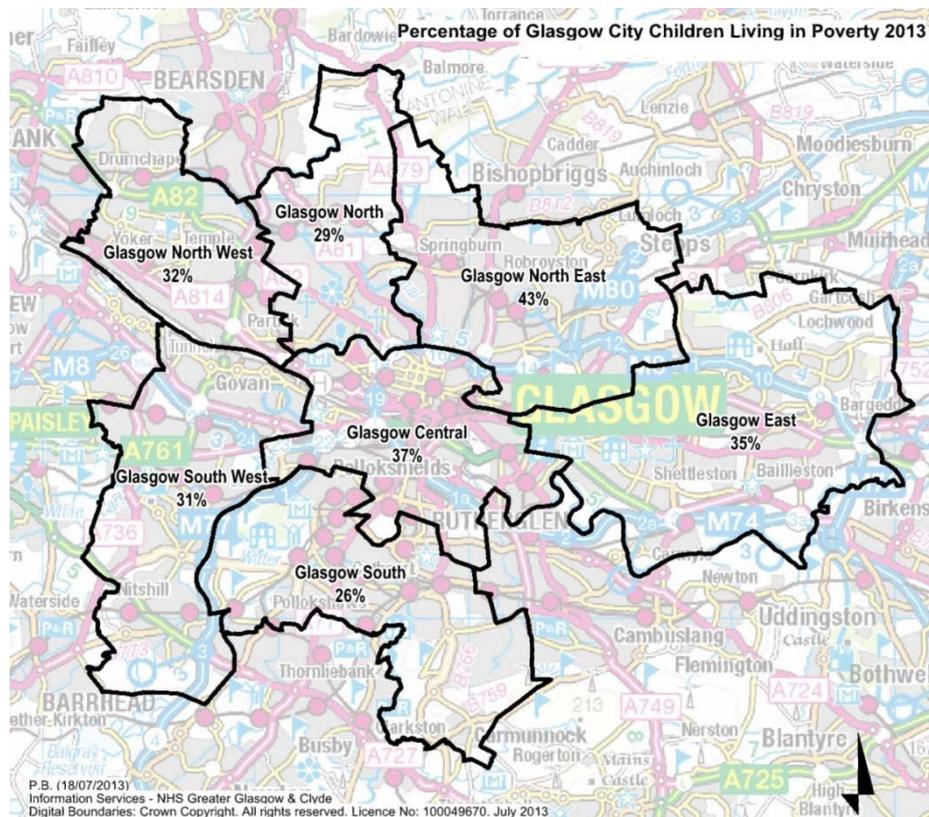


Figure 1.3: Percentage of children living in relative poverty NHSGGC 2013 by Glasgow City. (Source: End Child Poverty (2013))



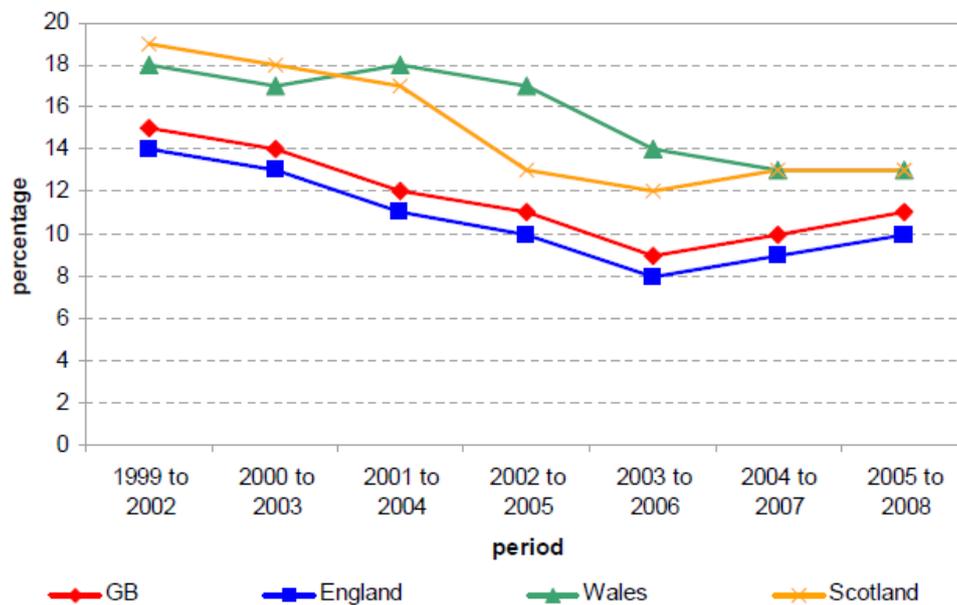
The 2011 Census reported that there were 88,464 minority ethnic people living in Greater Glasgow and Clyde (7.3% of the total population of the Board area). This varied from 1.4% in Inverclyde to 14.2% Glasgow City CHP's south sector. This compared with only 4% for Scotland. We know that there have been substantial changes to the minority ethnic populations in Greater Glasgow and Clyde, both in terms of an increase in numbers and in the profile of ethnic backgrounds and nationalities.

Persistent poverty

Persistent poverty is defined as children living in households where income is below 60% of the median income in at least three of the last four years. The problem for families who fall into this category is that they are income and benefit dependant. This means that families may have work that is irregular or below the living wage and therefore try to maintain working while they are also dependent on welfare benefits to survive. In the current recession, where families are trapped in low wages with no hope of wage rises, they are also disadvantaged by rapid welfare benefit changes.

The number of children in Scotland in persistent poverty is estimated at around 13% against the UK percentage of 9% as can be seen in Figure 1.4. In Glasgow City the estimate is 19%.

Figure 1.4: Percentage of children living in persistent poverty
 (Source: Scottish Government (2011a))



A short spell in poverty is not the same as a lifetime with resources stripped by need (Walker and Ashworth 1994). Time is crucial to health status in relation to life course experience. Long run income (income levels, income changes and experience of poverty) and persistent poverty are key determinants of health in addition short term falls in income can also have a detrimental effect on health (Benzeval and Judge 2001). Benzeval and Judge conclude that two sets of policies need to be considered. Firstly, policy must reduce the risk of persistent poverty. These can be achieved through education and sustainable employment opportunities. Secondly, where people can't access education and find well paid work, benefits need to provide an adequate standard of living.

The impact of poverty on health

Poverty is associated with worse outcomes for children. The experience and effects of poverty follows children into adulthood. Children growing up in low income households have poorer outcomes including health, emotional and behavioural problems and poorer educational attainment. Children from minority ethnic backgrounds have an increased risk of persistent poverty as do those with mothers who have a disability or long standing illness.

Children born into poverty are more likely than those born into affluent families to:

- die in the first year of life
- be born small, be born early, or both
- be bottle fed
- die from an accident in childhood
- become smokers and have a parent who smokes
- have poor nutrition including being formula and not breast-fed
- become a lone parent
- have or father children at a young age
- suffer from mental health problems (x3)*
- more likely to have a chronic disease
- more likely to live a proportion of their life with a life-limiting illness
- die in an accident (x5)*
- die younger

* More likely than children from affluent families

Figure 1.5 shows the infant mortality rate per 1,000 live births in NHS GGC by SIMD (Scottish Index of Multiple Deprivation) Quintile and illustrates the impact of poverty on infant health.

Figure 1.5: Infant mortality rate per 1000 births by SIMD Quintile NHSGGC, 2009/10 to 2011/12. (Source NRS/SMR02)

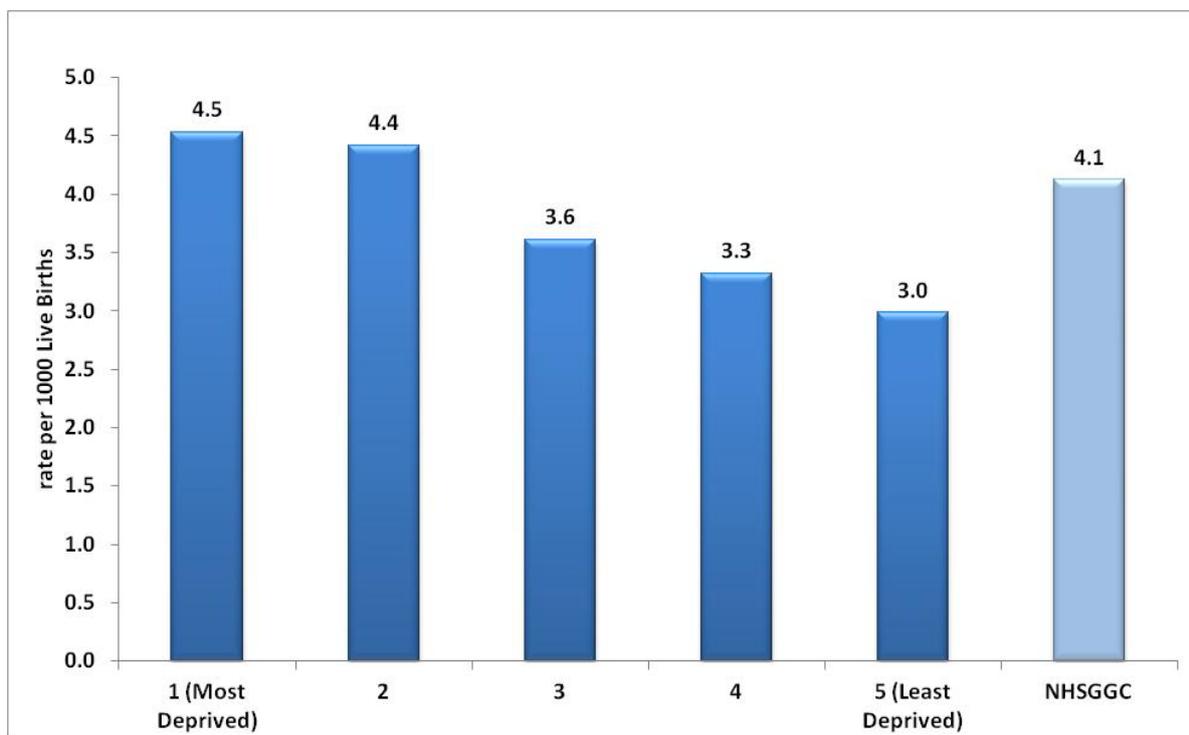
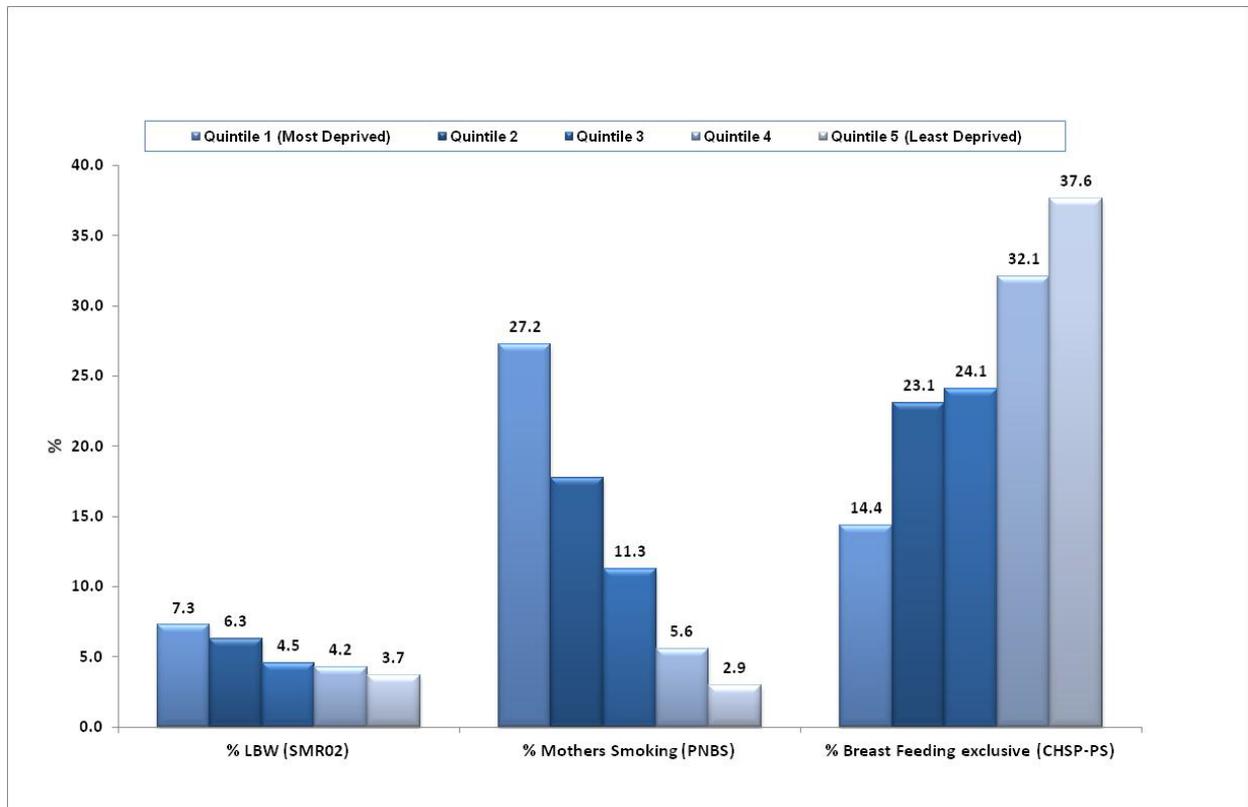


Figure 1.6 shows the rates by SIMD Quintile for low birth weight; the percentage of mothers smoking and percentage of mother who breast feed exclusively at 6-8 weeks in NHSGGC.

Figure 1.6: % Low birth weight, maternal smoking and breast feeding by SIMD Quintile NHSGGC 2011/12



National Policy

The UK Child Poverty Act 2010 enshrines in law the commitment to eradicate child poverty by 2020. The act sets out four targets related to relative low income, combined low income and material deprivation, absolute low income and persistent poverty.

At the heart of the Scottish Government's Early Year's Framework (2009) is a desire to see investment in early years. This means intervening not only when there is a crisis but working on prevention and early intervention. The framework sits alongside: *Achieving Our Potential: A Framework to Tackle Poverty and Income Inequality in Scotland* (2008a); and the *Equally Well Report on Health Inequalities* (2008b). These three social policy strands are central to the Child Poverty Strategy

for Scotland (Scottish Government 2011b). The strategy is underpinned by the principles of Getting it Right for Every Child (Scottish Government 2012).

The independent review, *Joining the Dots* (Deacon 2011) states that what we urgently need is to create a “bias for action” and radically shift energy, time and resources from analysis to action and from process to people. She contests that we don’t need more evidence on the importance of investing in early years; we need to ensure that we take action.

Strengthening the NHSGGC response

Child poverty is an issue for all our partners and therefore needs a co-ordinated response from every Community Planning Partnership that involves a bias for action to mitigate the impact of poverty on children and families. The following examples demonstrate the commitment to mitigate the impact of poverty.

We are working to ensure that equalities legislation drives organisational change to make our services sensitive to the needs of all our users. An inequalities sensitive enquiry approach (NHSGGC 2009) has been adopted by NHSGGC. The approach describes how frontline workers in our services can best respond to the social circumstances which affect patients’ health and wellbeing. Frontline staff are trained to enquire about underlying issues routine in patient care. A key focus for inequality sensitive practice has been the systematic identification of gender based violence. The practice has been extended to include employment, financial inclusion, patient and staff experience of discrimination, and literacy and numeracy.

Healthy Babies Programme

The aim of the Healthy Babies programme is to ensure we implement service changes from the Refreshed Framework for Maternity Care in Scotland (Scottish Government 2011c). The programme addresses health inequalities by focussing our activity on early intervention and prevention to target those in need in addition to providing universal services:

- Improving access to antenatal health care services

- Improving the assessment of health and social need
- Improving multidisciplinary and multi-sectoral delivery of care
- Ensuring equity in the quality of care for women and their babies

Components of the Healthy Babies programme include:

- **The Family Nurse Partnership**, a preventative programme which aims to improve outcomes for first time young teenage mothers and their children. This is done through structured home visits delivered by specialist family nurses from pregnancy up to two years of age. The family nurses will work alongside midwives delivering a programme of tailored support. It is hoped to recruit 250 women into this pilot scheme by October 2013 and, subject to evaluation results, roll it out across NHSGGC.
- **The Special Needs in Pregnancy Service (SNIPS)** adopts a multi-agency approach to delivering comprehensive care to women with substance abuse, asylum seekers, refugees, teenagers and homeless families. In Clyde, the SNIPS is an integrated health and social care service, providing care for women with special social and psychological needs. This award winning preventative programme focussed on early intervention to identify potentially vulnerable babies as early as possible. This approach will be integrated across NHSGGC.
- **Parents and Children Together (PACT)** are multi-agency teams who provide support to families in local communities who are expecting a baby or already have children less than five years of age. The principle aim of this service is early intervention. PACT teams work with families on a voluntary, planned and time limited basis to reduce the need for more intrusive and/or statutory measures. The teams help to build resilience in the families they work with and develop sustainable skills to meet a variety of child and parental needs.

Healthy Children Programme

Children and Family Teams are well established across NHSGGC to tackle the intergenerational effects of poverty by supporting vulnerable families to care for children from birth to nineteen years of age. They provide a service for vulnerable children and their families. In line with government policy, we have reviewed the effectiveness of our early years' services. As a result, we are now establishing and implementing our Healthy Children Programme, a planned approach to service provision for our children and families. The programme will implement the National Practice Model for children across NHS services. Getting It Right for Every Child (2012) helps staff to assess consistently children and families for needs against nationally agreed wellbeing indicators: safe, healthy, achieving, nurtured, active, respected, responsible, and included. The model also helps staff to create child-centred action to bring about improved outcomes for children. The programme links closely with local authority partners to ensure a consistent approach for children who need multi agency support.

Components of this Healthy Children programme include:

- The **Parenting Support Framework** for Glasgow (NHSGGC and Glasgow City 2009) aims to ensure that all parents are able to access a range of parenting interventions based on their specific needs. These programmes can also be accessed through education, housing and third sector organisations. In addition, the roll out of the 30 month assessment will ensure that children who require additional support around communication and behaviour are identified and supported. The framework is now in its third year of implementation and there has been substantial learning. The framework is being revised to ensure dedicated staff time for delivery of parenting interventions and improved co-ordination of attachment interventions, parenting programmes and intensive family support.
- **Ready to Learn 30 month health surveillance:** The most promising public health interventions available are those which improve parenting capacity and which prepare children for learning. A board-wide needs assessment identified

impoverished communication as an important unmet need for the population. Making contact at 30 months gives health visitors the opportunity to work alongside parents to identify children whose social, emotional and behavioural development puts them at risk of adverse life course outcomes. Once identified, children at risk are supported through appropriate services to give them the best start in education. Ready to Learn offers additional opportunity to engage families with information on nutrition, second hand smoke, play, safety and physical activity.

Employability

NHSGGC supports employability action in an attempt to address health inequality arising from unemployment and resulting poverty. Particular groups face significant barriers to work which are caused by their health issues and often compounded by prejudice and discrimination. The majority of people on incapacity benefit (70%), for example, have mental health related difficulties. They may or may not be accessing support from their GP and are unlikely to be accessing support from Primary Care Mental Health Teams or from secondary care. The role of the CH(C)P is to offer social interventions which can help people to join or re-join the employability pathway. The vast majority of people who have experienced a mental health problem continue to work successfully. The greatest barrier people with mental health problems face is being given the chance to prove their ability to work. Research indicates that once given this chance, they have lower sick leave than average and demonstrate strong loyalty towards their employer. NHSGGC commissions and supports employability services for people with mental health problems.

People who have had addictions problems also face considerable barriers to employment. Community Addiction Teams have worked to ensure that employability is discussed as part of people's care plans. Local bridging services are then able to support people to access employability advice.

The recession in 2009, combined with welfare reform and austerity have had an impact on unemployment. While job loss was greater for men than women in the

initial stages of the recession, the EHRC (Hogarth et al 2009) identified the following issues for women: women are less likely to register as unemployed and are less likely to be able to claim benefits; where women are in work they earn less than men, tend to work in low status jobs and continue to carry the majority of childcare and domestic responsibilities; women were already in a more vulnerable position in the labour market and more likely to be in part-time work although there is some evidence that men are moving to part-time work and in jobs traditionally taken up by women as a result of the recession; there are some indirect consequences of the recession which may affect women more than men, for example, increased gender based violence, relationship breakdown, debt and associated concerns over child wellbeing.

These labour market and recession issues all have a major impact on lone parents, 90% of whom are women. Lone parents whose children are five now claim job seekers allowance which means they are required to undertake job related activity. Lone parents could be at risk of losing family benefit as sanctions if they fail to meet the Department of Work and Pension requirements.

One Parent Families Scotland, an organisation which supports lone parents, believes that many families have to make difficult choices and a combination of the increased cost of living, benefit changes and sanctions are making these choices even harder. Many families on low incomes live well below the poverty line and nearly a quarter of the poorest families can't even afford to warm their homes (Consumer Focus 2012). While work can be a route out of poverty, this is challenging for lone parents because they need to find work which is flexible enough to meet their childcare responsibilities and is well paid enough to bring them above the poverty line.

Healthier Wealthier Children

Healthier Wealthier Children is a children and families financial inclusion project. It is part of NHS GGC's aim to prioritise routine enquiry on social issues including money worries. In just over two years, the project received 4,844 referrals, with a

£4,358,672 gain to households. 38% of the referrals to the service were lone parent women — who we know are at higher risk of poverty. Outcomes have included reduced stress, improved budgeting skills and better access to crisis loans e.g. for cookers or washing machines. The project has been mainstreamed across NHSGGC. Plans are being developed for innovative work which involves money advice services in antenatal education for pregnant women and outreach money advice clinics for pregnant women with complex needs.

Healthier Wealthier Children has been recognised as a model of good practice in the Equally Well Review (Scottish Government 2010), National Money Advice Service Good Practice Guide and at the Scottish Health Awards.

What more can the NHS do to tackle child poverty?

As no one agency alone can address the issue, community planning offers a collaborative route to identify resources that will mitigate the impact of child poverty at a local level. The NHS is a key partner in community planning partnerships.

The Director of Public Health for NHSGGC and Glasgow has prioritised child poverty for public health action and has adopted an influencing role at both national and local level towards a bias for action.

A key principle in work on poverty has been to ensure that we stay engaged with communities and families. This has been achieved through the Poverty Truth Commission where the maxim “nothing without us is about us” has been upheld. Glasgow City community planning partners, with expert advice and input from the Child Poverty Action Group and One Parent Families Scotland, have developed a Child Poverty Action Plan. The plan was recently tested with families and communities supported by the expertise of the Poverty Alliance. Glasgow’s Action Plan for Change (2013) is now part of the work of the Poverty Panel led by the leader of Glasgow City Council.

Community Planning Partnerships must work to reduce the impact of poverty on health, and some of the initiatives suggest that NHS staff can also support families to access better financial support. However, it should be remembered that the greatest proportion of children in poverty are living in absolute or material poverty, which can be addressed by measures to increase the income of households containing children.

Challenges for NHSGGC and partners

- **Measuring child poverty.** Indicators for children's health and wellbeing are being developed by the Glasgow Centre for Population Health and Glasgow City Council to support strategic planning and monitoring for child poverty.
- **Mainstream services** are a valuable resource for parents and children. They should be delivered in a way which is sensitive to the needs of parents and children living in poverty and understanding of the inequality they face.
- **Gender issues:** Women are more likely to experience poverty than men. A gendered analysis is essential to ensure that women and their children are not further disadvantaged particularly by the recession and public sector cuts. Service providers need to address the stigma women and children often experience as a result of their experience of poverty (Women's Budget Group 2008).
- **Child Care:** Accessible, affordable, quality child care is essential. It should be flexible enough to enable parents to gain employment and access training opportunities.
- **Employment and financial inclusion** are important to reducing the extent and incidence of child poverty. Changes to welfare reform are already impacting on parents and they will continue to be directly affected by changes in policy. We need to be able to inform our clinicians and practitioners of these changes and make them aware of the impact on households to ensure appropriate service responses.

Priorities for Action:

Priority 1: Fully support those at the front line of service delivery

We need to:

- Improve engagement with frontline staff in delivering inequalities sensitive services.
- Fully support staff to build supportive, non-judgemental relationships with families.
- Support those working with families with very young children to engage in professional reflective supervision and development, in recognition of the emotionally demanding nature of their work.

Priority 2: Strengthen involvement of senior leaders in advocacy and influence

We need to:

- Provide effective leadership and accountability in Community Planning Partnerships, promoting a bias for action on child poverty including action to improve health of pregnant mothers and employment opportunities for parents across government, public services, employers and the voluntary sector.
- Assess the Clinical Services Review, forthcoming strategic plans of new integration bodies and other major strategies for their impact on child poverty.
- Advocate for a comprehensive early education and child care strategy for Scotland.

Priority 3: Improve mutual clarity of partnership roles in effective delivery

We need to:

- Influence Community Planning Partnerships to define the degree of local autonomy for alleviation of child poverty, for example by adopting the living wage across all sectors and through procurement policies.

Priority 4: Strengthen evaluation, innovation and improvement activities

We need to:

- Improve the involvement of families in development of plans and services to ensure they reflect their experience of poverty and their needs.
- Ensure training, support and development of staff in reducing stigma and discrimination against those living in poverty.
- Encourage creative ways of organising mutual child care.
- Review and revise NHSGGC's Parenting Framework to reflect experience to date.
- Work with Community Planning Partnerships to plan an extension of the Healthier Wealthier Children model.
- Improve support for vulnerable families and fully engage with Triple P parenting programmes.

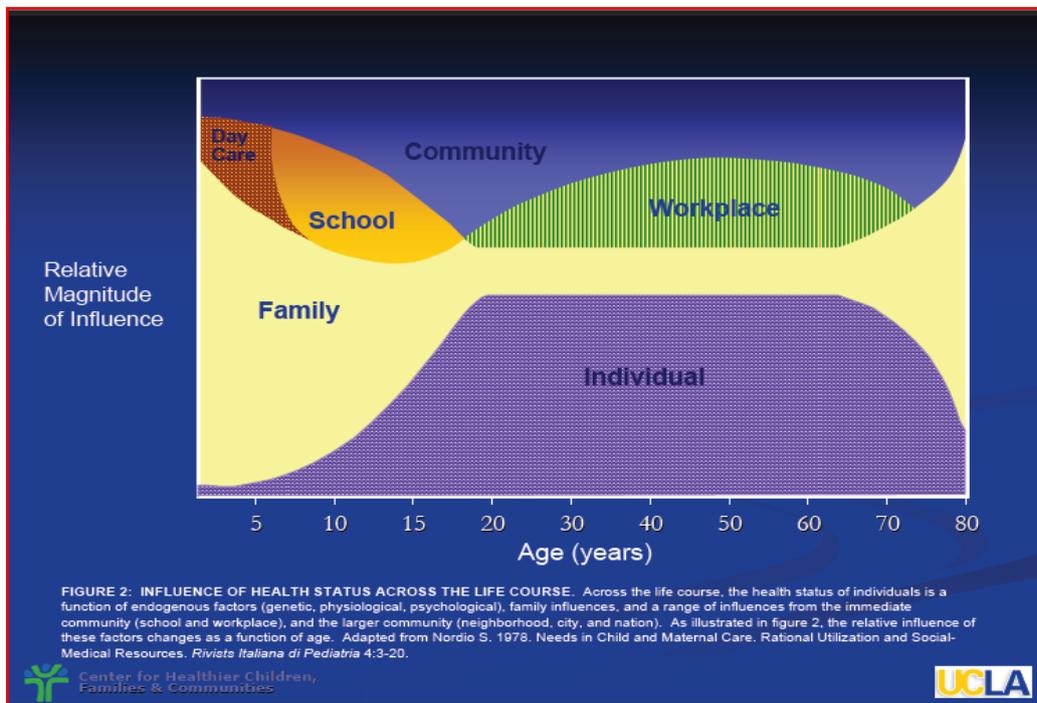
Chapter 2: The transitions of adolescence

Adolescence is the term used to describe the period of transition from dependent child to the relatively independent adult. Unlike the term puberty – which is defined by biological changes – adolescence has no scientific definition nor defined age range. For the purpose of this report, adolescence will encompass young people aged between 11-24 years. The American Academy of Child and Adolescent Psychiatry (2011) describes adolescence across three age groupings: early (11-13 years), middle (14-18 years) and late (19-24 years). These groupings are distinguished by differing experiences, pressures and transitions faced. The complex interplay between these variables will differ depending on the individual's exposure, vulnerability and resilience/ability to cope as well as their life circumstances.

Physical aspects of puberty and ongoing brain development continue until about 25 years and influence susceptibility to risk taking behaviours and peer influences. A number of notable life course transitions are routinely experienced e.g. primary to secondary education, education to employment, family home to independent home or becoming a parent. These have an impact on health outcomes (Hogg 2013; Jackson et al 2010).

Figure 2.1 illustrates the differential influence of settings at different ages and stages of adolescent development and presents a framework for locating interventions.

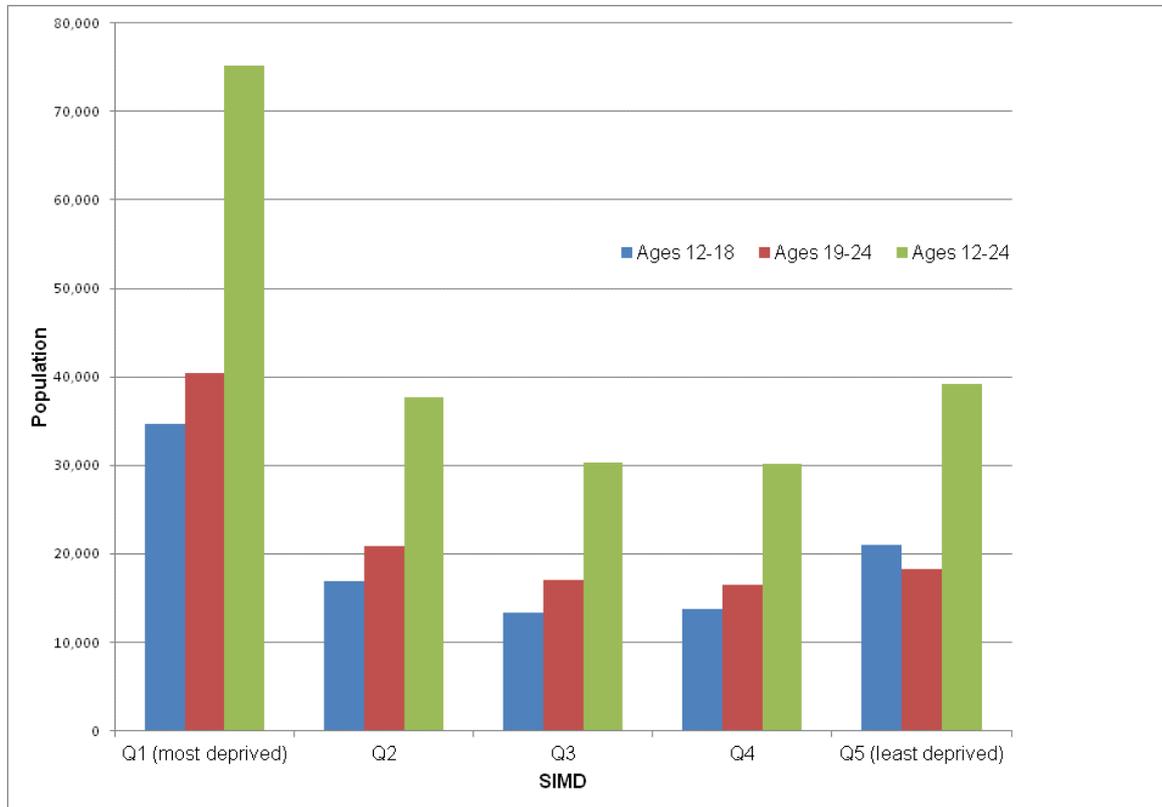
Figure 2.1: Influence of health status across the life course
 (Source: Haflon (2009))



The picture across NHSGGC

An estimated 212,598 young people reside within the GGC board area (National Records of Scotland (NRS) 2012). Over 75,000 young people are estimated to live in the most deprived areas defined by Scottish Index for Multiple Deprivation (SIMD 2012), as shown in Figure 2.2. Young people born in the area, on the whole, have a significantly lower life expectancy than the rest of Scotland but where you are born within NHSGGC also has an impact.

Figure 2.2: Census 2011 Population Estimates Greater Glasgow and Clyde
 (Source: Calculated on a pro-rata basis using Scottish Area Population Estimates (SAPE) 2011 and SIMD 2012 rates)



Individual characteristics such as ethnicity, cultural background and faith, individual physical and biological make up as well as gender norms and values that can determine health outcomes. If population modelling (based on data from a range of sources applied to 2011 census data) of protected characteristics in NHSGGC is applied to young people, the estimated number of young people in the following groups would be:

- 15,620 from black and minority ethnic groups
- 2,126 asylum seekers
- 12,756 lesbian, gay, bisexual, and transgender.

In addition to protected characteristics:

- 2,126 with communication impairment
- 29,764 with literacy/numeracy issues

Whilst damaging lifestyle behaviours among young people have decreased across Scotland over recent years, data from lifestyle surveys show this decrease is less in the NHSGGC area (Black et al 2011; NHSGGC 2012; Currie et al 2012).

Adolescence is a period during which risk taking behaviours emerge (Gore et al 2011; Alwan et al 2010). These behaviours tend to cluster, further increasing the vulnerability of the young person involved.

Data from the Glasgow City Schools Health and Wellbeing Survey for S1-S4 pupils (NHSGGC 2012) demonstrates this clustering of behaviours: almost 200 pupils engage in regular smoking, drink alcohol once a week or more and have taken drugs. This clustering of behaviours carries on into older adolescence and adulthood with multiple risk taking behaviours most prevalent in the most deprived communities. This may suggest that – although many young people experiment with risk taking behaviours – children from more affluent areas are more likely to modify their behaviours as they mature.

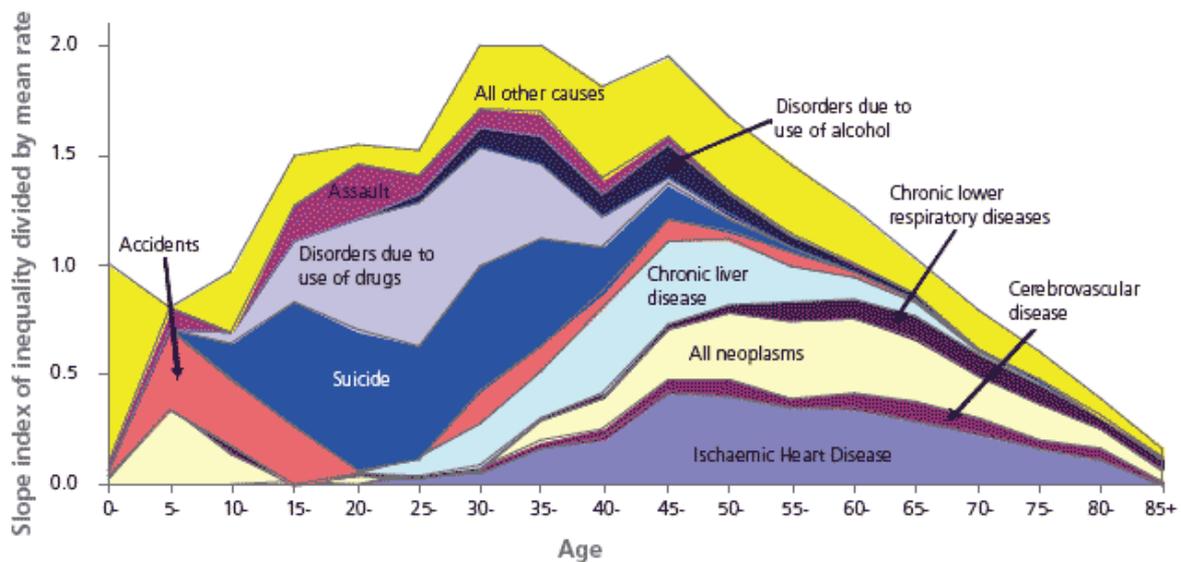
Recent reports suggest vulnerable children are also at increased risk of social isolation and reliance on internet based social media, early sexualisation in the form of sexting and cyber bullying (Ringrose 2012) as well as increased use of legal highs (Scottish Drugs Forum 2013).

Risk Factors

The impact of child poverty is a major cause of ill health both in childhood and adolescence in later life (Gordon 2011). Children who grow up in poverty are more likely to suffer from poverty during their adult lives than non-poor peers. The direct association of child poverty with educational attainment is described by Gordon (Gordon 2011) as one where “the lack of command over resources over time that constitutes poverty results in social and material deprivations which are harmful to children’s health and education.”

Adolescence is a necessary developmental stage for independent living and for most this will be positive, punctuated by first experiences and enjoyment. For a minority of young people, however, adolescence can become reckless and damaging. Figure 2.3 illustrates the impact of drugs, poor mental health and physical violence as major causes of death in young people.

Figure 2.3: Inequalities in mortality in Scotland 1981-2001
(Source: Leyland (2007))



Protective factors

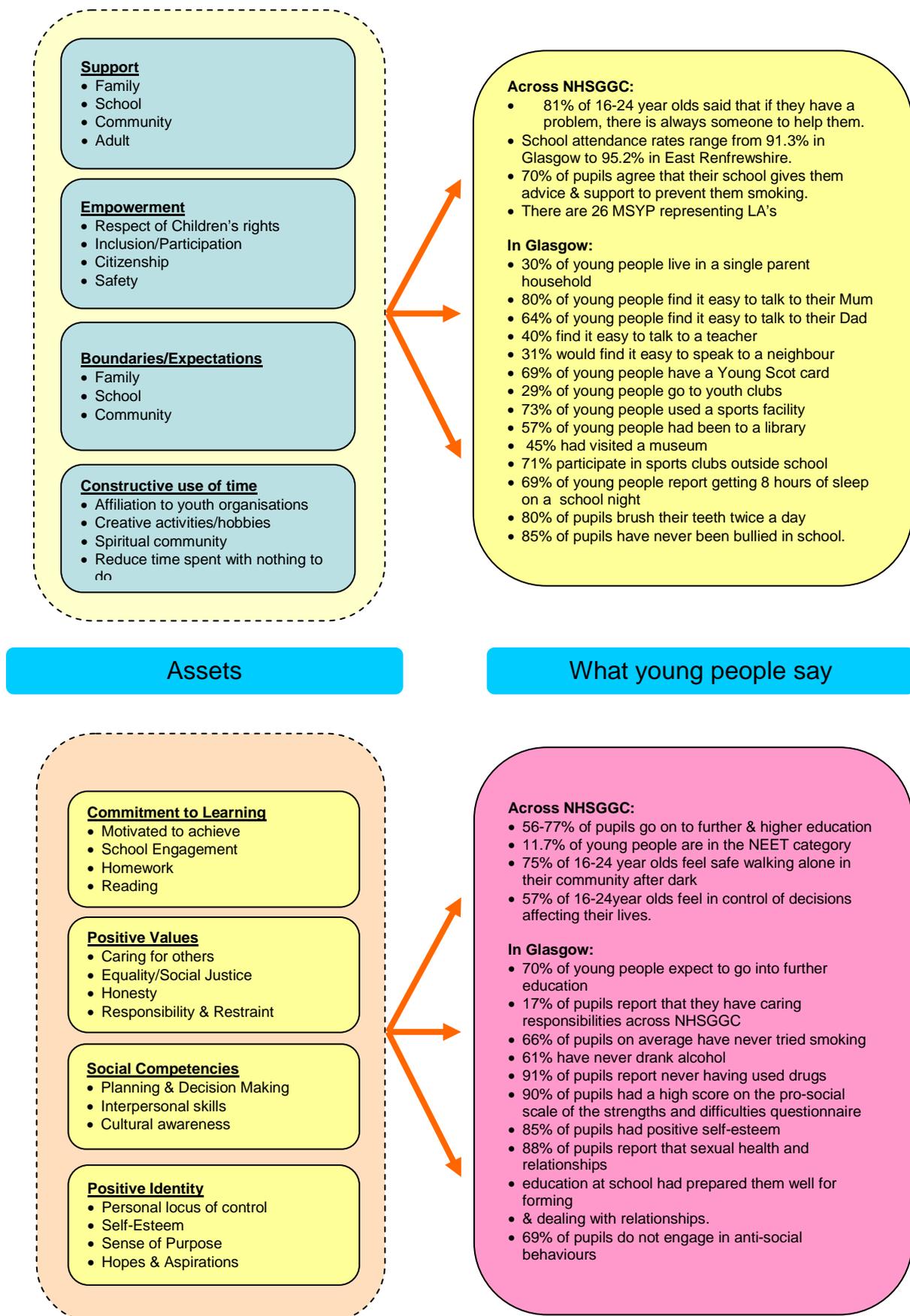
The US-based Search Institute has developed a comprehensive list of 40 developmental assets that cumulate within young people and mitigate the impact of negative social determinants of health and life circumstances (Search Institute 2006). The Search Institute suggests these assets are important to positive health outcomes and that there is a quantitative link between the number of assets and the levels of resilience. Critical to this concept is the recognition that protective factors can be developed and young people can acquire an increasing range of assets.

The range of life circumstances which increase vulnerability, coupled with poorer lifestyle choices, is a potent mix for poorer health outcomes and widening inequalities. Patterns of access to health services and programmes for health surveillance and protection are often significantly impaired for vulnerable children

when compared with their more affluent counterparts (Scottish Government 2007). The emphasis on building assets within young people is therefore critical if we are to reduce the vulnerability associated with the widespread deprivation and challenging circumstances of our children and young people.

The SEARCH Developmental Assets have been matched with local health and wellbeing indicators (NHSGGC 2012; NHSGGC 2013; ISD 2010) in Figure 2.5 to provide insight into the level of development of different assets at a population level.

Figure 2.5: Local data mapped to developmental assets proposed by the Search Institute (2006). (Sources: NHSGGC (2012); NHSGGC (2013); Black et al (2011))



National Policy Context

There is a strong body of opinion emerging (Lancet 2012 and WHO 2012) that the young person rather than the health issue should take centre stage and a better understanding of the unique challenges to their health and development is required for their immediate health and the longer term consequences on adulthood and older age.

Applying the theory of Getting it Right for Every Child (Scottish Government 2012), The Children and Young People (Scotland) Bill (2013) and United Nations Convention on the Rights of the Child (United Nations 1989) to the ecological/life course approach should not just address deficits through statutory service response but also proactive interventions to increase protective factors. The Resilience Matrix (Scottish Government 2012, p.22) is a key tool for practitioners, and developing an asset focused environment through which services, agencies and young people can build capacity as well as respond to individual needs is central to this discussion.

The engagement and involvement of young people is crucial to developing a realistic and relevant understanding of youth health issues. To describe the factors that affect the health of a young person it is best done by young people themselves and work undertaken within East Renfrewshire illustrated in Figure 2.6 provides insight in to the complexity of this concept.

- Bridging the school and employment gap with learning progression taking place in a range of positive destinations most situated to the learning needs of the young person (YouthLink Scotland 2013)
- The increasing importance of peers on health outcomes both in relation to peer norms and peer modelling of behaviours (Jackson et al 2010)
- Acquiring of social capital through engagement and participation in local communities (McPherson et al 2013; Morgan 2009).

A comprehensive multi agency approach to improving mental health and wellbeing in children and young people has already been developed within NHSGGC. The development of local networks of services focusing on resilience and early intervention across education and community settings has wider benefit than just supporting mental health. It affirms the need for this approach to be adopted in relation to the wider health needs of young people. The framework describes actions required to support protective factors and to promote both mental wellbeing and physical health outcomes. This framework will be a major strand of action on which to build.

Education is a key determinant for health. The schools setting has long been central to health development approaches for young people and the Health Promoting School was legislated as part of the Schools (Health Promotion and Nutrition) Scotland Act (Scotland 2007) recognising the importance of the wider school experience and social environment in supporting health development. This, in conjunction with the inclusion of Health and Wellbeing as a core component of Curriculum for Excellence (CfE) (Scottish Executive 2004), provides a robust foundation for schools to develop comprehensive curricular programmes and experiences that seek to increase knowledge and skills, and provide an inclusive and enabling environment in which young people can exercise healthier choices and maximise their potential.

NHSGGC has retained a strong focus on supporting school health promotion; local school health co-ordinator roles are funded within each CH(C)P. Whilst these roles are engaged in a number of the projects described here, this dedicated workforce could be capitalised upon to support school and community connectedness, strengthening opportunities to support 'work readiness' and employability skills of young people.

The Curriculum for Excellence (Scottish Executive 2004) approach to health and wellbeing is evident across all local authorities. Local and national school surveys identified opportunities for an increased focus within the curriculum on relevant public health issues. These issues should be underpinned by adopting a clustering approach to risk taking and health behaviours with a focus on increasing common protective factors and assets with young people. Work to support schools to address health development and strengthen life readiness skills with young people can be further developed.

The Valuing Young People framework (Scottish Government 2009) developed with young people recognises the role of youth work and community based services in engaging young people this is supported by a number of Scottish Government evidence reviews.

The local authorities covered by NHSGGC benefit from a strong youth third sector. Networking agencies such as Social Care Ideas Factory and local Councils for Voluntary Sector support the third sector to work more with young people. There is scope to facilitate more joint working and build capacity for health development with third sector organisations. There is also potential to link third sector organisations with the activities and services provided by statutory agencies for young people. Scottish Government (2008) makes the case that "Local agencies should provide high quality, consistent information to young people in a whole range of settings, including easily accessible drop-in services, staffed by health professionals and youth workers." The resources required and mechanisms for delivery, however, are not prescribed. Youth-friendly health services were highlighted as one of the nine delivery pillars that are important to the delivery of the Scottish Government National

Outcomes: “Our young people are successful learners, confident individuals, effective contributors and responsible citizens.”

The increasing autonomy associated with adolescence increases the importance of independent access to services including health (Scottish Government 2007). The need for age appropriate services and advocacy within healthcare based on the differing physical, social, emotional and cultural needs of children and young people across the age spectrum from birth to the late teens is recognised within Building a Health Service Fit for the Future (NHS Scotland 2005). The active engagement of young people and appropriate advocacy within both youth and mainstream health services is aligned with the United Nations Convention on the Rights of the Child.

Despite activities to review and refresh service models, the range of youth health services delivered and their links to wider primary care, specialist children’s services and wider statutory services vary. Good practice is evident but the absence of common expectations for youth health services creates differential access to services and does little to engage young people or other youth service providers. The provision of mainstream community and specialist services for children and young people is subject to local integration with partner agencies. Opportunities to develop a defined and more comprehensive approach to youth health services, including advocacy in health services routinely used by or targeting young people, is worthy of consideration. The added value of a discreet service should be articulated by both NHSGGC and young people in line with best practice identified in Walk the Talk (Scottish Executive et al 2000). The ability of youth health services to contribute to health development in the context of Getting it Right for Every Child (Scottish Government 2012) should be explored.

Local implementation and practice

Therefore a number of issues impact on the health of young people in Greater Glasgow and Clyde and actions can support the following health outcomes:

Supporting young people to adopt healthy behaviours

- Interventions that influence access to and affordability of products such as condoms, alcohol and tobacco are effective in addressing health behaviours such as reducing unintended pregnancy, harmful drinking and tobacco use in young people (Catalano 2012; Booth et al 2008) benefit all young people. Local examples include test purchasing and contraception programmes.
- Programmes in early adolescence should address multiple risk factors and promote a sense of control, self esteem and understanding of risk as well as developing communication, inter-personal relationships and ability to assert personal rights. The programmes should be contextualised in relation to the social norms experienced by young people and should account for clustered health behaviours rather than a single topic approach and build on peer led models. These programmes can build on topic specific programmes such as the Take a Drink project in secondary schools or ASSIST peer led tobacco intervention programme.
- Benefits of building the capacity of youth organisations to address youth health issues and promote health development skills in community settings is described by Catalano (2012). Examples include the development of Tobacco Control in Youth Sector: Tobacco Policy Support Guide (ASH et al 2003) and the H4U staff training in Youth Achievement Award in North East sector.
- The importance of developing modelled behaviours and building parenting skills and confidence at all stages of adolescence. Current parenting programmes such as Triple P are available across NHSGGC and should be promoted.

Supporting young people to develop and engage in a healthy culture

- There is a need to improve engagement of young people in planning and delivery of programmes and services to change behaviours and influence policy development. Previous examples of good practice include The Big ShoutER, W-WEST (tobacco advocacy group), and Glasgow City school health summits.

- The school setting remains a credible and valuable environment for health improvement. We must recognise the increasing sophistication of young people as consumers of information, food and drinks and social activities. Work to enhance school connectedness can be strengthened by collaborative working which increases participation opportunities, culture of positive reinforcement and increase interpersonal communication between staff and pupils. This has been found to be an effective approach for early and middle adolescents drawing on evidence from Gatehouse project (Australia) and Seattle Social Development Project (USA).

Supporting young people to develop social connectedness

- Recommendations to improve work readiness for young people can be delivered through skills development from employability awards, sports or hobby participation, learning and volunteering opportunities as well as activity agreements and progressive accreditations. Bridging the gap from schools to such programmes is important in middle adolescence. Extending participation in schemes such as Duke of Edinburgh helps support positive school and community interface.
- The expansion and development of local networks (schools, further education facilities, young people services, youth work organisations) to facilitate cross referral and widen youth engagement across organisational interfaces is required to support a model of social prescribing. Agencies such as Social Care Ideas Factory and local Councils for Voluntary Sector provide starting points.
- The opportunity for social prescribing for known vulnerable children is supported by Getting it Right for Every Child (Scottish Government 2012). There is potential to support young people to attend opportunities tailored to developing key protective factors or assets. Examples include Model of Integrated Diversionary Activities and Services (MIDAS), North West Glasgow along with employability programmes such as Modern Apprenticeship and Opportunities for All.

Reducing the impact of health inequalities in young people

- Interventions targeting specific groups of young people within schools and/or specific schools, based on local data and evidenced need can provide an effective and enhanced approach. Targeted programmes are most effective when delivered alongside universal programmes such as mainstream CfE. The Young Persons Support base at Smithycroft (pregnant young women), the Family Nurse Partnership and the Young Parents Support project at Rosemount Lifelong Learning are examples of approaches to develop life skills in specific groups.
- Groups of young people with life circumstances such as homelessness or having a caring responsibility will not necessarily be reached by programmes in traditional settings as they may not be attending school, or their links with family or community are fractured. We need to improve the identification and targeting of these young people to ensure access to support for health development.
- The Welfare Reform Act (2012) is likely to have an adverse impact on our most vulnerable young people due to changes in the benefit arrangements which will result in increased family fuel and food poverty, reassessment for passported benefits, and a widening of the circumstances in which jobseekers can receive sanctions which could result in destitution, debt or homelessness. Proposed changes within the housing sector will make it more difficult for young people to live independently, and be required to have budgeting skills as housing benefit will be paid directly to recipients as opposed to landlords. Young people who are transitioning from school into the workplace will also be affected by reduced opportunities for employment as a result of the current economic climate. Work is ongoing to support families and young people to access income maximisation, debt management, employability interventions and benefit from national entitlements available through the Young Scot Card.

We need to ensure these NHSGGC examples are scaled out sufficiently to achieve the required impact.

Priorities for Action

Priority 1: Develop clearer focus on youth health as a priority

We need to:

- Influence local Community Planning partners to address the needs of young people who are exposed to persistent poverty.
- Encourage local integrated children's services planning partnerships to adopt a clearer focus on youth health and adolescent well-being.
- Ensure that a stronger focus on youth health, including the implementation of the Mental Health Framework for Children and Young People, is subject to routine monitoring across NHS GGC.

Priority 2: Strengthen evaluation, innovation and improvement activities

We need to:

- Review youth health services in NHS GGC to adopt common service characteristics; acknowledging local needs but with core components, branding, referral routes and connectivity with the wider youth sector.
- Ensure that health services routinely accessed by young people demonstrate best practice as identified in 'Walk the Talk'.
- Learn from existing teen parenting support to extend reach and uptake.

Priority 3: Develop a robust youth health promotion programme

We need to:

- Develop a programme of joint work with health improvement, education and networking agencies such as Social Care Ideas Factory and local Councils for Voluntary Sector as well as individual third sector organisations to:
 - Pilot a model of multi-agency social prescribing which identifies and supports vulnerable young people to access a range of asset building interventions and opportunities.

- Develop greater health focus within existing youth networks and agencies to enable and respond to this inter-agency referral.
- Develop a robust youth health promotion programme that addresses multiple risk taking behaviours through life skills for use within education and youth settings.
- Target health promotion programmes within schools or groups of young people with greatest health need, ensuring programmes are contextualised by social norms and reflect recognised peer influencers. Support the delivery of universal programmes through the consolidation of mainstream 'Curriculum for Excellence' delivery.
- Strengthen health promoting environments and ethos within individual schools and further education establishments.
- Support schools to develop stronger links with local youth sector organisations to enhance the range of non-curricular opportunities to build assets and strengthen pre-employability skills including the development of local directories.

Chapter 3: Promoting Healthy Ageing

Improvements in health mean people are living longer; average life expectancy is now 75 years for men and 80 years for women. Scotland's 2011 census (National Records of Scotland 2013) shows that, for the first time, there are more people aged over 65 than there are under 15. By 2035, figures predict an 80% increase in the proportion of people in Scotland who are aged over 75 (National Records of Scotland 2012).

The population of NHS Greater Glasgow and Clyde (NHSGGC) is also ageing. By 2035, NHSGGC will experience a decline in the number of children under 16 years of age and a significant rise in number of adults over 75 years of age (see Figures 3.1 and 3.2).

Figure 3.1: NHSGGC 2010 population profile by sex and age group
(Source: National Records of Scotland (NRS) (2012))

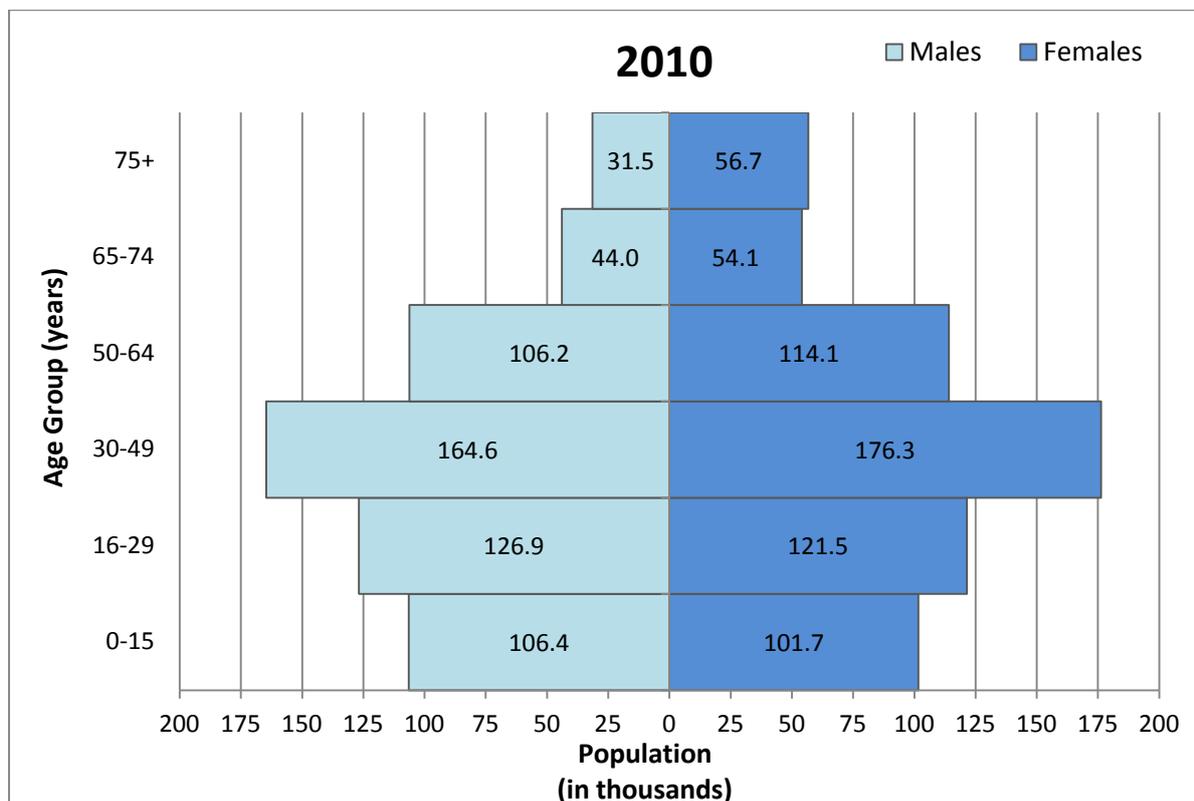
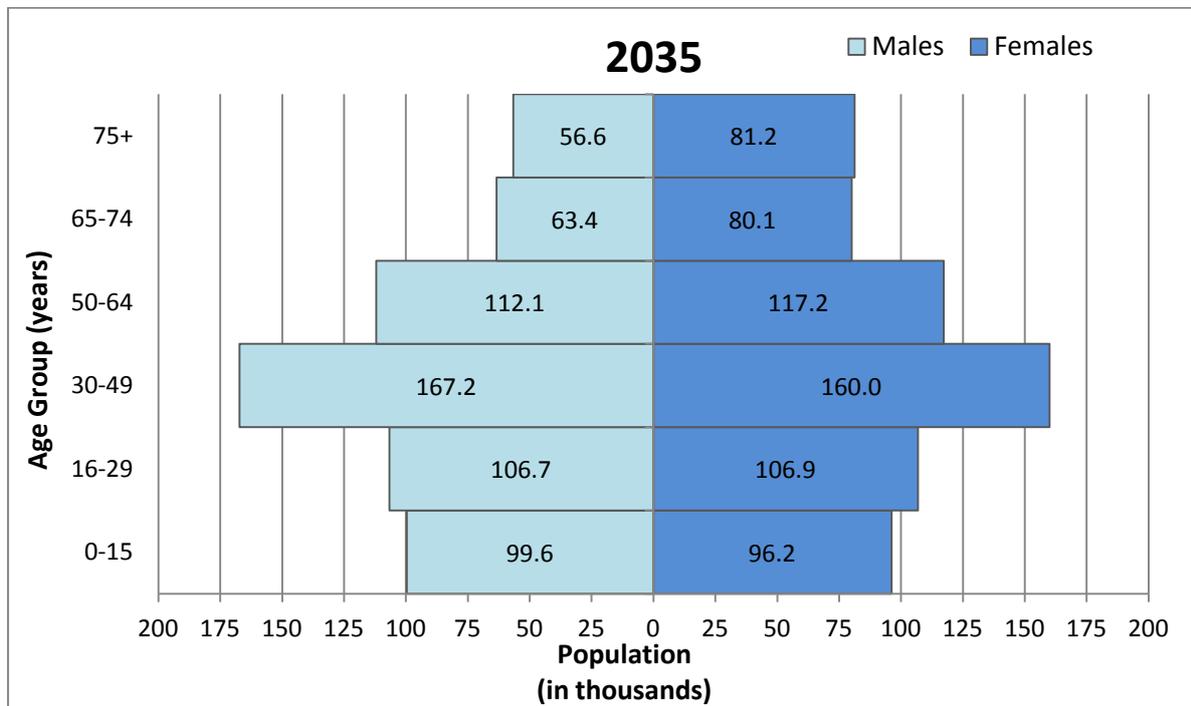


Figure 3.2: NHSGGC 2035 projected population profile by sex and age group
 (Source: National Records of Scotland (2012))



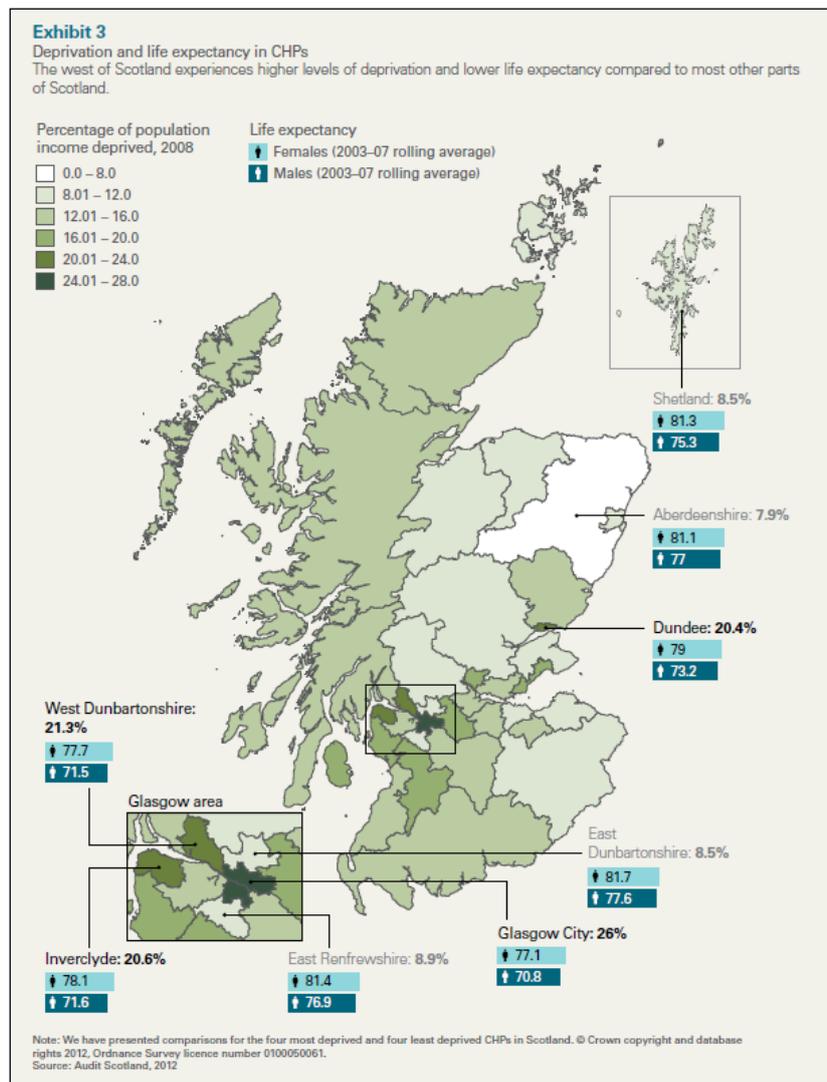
The challenges of ageing, poverty and health

By 2035, the predicted number of NHSGGC residents who are over 65 years will increase by over 50%. This compares to over 60% for Scotland as a whole (see Table 3.1). The predicted population change is lower in NHSGGC because poverty continues to be significant driver of premature ill health and premature mortality (see Figure 3.3).

Table 3.1: NHSGGC population projections of over 65 by CH(C)P
 (Source: National Records of Scotland (2012))

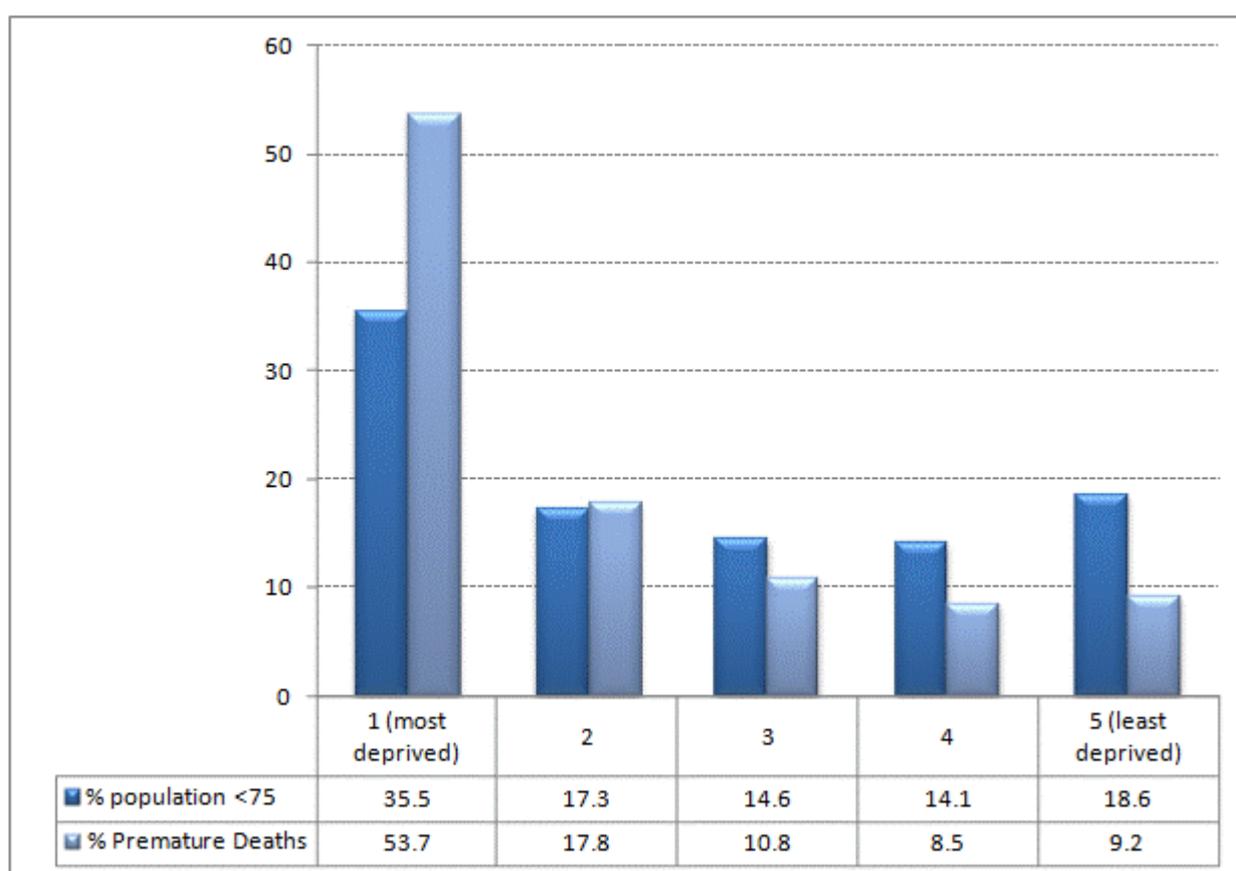
Area	2010 population (thousands)	2035 population (thousand)	Increase (thousands)	% increase
SCOTLAND	879.5	1430.6	551.1	62.7
East Renfrewshire	16.1	25.5	9.4	58.5
East Dunbartonshire	19.8	30.7	10.9	54.8
Renfrewshire	28.4	43.7	15.3	53.9
West Dunbartonshire	14.9	22.7	7.8	52.0
Greater Glasgow & Clyde	186.2	281.4	95.2	51.1
Glasgow City	80.9	118.4	37.6	46.5
Inverclyde	14.4	20.5	6.0	41.8

Figure 3.3: Deprivation and life expectancy in Scotland
 (Source: Audit Scotland (2012))



Poor health and unfavourable health-related lifestyles are clustered within certain population subgroups, particularly among those living in our most deprived areas. Thirty six percent of our population under 75 years of age live in the most deprived SIMD quintile but account for over half (54%) of all NHSGGC's premature deaths (see Figure 3.4).

Figure 3.4: Distribution of NHSGGC population aged <75 vs premature deaths, by SIMD quintile. (Source: National Records of Scotland (2009) to 2011, SAPE 2010: supplied by NHSGGC Information Services)



As the population ages, the prevalence of morbidity (the presence of disease or medical conditions) and multiple morbidity (where an individual has two or more diseases or medical conditions) increases dramatically (Figure 3.5). However this increase in prevalence is also demonstrated with increasing levels of deprivation (Figure 3.6).

Figure 3.5: Prevalence (%) of population with a long term conditions by age. (Source: NHSGGC Health & Wellbeing Survey 2011)

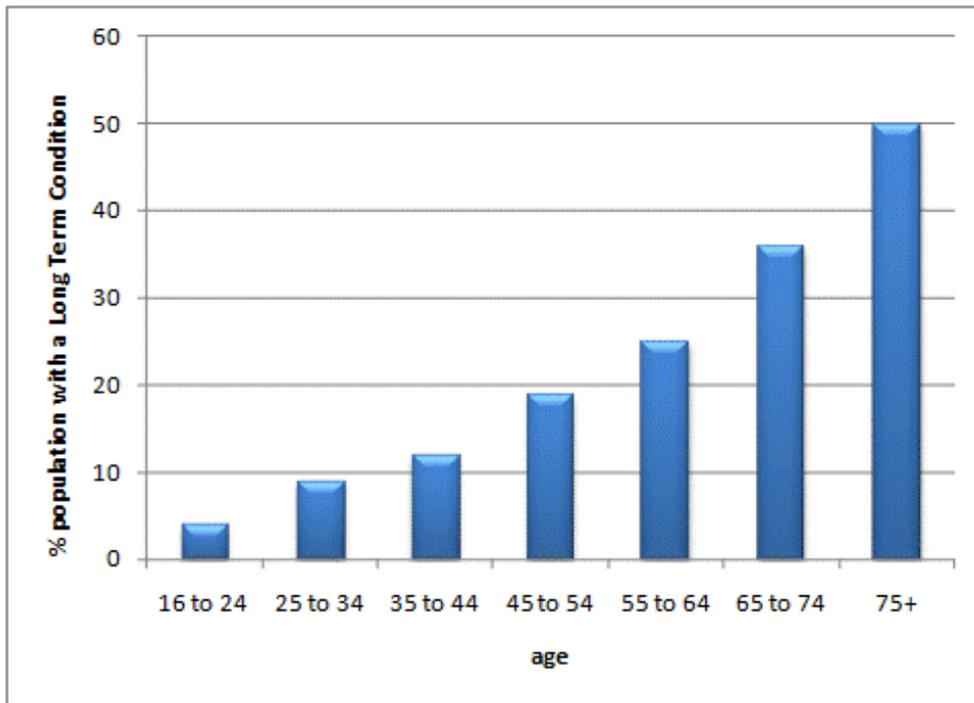
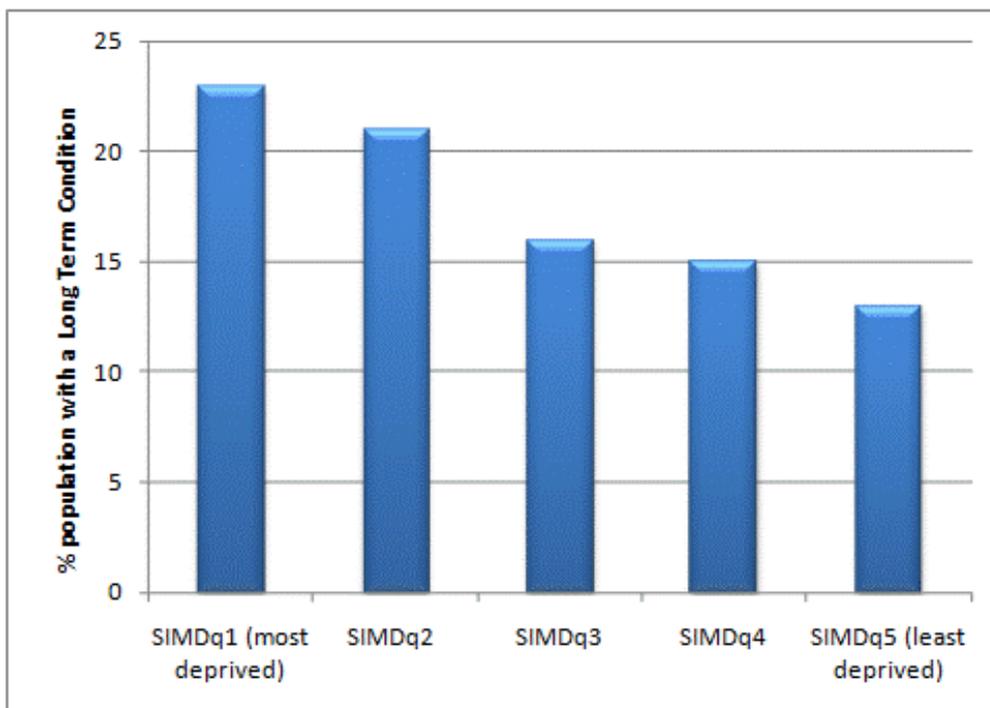


Figure 3.6: Prevalence (%) of population with a long term condition by deprivation. (Source NHSGGC Health & Wellbeing Survey 2011)



Communities with higher proportions of older people are often less deprived. Table 3.2 shows that 60.2% of East Renfrewshire CHCPs populations over 65 years of age reside in the least deprived neighbourhoods. Therefore as both age and deprivation are directly associated with higher prevalence of long term conditions, both factors must be taken into account when planning services for a healthy ageing population.

Table 3.2: % Population aged 65 plus by CHCP/Sector & SIMD quintile SAPE 2011 (SIMD 2012)

	1 (most deprived)	2	3	4	5 (least deprived)
Glasgow City	52.9	19.3	10.1	9.9	7.8
NE Glasgow	67.8	13.0	7.7	9.8	1.6
NW Glasgow	47.9	17.2	10.7	8.8	15.4
South Glasgow	44.3	26.5	11.5	11.0	6.7
East Dunbartonshire	2.2	15.7	6.5	17.6	58.1
East Renfrewshire	5.9	9.3	7.7	16.9	60.2
Renfrewshire	26.1	17.2	23.1	14.3	19.3
Inverclyde	41.9	13.6	12.7	19.0	12.8
West Dunbartonshire	30.4	32.0	23.6	10.1	3.9
NHSGGC	35.3	18.2	13.4	13.2	19.9

The primary purpose of NHSGGC is to enable its population to live longer, healthier lives. Two outcome measures show how successful we are in achieving these objectives:

- Life expectancy (LE): an estimate of how long the average person might be expected to live; and
- Healthy life expectancy (HLE): an estimate of how many years they are expected to live in a healthy state, free from morbidity.

Average life expectancy in NHSGGC is rising but it is the lowest in Scotland and among the lowest in Europe. Male life expectancy at birth among NHSGGC residents is 70.8 years. Deaths are considered to be premature when they occur before the usual age of death; in Scotland, this is defined as 75. Not only do NHSGGC residents have, on average, shorter lives compared with other Scottish residents but they also spend more years in ill health. Figure 3.7 shows the size of the gap in both life expectancy and healthy life expectancy between NHSGGC and other Scottish health boards.

Figure 3.7: Life expectancy (LE) and healthy life expectancy (HLE) at birth by NHS Board area in Scotland, males 1999-2003. (Source: ScotPHO/NRS)

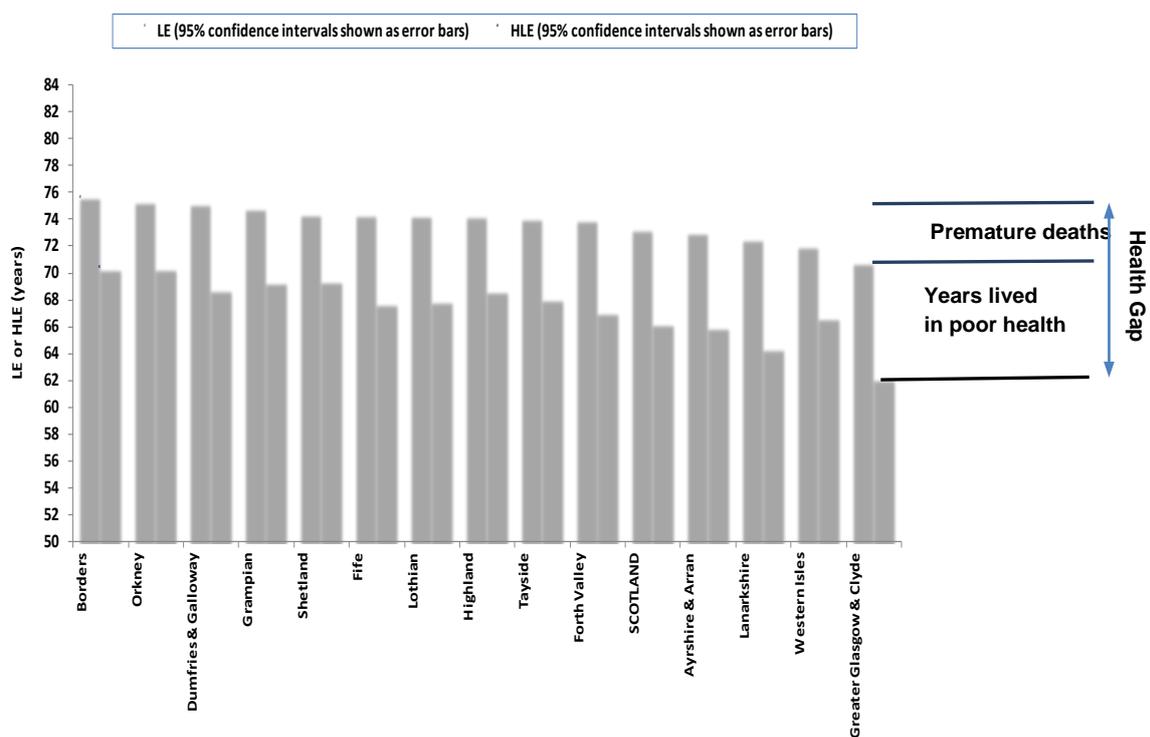
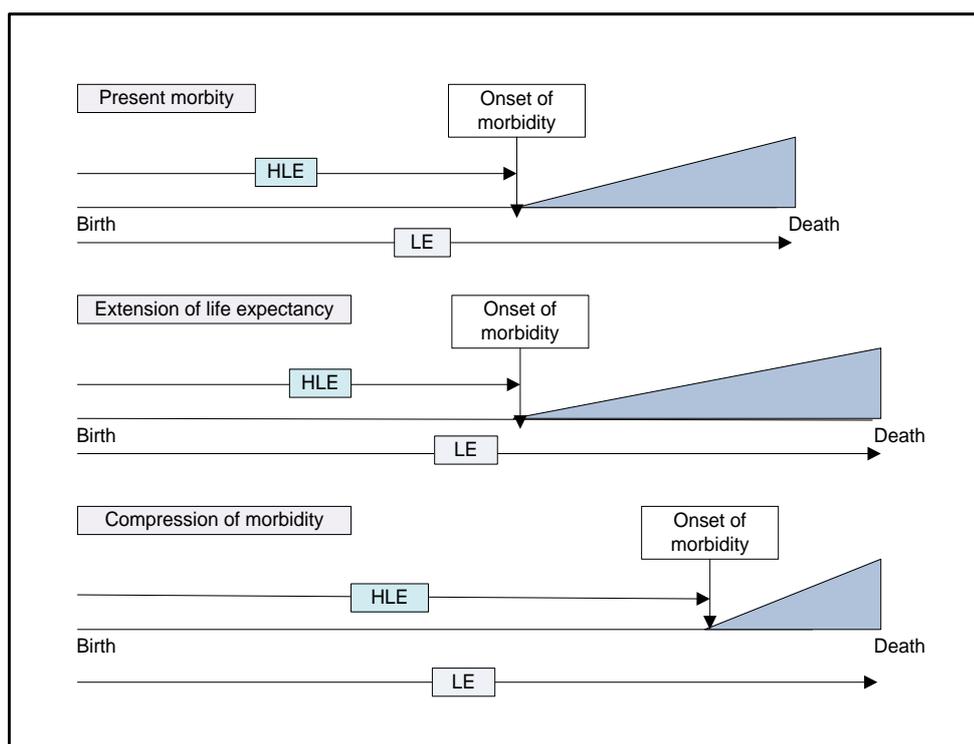


Figure 3.8 represents the compression of morbidity hypothesis. This hypothesis suggests that to reduce premature mortality, public health and health care systems should aim to minimise the number of years that a person lives in poor health. This would narrow the gap between life expectancy and healthy life expectancy.

Figure 3.8: Compression of morbidity. (Source: Adapted from Fries (2003))



The major causes of chronic disease and morbidity are highly preventable. If risk factors such as smoking, obesity and physical inactivity were eliminated, at least 80% of all new heart disease and type 2 diabetes would be prevented. 70% of new stroke cases and 50% of cancers cases would also be prevented.

Although behavioural risk factors are the immediate causes of our increasing burden of chronic disease, there are fundamental root causes which shape the extent and distribution of long term conditions in NHSGGC. For many individuals, particularly those who experience material disadvantage, risk factors often cluster and interact. People living in poverty are more likely to maintain risk behaviours for several

reasons. These include inequality of opportunities, constrained choice of consumption patterns, psychosocial stress and cultural norms.

Data from the Scottish Health Survey (Bromley et al 2013) show the prevalence of risk factors (smoking, alcohol, diet, overweight/obesity, and physical inactivity) to be exceptionally high in the Scottish adult population; 97.5% have at least one of these behavioural risk factors. Residents of NHSGGC’s most deprived communities have a greater than 3-fold increased risk of having multiple (i.e. four or five) risk factors than the least deprived.

Physical activity plays an important part in preventing diseases and conditions which are the primary cause of loss of function and independence in later life (Warburton 2006). Older people can live vigorous and active lives until a much later age than in the past. They can continue to be economic and social contributors if they are encouraged and supported to do so.

The percentage of adults achieving the recommended levels of physical activity declines with age (Bromley et al 2013). Local data (NHSGGC 2013) indicates that 40% of our population aged 50 and over and 33.2% of those 65 and over achieved these recommendations. Table 3.3 shows the number of adults in NHSGGC over 50 years of age who achieve physical activity recommendations.

Table 3.3: Adults aged over 50 in NHSGGC who meet physical activity targets. (Source NHSGGC Health and Wellbeing Survey 2011)

Age range	Number meeting target persons	Total Sample persons	% meeting target persons
50 to 64	610	1328	45.9%
50 plus	988	2468	40.0%
65 plus	378	1140	33.2%

Local implementation and Practice

Local policies and frameworks have explicitly defined action to address inequalities in health within NHSGGC as a leading priority at the centre of all NHSGGC planning and service delivery.

The primary aim of the **NHSGGC Anticipatory Care Framework (2011)** was to prioritise high impact actions for reducing the preventable burden of ill-health associated with all Long Term Conditions (LTCs). The framework is underpinned by the following three principles:

- A focus on the risk factors that make the biggest contribution to our total burden of disease and to our socially determined inequalities in health status.
- An integrated spectrum of primary, secondary and tertiary prevention activities is explicitly woven throughout all clinical care.
- Prioritisation of NHS interventions that offer strongest evidence of effectiveness in addressing preventable risk factors for long term conditions (LTCs).

The **NHSGGC Integrated Prevention for Long Term Conditions report (2012)** outlined evidence that well integrated primary, secondary and tertiary prevention programmes reduce morbidity and the associated impact on both the individual and health care systems:

- **Primary prevention:** protection of health by measures which eliminate causes and determinants of poor health, delivered either at a whole population level or to individuals.
- **Secondary prevention** (also called screening): a systematic public health intervention which involves proactive testing for a disease or risk factor in a population with neither signs nor symptoms of the disease being sought, but whose members have some characteristic that identifies them as being at risk. The rationale for screening requires clear evidence that population health outcomes are improved by early detection and treatment.

- **Tertiary prevention:** measures intended to reduce or eliminate long term impairments, disabilities and complications from established disease. This includes interventions intended to prevent or actively manage acute exacerbations of disease, as well as longer term work to maintain health and prevent chronic deterioration of an existing LTC over a period of many years.

Keep Well

Keep Well is now in its sixth year in NHSGGC; the programme has delivered over 60,000 health checks within our most deprived communities. A Keep Well consultation (health check) is intended to identify individuals at particular risk of preventable serious ill-health, offering appropriate interventions and initiates monitoring and follow-up. In April 2013, NHSGGC extended the Keep Well eligibility age range to 35-64 years of age, and the target population including:

- Individuals residing in our most deprived communities
- South Asian ethnic subgroups
- Black and Afro-Caribbean ethnic subgroups
- Offenders
- Gypsy/travellers
- Homeless individuals
- Those affected by substance misuse.

At April 2013, 151 GP practices within NHSGGC's most deprived communities are now participating in the programme; approximately 60% of NHSGGC GP practices. 15,804 health checks were delivered during 2012/13 contract year, exceeding NHSGGC's annual performance target of 13,000 by 21%. Table 3.4 provides a breakdown of this activity.

Table 3.4: Keep Well health checks 2012/13
 (Source: Keep Well local enhanced service data)

2012/13 GP Practice Keep Well Local Enhanced Service (LES) programme			
SIMD Quintile / Carers	Completed checks		
	New	5yr Review	Total / (%)
1– Most deprived	10,241	320	10,561(70.0%)
2	1,593	37	1,630 (10.8%)
3	1,055	32	1,087 (7.2%)
4	931	45	976 (6.5%)
5 – Least deprived	635	21	656 (4.3%)
Unassigned	181	6	187 (1.2%)
All	14,636	461	15,097 (100.0%)
Number identified as a carer (sub-set of total figure above)			1,229 (8.1%)
Dedicated target group programme health checks (2012/13)			
Number of completed health checks			
Prisons Programme			314
South Asian Anticipatory Care Pilot (SAAC)			423
Total Completed Keep Well health checks (Keep Well LES, Prisons & SAAC)			15,804

Table 3.5 shows the number of new diagnosis of diabetes, coronary heart disease and hypertension following patients attending their first keep well health check. Despite overall low number of patients with previously undiagnosed conditions, NHSGGC Keep Well evaluation clearly evidences high prevalence of individual and multiple health behaviour/modifiable risk factors. During 2012/13 contract year, Keep Well local enhanced service data showed that 5,160 patients attending a first Keep Well health check were classified as a current smoker.

Table 3.5: Number of new diagnosis of diabetes, coronary heart disease and hypertension (Source: NHSGGC National Indicators Report)

Chronic Disease	Total Number of <u>first</u> health checks	Number of people with a new chronic diagnosis (2)
Diabetes	14,562	101 (0.69%)
CHD	14,562	17 (0.12%)
Hypertension	14,562	180 (1.24%)

11,670 referrals to health improvement services were recorded as a result of attending a GP practice-based Keep Well health check during 2012/13.

The Keep Well programme aims to explicitly target Scotland’s most deprived neighbourhoods by building capacity and systems in general practice to systematically address health inequalities. The programme offers an opportunity to tackle health inequalities through integrated primary and secondary prevention for a wider gamut of preventable morbidity, rather than a narrow clinical CVD prevention programme. The delivery of the Keep Well health check provides a catalyst for GP practice engagement and offers opportunity to engage patients in individual level health improvement. However, it is vital the programme aims to strengthen and support area level health improvement through integrated working across general practices, health improvement teams/services and community/voluntary sector services.

The **Drumchapel Community Orientated Primary Care (COPC) Pilot** — a partnership between Drumchapel GP practices, Glasgow City CHP North West Sector, Public Health and local community services and organisations — aims to strengthen the ability of local general practices to function as a coherent local public health programme. It combines the resources available from public health (e.g. local epidemiological profiling, service evaluation etc.) and health improvement (e.g. tailoring services and interventions to align with patients’ needs) with practices’ own clinical experience and local knowledge.

The NHSGGC Chronic **Disease Management (CDM) and Keep Well Enhanced Services programme** has been developed and redesigned to ensure that the programme is fully aligned to need. New primary care consultation support templates have been developed to support person centred consultations to engender the confidence, motivation and ability of patients and healthcare professionals to make healthy choices and obtain the appropriate follow-up services and support. In addition, new health behaviour and life circumstances templates have been developed to now include **routine enquiry** including health behaviours and social issues relating to financial inclusion, employability, literacy and caring within all CDM and Keep Well consultations.

NHSGGC works in partnership to **fund financial inclusion services** across the health board area. These services offer free and impartial advice to residents of NHSGGC on a range of financial issues including financial capability, welfare and debt advice. Services operate across community settings and within NHS Acute hospital settings. A total of 2,544 referrals were made to Glasgow City acute hospital financial inclusion services between 1st April 2012 and 31st March 2013. Of these referrals, a total of 1,751 were people over the age of 55 years. In the first quarter of 2013 the service received a total of 642 referrals, of which 458 were over the age of 55 years. During 2012/13, over 400 individuals were referred to community financial inclusion services as a direct result of attending a Keep Well health check.

East Dunbartonshire Older People's Income Maximisation Programme — a partnership between East Dunbartonshire CHP and East Dunbartonshire Citizens Advice Bureau — provides advice, signposting and direct support on a range of financial related issues, including benefits advice, money advice, and housing. In 2012 East Dunbartonshire Citizens Advice Bureau (CAB) reported that the financial gain for those referred to the programme was £193,948.00. This figure has been surpassed in the first quarter of 2013.

East Dunbartonshire Older People Access Line (OPAL) is a telephone helpline for older people and their carers operated by the local Citizens Advice Bureau and Caertas Advocacy. The service assists anyone concerned about issues that affect older people by providing a single gateway to voluntary sector services. An integral part of the programme is to build capacity of existing voluntary organisations, as well as identifying service gaps. Referrals have been received from Social Work, NHS including GPs; and Care and Repair as well as self-referrals. In the first six months of the service, 142 clients accessed the service, 42 of these consultations related to financial advice and information.

Generations Together (Glasgow City South Sector) originated from the Shaping the Choreography of Care Project that involved the Institute of Research and Innovation in Social Services (IRISS), the School of Art, social work, NHSGGC and others. Generations Together aims to develop strategies and actions for the future support for older people's wellbeing, including intergenerational working. To date, NHSGGC and IRISS have been working with a primary school in the Gorbals to develop a series of intergenerational projects to improve perceptions and challenge stereotypes. Projects are co-produced by the participants.

Silver Deal Active Programme is a partnership initiative between Glasgow Housing Association, Glasgow Life and NHSGGC. The programme aims to encourage older adults to be more active, more often. In addition to physical activity sessions, Silver Deal Active also provides an arts programme encouraging social interaction amongst the target audience, improving positive mental health and wellbeing. Following the success of the programme in Glasgow, NHSGGC has provided funding to establish similar programmes across the board area.

Still Game in East Renfrewshire is a national programme promoted by the Scottish Premier League Trust. This programme offers people over 60 years the opportunity to participate in a short programme of weekly activity sessions at St Mirren Football Club. East Renfrewshire CH(C)P supported the programme in a unique way by deploying a community health development worker to target older adults who are less likely to engage in physical activity opportunities. Initial findings from Still Game programme suggest participants experienced increased confidence levels, higher levels of community participation and reported health and wellbeing benefits. There was increased co-production of service design and delivery.

Revive (Glasgow City South Sector) is a 10 week programme for over 50s. It comprises taster sessions of locally available activities such as exercise, arts and crafts, various health talks and a museum visit. It has been run in four areas across the south so far. It will be adapted for sheltered housing and/or care homes.

The **supported home exercise programme** led by the community falls team is an 18-month project aiming to implement and evaluate new models of care. The programme adopts the evidence-based Otago model (NZFP 2004) (which is proven to reduce falls and falls-related injuries. It is being piloted in community rehabilitation services to support frail, elderly, housebound individuals who are unable to access other physical activity options. If successful, the longer term aim is to roll out the model across NHSGGC.

Issues

- Many older people lack a trigger for being asked about money. Hospital settings and primary care settings offer a unique opportunity to routinely enquire about this
- Tackling the burden of preventable ill-health and resultant demand on healthcare services requires the balance of spend to be shifted in favour of prevention. However, only 3-4% of total NHS expenditure currently goes toward population-wide prevention and public health programmes, with most spending focused on illness care services

- It is vital that NHSGGC maintains a clear focus on achieving concerted whole system action on the risk factors that make the biggest contribution to our total burden of disease and to our socially determined inequalities in health status
- Strengthened connectivity and more effective functional relationships are needed between clinicians and the wide range of support services that exist. More intensive organisational development is needed to build familiarity and meaningful collaboration between clinicians and support services, service change tailored to local context, clinical and social need and continuously modified through bi-directional feedback

Priorities for Action

Priority 1: Strengthen involvement of older adults in physical activity

We need to:

- Fully recognise the importance of physical activity participation as a major determinant of healthy ageing.
- Ensure that physical activity interventions actively encourage participation of adults across the life course, including those over 75 years of age.

Priority 2: Mainstream delivery of evidence based anticipatory care

We need to:

- Ensure that the strategic focus of Keep Well is more clearly focussed on provision of systems to support integrated anticipatory care, particularly in NHSGGC's most disadvantaged communities with discontinuation of the current reliance on the cardiovascular 'health check' component.
- Deliver training to all staff in NHSGGC acute and primary care services to routinely raise the issue of money and employability.
- Extend delivery of the Chronic Disease Management Local Enhanced Service to encompass wider long term conditions and address multiple morbidity to support person centred care.

Priority 3: Improve coherence of services for older people and their informal carers

We need to:

- Develop a single point of access to health, social care and community service information for staff, patients and public in each local CH(C)P area.

Chapter 4: “Getting it Right” for Looked After and Accommodated Children and Young People

Looked after and accommodated young people (LACYP) are a particularly vulnerable group (Scottish Government 2012a). Many fail to reach their full potential and go on to have major problems in later life. (Scottish Government 2003; 2007) Children’s Social Work Statistics (Scottish Government: 2012b) show that – at March 2011 – there were 16,231 LACYP in Scotland; which represents 1.5% of all 0 to 18 year olds in Scotland. Rates vary by local authority but the highest proportion of looked after and accommodated young people are found in Glasgow City (3.2% of all 0 to 18 year olds n=3,834). Over one third (34.3% n=5,570) of all LACYP in Scotland live in the six local authorities wholly administered by NHSGGC (Glasgow City, East Dunbartonshire, East Renfrewshire, Renfrewshire, Inverclyde and West Dunbartonshire). This represents 2.4% of all 0 to 18 year olds in NHSGGC (Scottish Government 2012c).

Characteristics of LACYP

The legal definition of LACYP is set out in The Children (Scotland) Act 1995 (Scotland 1995). Care can be provided according to four main settings: in the child’s home (under local authority supervision); with a relation or family friend (kinship care); in a foster home; or in residential care.

Figure 4.1 shows the % of LACYP by placement type in Scotland and NHSGGC. Nine percent of all LACYP across Scotland were in residential care in 2011; just over one third (34%) were cared for at home, 31% were in foster care, and 24% were in kinship care. The residential care figure for NHSGGC was similar to Scotland at 8% but this masks considerable local variation from 17% (n=25) in East Dunbartonshire to 6% (n=241) in Glasgow City and 4.5% (n=7) in East Renfrewshire. However, as the actual numbers of young people involved is small, these figures need to be interpreted with caution.

Figure 4.1: % LACYP by Placement Type at March 2011 NHSGGC local authority areas and Scotland (Source: Scottish Government: 2012b)

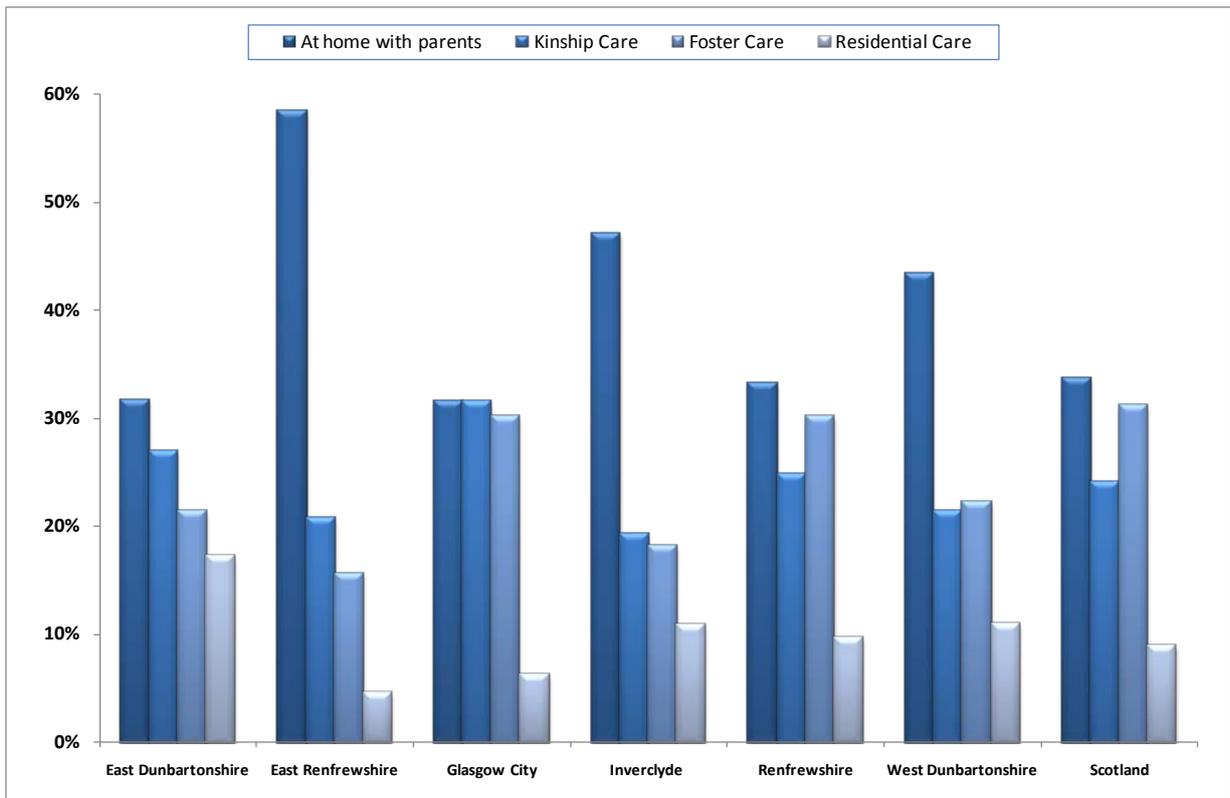
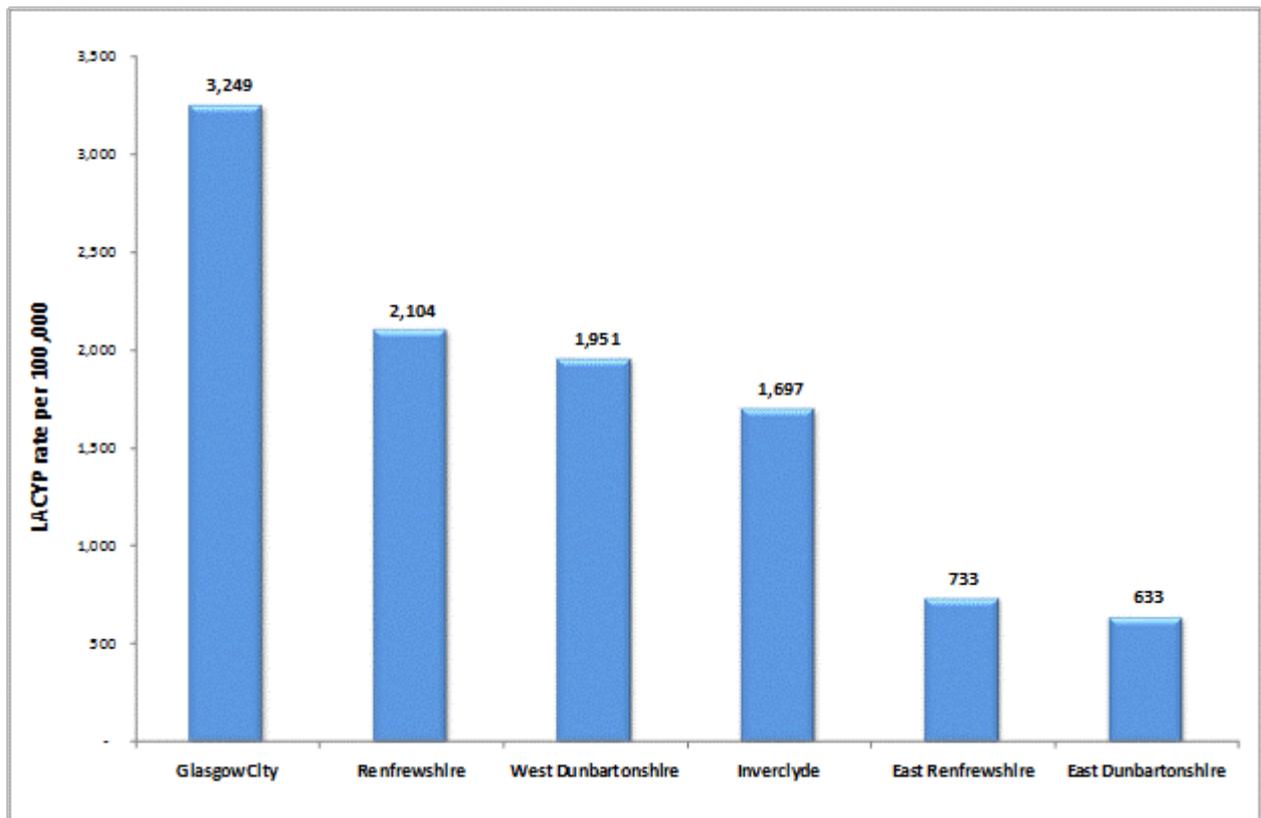


Figure 4.2 shows the LACYP rate per 100,000 population by NHSGGC local authority area in 2011. Rates vary considerably ranging from 633 per 100,000 in East Dunbartonshire to 3,249 in Glasgow City.

Figure 4.2: LACYP Rate per 100,000 population aged 0 to 18 at March 2011
NHSGGC local authority areas (Source: Scottish Government: 2012b)



- **Trends:** The rate of young people who are being looked after or accommodated has been rising steadily since 2005 (see Figure 4.3). NHSGGC has the highest rate in Scotland with the Glasgow City rate higher still (Lachlan et al 2011). The 2011 rates shown in Figure 4.3 are not directly comparable with those for 2005 to 2009 as they relate to those aged under 18 whereas the earlier years relate to those under 21. However the graph demonstrates variations between areas as noted above. For example, the 2011 Scottish rate of 1,469 per 100,000 is considerable less than the NHSGGC rate of 2,371 per 100,000, whereas the Glasgow City rate was higher at 3,249 per 100,000.

Figure 4.3: LACYP rates per 100,000 population NHSGGC, Glasgow City and Scotland 2005 to 2009 and 2011 (Source: Scottish Government: 2012b)

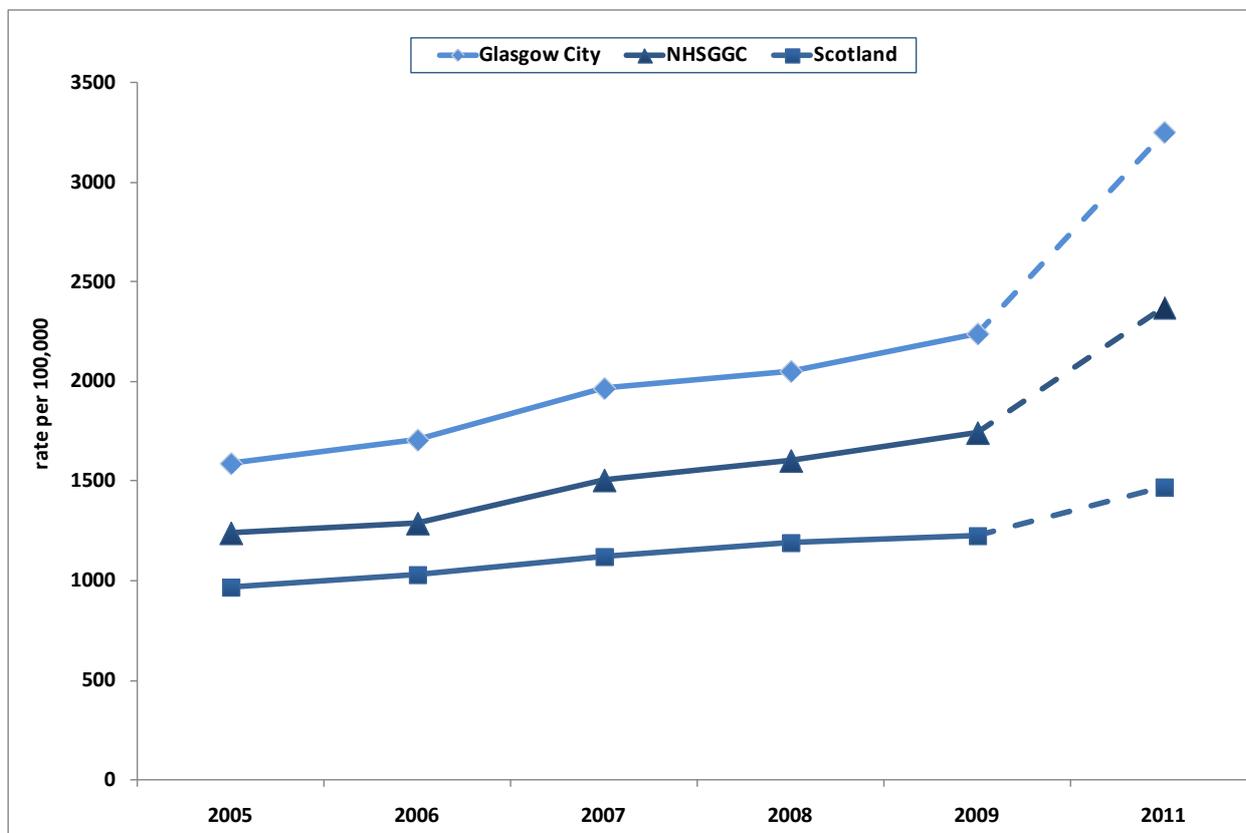
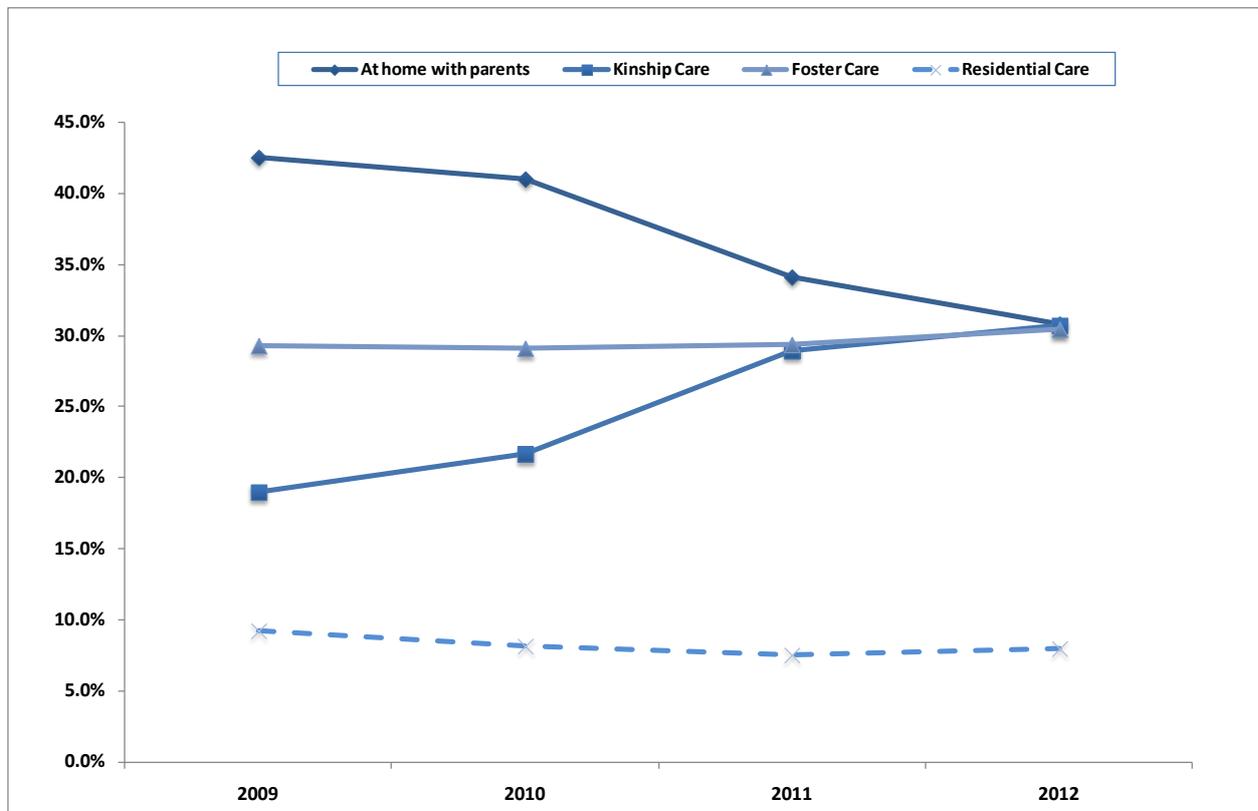


Figure 4.4 shows the trends in the proportions of LACYP in NHSGGC by placement type from 2009 to 2012. Getting it right for children in foster and kinship care (Scottish Government 2007) stated that Kinship care should be the first choice for placements. There has been a steady increase in the proportion of LACYP in Kinship care over this time period rising from 20% to 30% (CLAS 2012) and it is expected to rise further (Kidner 2012). This increase in Kinship care is mirrored by a decrease in those living at home with parents (42% to 30%). Foster and residential care has remained fairly constant at 30% and 9% respectively.

Figure 4.4: % LACYP by Placement Trends NHSGGC 2009 to 2012

(Source: SG CLAS 2012)

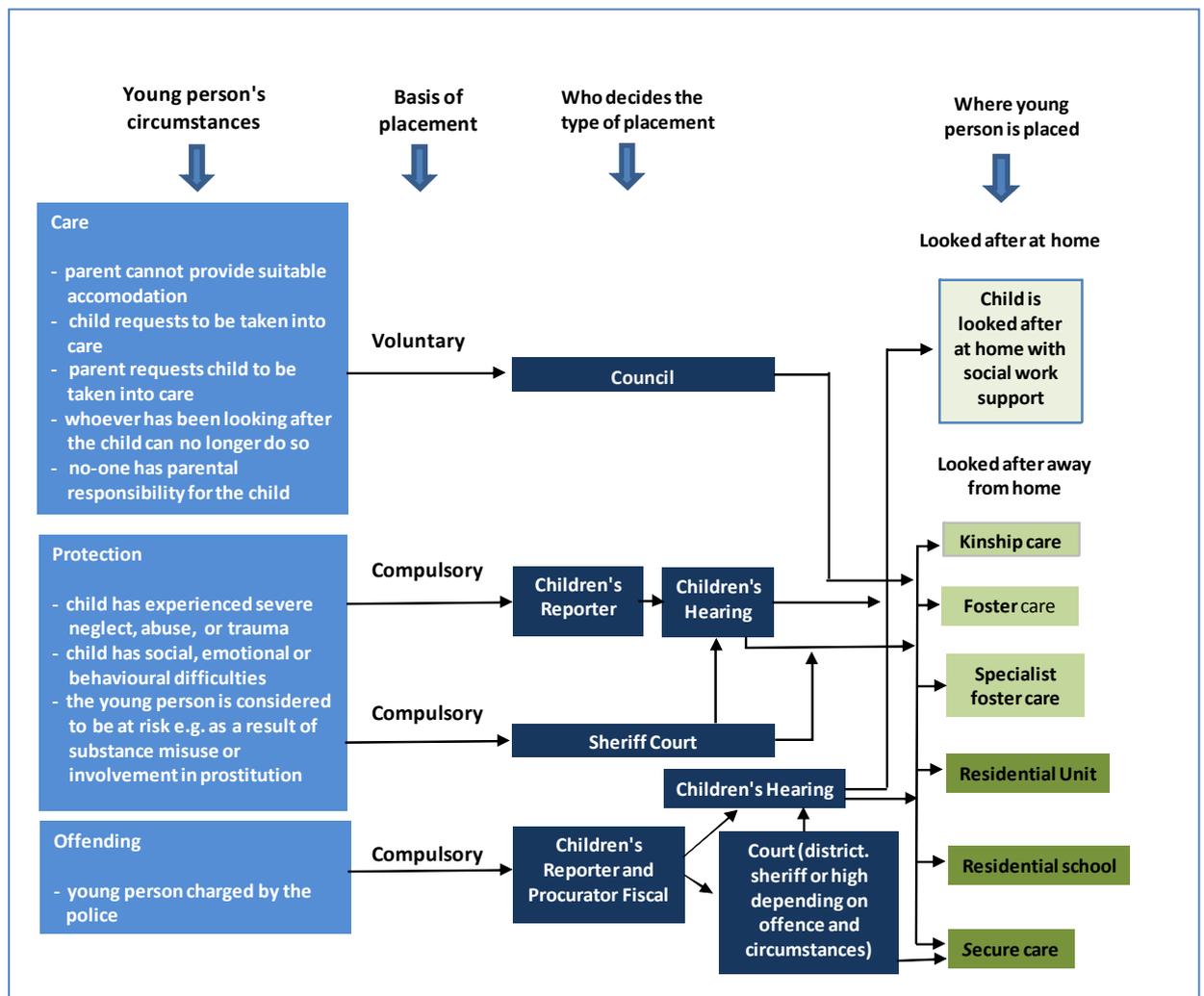


Demographic characteristics: The majority of LACYP are under 18 years of age but figures can also include those up to the age of 21 as local authorities have a duty to provide support to those formerly looked after who go onto further education. This age range will be extended as forthcoming changes in the Children and Young People Scotland Bill will mandate for local authorities to extend the term of responsibility for a young person up to and including 25 years of age (Scotland 2013). In 2011, 18% of LACYP in NHSGGC were under 5 years of age and 12% over 16. Just over half (54%) were male, 4% came from a BME group and 14% had additional support needs (Scottish Government 2012c).

- **Pathways into care:** There are multiple reasons why a child or young person may need local authority care. Lack of parental care was the most frequent cited reason (37%) in Glasgow City in 2012 (Scott et al 2013). Parental drug and alcohol misuse is a contributory factor in a significant number of cases (24%). Socioeconomic deprivation is likely to be a major upstream determinant of need for care (Lachlan et al 2011; Scott et al 2013). Figure 4.5 outlines the various routes by which a child or young person can enter care. Some children may experience more than one trauma before the need for care is identified. There are significant gaps in Information on the health needs of LACYP. A survey of the views of stakeholders show that there is wide agreement that a national health surveillance system would improve this situation especially in tracking LACYP who are placed out with their own board area (Scott et al 2013). A ScotPHN survey in 2010 showed that approximately one quarter of all children and young people in residential care from NHSGGC were placed in local authorities outside the board area (Lachlan et al 2011). There is a degree of instability in many placements which further complicates this; 42% of LACYP from Glasgow City had more than one placement during their care episode and 20% had 3 or more. The median time in care in Glasgow City council is 4 years. Individuals with more care placements tended to be older and have been in care longer (Scott et al 2013).

Figure 4.5: Pathways into Care

(Source: Audit Scotland: Getting it right for children in residential care (2010))



LACYP Health Needs

The Scottish Directors of Public Health group has identified the health needs of LACYP as a national priority. Two recent ScotPHN needs assessments carried out in response to this underlined how little we actually know of the health needs of this group and the challenges facing them (Lachlan et al 2011; Scott et al 2013). A literature review conducted for the Glasgow Centre for Population Health (GCPH) has shown that very few studies have explored the physical or mental health of LACYP. The prevalence of specific conditions varies considerably between the studies; they also lack comparisons with children and young people who are not

looked after and the measures used lack consistency (Scott et al 2012). The review also found that studies examining health behaviours had similar limitations and no studies were found which reported the prevalence of sexual risk taking behaviours in LACYP. The review also highlighted several important unanswered questions e.g. after controlling for deprivation, what health needs are associated with being looked after and do health problems differ by reason for care or care setting?

National Policy

Over the last five years, a range of national documents have highlighted the poorer health, education and life chances associated with being looked after or accommodated. These documents have called for the major institutions in our nation to do more to assist our most vulnerable young people to achieve their potential. Most recently, our Chief Medical Officer noted the importance of positive experience in the early years being associated with positive health outcomes in later life (Scottish Government 2012a) In addition, recent reports on early intervention, risk-taking behaviours and mental health and wellbeing, all highlight the importance and validity of continued support throughout childhood and adolescence especially with respect to ensuring that vulnerable young people are supported to develop and sustain secure attachments with a 'Good Adult'. (Allen 2011a, Headstrong, <http://www.headstrong.ie/>)

- **We Can and Must Do Better** (Scottish Executive 2007) draws upon young peoples' accounts of being looked after or accommodated in Scotland. The report makes recommendations which should create opportunities for success whilst putting in place safety nets at every stage of a young person's life. Five themes were identified around which specific recommendations for agencies and institutions supporting our young people. These are: working together; becoming effective lifelong learners; developing into successful and responsible adults; being emotionally, mentally and physically healthy; and feeling safe and nurtured in a home setting.

- These themes were developed further in **Getting it Right for Every Child** (GIRFEC) (Scottish Government 2012c) where a commitment to keep all our children and young people, safe, healthy, achieving, nurtured, active, respected, responsible and included was made (GIRFEC 2012 p3). These themes were developed into commitments and expectations for children, young people, their families; practitioners and managers (GIRFEC 2012 p5). Tools have been developed to support multi disciplinary and interagency child centric assessment of need such as The Well-being Wheel and My World Triangle (GIRFEC 2012 p9 and 16).
- The **Children and Young People’s Bill** (Scotland 2013) made further recommendations which offer the means to provide a more co-ordinated package of care between partners. It sets the challenge of ensuring the public sector considers children’s rights in line with the United Nations Convention on the Rights of the Child (United Nations 1989). The bill outlines the role of the Children’s Commissioner in relation to the rights of the child as well as laying out new duties and responsibilities for both local authorities and health boards in relation to Children’s Services Planning, shared assessments and the single plan for children. The bill also includes changes to mandate support given to kinship carers, and changes to the Children’s Hearing System. This piece of legislation represents one of the most significant changes to the care system in Scotland for a while.
- The role of the health service in supporting LACYF was made explicit in a letter from the Scottish Executive to Chief Executives in 2009 (Scottish Government 2009). NHS health boards were urged to:

“Assess the physical, mental and emotional health needs of all looked after children and young people for whom they have responsibility and put in place appropriate measures which take account of these assessments. They will ensure that all health service providers will work to make their services more accessible to Looked After and Accommodated children and young people, and to those in the transition from care to independence”

Health boards were set targets to conduct multi-disciplinary health assessments within four weeks of notification and to improve recording and reporting information from the assessments.

Local implementation and practice

The NHS board has implemented and developed a number of practices in response to these national policies. These have involved increasing our understanding of the health needs of LACYP, improving health surveillance, adopting early intervention practices, and developing integrated and coordinated action across the range of agencies involved in the care of LACYP.

NHSGGC and Glasgow City Health and Wellbeing (HWB) Survey of LACYP: In recent years we have been able to gain a greater understanding of the health and wellbeing of 11 to 16 year olds in Glasgow City through their response to the Glasgow Schools HWB Survey (NHSGGC 2012). We are now carrying out a study to explore the health and wellbeing of young people looked after by Glasgow City Council. We hope this study will improve our understanding of the health needs of this group (refer Box 4.1). The HWB survey has been commissioned in conjunction with our partners in Glasgow City Council Social Work. Results will be available and a full report of the findings will be published by the autumn of 2014.

Box 4.1: Health and Wellbeing Survey of Children and Young People Looked After by Glasgow City Council

Survey aim: To increase our knowledge and understanding of the health, health behaviours and potential health determinants of young people aged 11-16 years looked after by Glasgow City Council, and to compare these with the general school population of 11-16 year olds in Glasgow.

A questionnaire has been developed that explores the following issues:

- Demography including age, gender, deprivation category and ethnicity
 - Mental health and wellbeing , including what worries LACYP
 - Bullying, discrimination, illness and disability
 - Oral health, diet, exercise and travel
 - Smoking, alcohol and drug use
 - Sexual health
 - Awareness and use of health services and youth clubs
 - Social and anti social behaviour, carer status and future hopes
-

Improving Health Surveillance: Across the NHSGGC area, children who become looked after are assigned to a specialist LAC nursing team. A health needs assessment is carried out on all children and young people entering the care system, and surveillance data collected. The utilisation of child health surveillance records has been challenging, and is further complicated by the range of different information management systems in use across the public sector. In a number of high profile cases concerning looked after young people, reports have highlighted the challenge of data-sharing arrangements between agencies, and the implications for poor outcomes resulting from this. A number of inquiries and reviews have made reference to the contribution of inadequate surveillance and data arrangements, e.g. Fatal Accident Inquiry into the deaths on Erskine Bridge (Anderson 2012), the Victoria Climbié Inquiry (House of Commons Health Committee 2003), Baby P inquiry (Laming 2009), and Declan Hainey significant case review (Renfrewshire Council 2012). Recent reviews of health visiting, school nursing and specialist paediatric nursing have been accompanied by an investment in information management system EMIS Web. This system will be implemented across primary

care to support improved integrated record management, and implementation of GIRFEC.

Mental Health Screening: In response to We Can and Must Do Better (Scottish Executive 2007a) and CEL 16 (Scottish Government 2009), NHSGGC has begun a programme of implementation with partners in social work and education services. Work is underway to develop and agree mental health screening tools that can be utilised across the health board area for all children entering the care system. In addition, Child and Adolescent Mental Health Services (CAMHS) have a Board-wide team who offer specialist services to looked after and accommodated children across the care settings.

Early Intervention: Graham Allen MP published a series of reports examining early intervention and found improved outcomes for children and young people, and significant savings for society (Allen 2011a and 2011b).

“Early Intervention is an approach which offers our country a real opportunity to make lasting improvements in the lives of our children, to forestall many persistent social problems and end their transmission from one generation to the next, and to make long-term savings in public spending.”

Early intervention is vital for children who are looked after given that they have some of the worst health outcomes of any population group. For example, studies have found that smoking rates were 4 times higher in LACYP than in the non-looked after population of British 11 to 15 year olds (Williams et al cited in Scott 2012 p17) and that smoking prevalence rates in Scottish LACYP was 40% compared with 32% and 34% in England and Wales respectively (Meltzer et al cited in Scott 2012 p17).

Health improvement staff across the NHS Board work with local authorities to support policy development and implementation, as well as implementing interventions aimed at supporting improved lifestyle choices e.g.

- Renfrewshire Health Improvement staff have been working with the local authority to support the Kibble residential and secure unit in Paisley to become a health promoting care home (<http://www.kibble.org/>).
- There is a focus on work with parents, kinship and foster carers in relation to reducing children's exposure to environmental tobacco smoke.

Inter-agency working: There is widespread recognition that improving health outcomes requires integrated and coordinated action across a range of agencies. For young people it is important to identify the settings and agencies with which young people are engaged. Due to the extreme vulnerability of LACYP, there are a range of service providers working in partnership with social work services, the NHS and education to maximise youth engagement and provide a range of supports and activities to improve health outcomes.

Some of the larger voluntary organisations are responsible for providing foster care, residential care and community support for looked after young people. The diverse range of care and support models, along with the vast array of providers, can present challenges for statutory organisations in ensuring communication and partnership is inclusive. The second tier voluntary organisations Social Care Ideas Factory (SCIF) and the Glasgow Council for Voluntary Services (GCVS) provide a platform and mechanisms for improved partnership working.

The fatal accident on the Erskine Bridge (Anderson R. 2012), highlighted the poor mental health of many young people in care. The NHSGGC Mental Health Improvement and Early Intervention Strategy (2012) has six priority areas for action (Box 4.2). Of the six areas in the strategy, dialogue through SCIF has generated partnerships with third sector organisations who feel they can play a significant role in the delivery of 'One Good Adult' for LACYP. Work with the third sector is in development and SCIF are already working across planning structures such as the Choose Life strategy group in Glasgow, to support vulnerable young people.

Box 4.2: NHSGGC Mental Health Improvement & Early Intervention Strategy for Children and Young People, 2012

<p>One Good Adult Importance of dependable adult to supporting and protecting mental health of children and young people - e.g. strengthen parenting, mentoring, guidance, befriending initiatives</p>	<p>Resilience Development in Schools Whole school approach to mental health and wellbeing - ethos, curriculum, positive behaviour, anti-bullying, pastoral care . . .</p>	<p>Resilience Development in Communities Strong network of youth services, voluntary and community organisations, confident and skilled to support and intervene</p>
<p>Guiding Thru the Service Maze Children, families & young people have a range of support options for early intervention and can be helped to find their way to appropriate help quickly</p>	<p>Responding to Distress Frontline staff in many agencies are confident and supportive to intervene and help children and young people in situations of distress, including self harm and risk of suicide</p>	<p>Peer Help & Social Media Those who share their problems enjoy better mental health - build opportunities for young people to provide peer support, and to use social media for wellbeing</p>

Across NHSGGC work is progressing against all six strategic priority areas detailed above e.g.

- Across NHSGGC, referral criteria have been agreed and developed into an online tool for practitioner use. This is being piloted in Glasgow, with a view to being rolled out across the NHSGGC board area. Use of this referral pathway should support appropriate referral of young people to mental health and wellbeing support services as well as to CAMHS, based on need.
- Within each locality, discussions between health improvement teams and local authority education departments are ongoing to ensure that mental health and wellbeing curricular resources are in place, and meet the requirements of curriculum for excellence.
- NHSGGC is working in partnership with voluntary sector social care providers to develop resources and identify where support is required to implement the Mental Health Improvement and Early Intervention Strategy for Children and Young People.

- Research into how young people use social media to access help and services has been commissioned; the findings will influence the ways in which we engage young vulnerable people in the future.
- A training plan has been developed for use across the NHSGGC board area to ensure that all NHS staff who work with young people are equipped and confident to identify and deal with a range of mental health and wellbeing issues. Work has begun with partners and voluntary organisations to extend the use of the training plan to build capacity across the board area.

Priorities for Action

Priority 1: Build our knowledge of the health needs of LACYP

There is a lack of locally based information on the health needs of LACYP. The forthcoming health and wellbeing survey will enhance this knowledge and will be a key resource in strengthening our understanding of this vulnerable group.

We need to:

- Fully utilise the data collected in the survey.
- Provide reports and tailored analyses to inform service planning and delivery, outlining any policy implications.
- Ensure the findings are widely disseminated through presentations, seminars and workshops with our partners.
- Use the knowledge gained to stimulate further research.

Priority 2: Improve our local Intelligence gathering: ScotPHN needs assessments have highlighted our lack of knowledge of the health of LACYP

We need to:

- Develop a local electronic core data set from the routine physical and mental health assessments of LACYP.
- Agree local codes for child health systems to include looked after status.
- Develop links between Local Authority and NHS datasets, possibly through Safe Haven using the child's CHI number (Community Health Index) as a secondary identifier. This would require that all local authorities record the CHI number for every child. The CHI number is key to this as LACYP often change address and surnames.

Priority 3: Improve health surveillance across the NHS Board area

The implementation of EMIS Web and TrakCare systems will improve integrated patient records management. The LAC nursing and CAMHS teams play a vital role in ensuring health needs assessments and mental health screening are carried out and recorded and data are used for individuals' care and for service planning and evaluation.

We need to:

- Work with our local authority, care service partners and the LAC nursing team to carry out health needs assessments as outlined in CEL16.
- Agree the use of specific tools (e.g. CORE10 DAS SDQ) to assess mental health needs and ensure referral to appropriate services.
- Monitor health care pathways.

Priority 4: Improve mechanisms for sharing information: NHSGGC works closely with our partners from statutory and third sector agencies

We need to:

- Embed the GIRFEC approach in our approach to working with partners.
- Engage with all agencies involved with LACYP ensuring our links are robust.
- Ensure there are effective links between our own health improvement and specialist children's services.

Priority 5: Promote early interventions

Early intervention is important for LACYP as they experience some of the worst health outcomes of any population group. All agencies and staff involved with LACYP must understand the dangers of smoking and exposure to second-hand smoking. They must make every effort to support LACYP to avoid smoking and to encourage young people to access support to quit smoking.

We need to:

- Learn best practice from ongoing projects e.g. the collaborative health promotion work undertaken in the Kibble Centre in Renfrewshire and board wide training in smoking brief interventions.
- Ensure smoking prevention and cessation is prioritised for all LACYP.
- Provide training to care staff to enable them to deliver brief interventions in smoking cessation.

Priority 6: Kinship carers require financial, practical and emotional support

There has been a substantial increase in the number of LACYP in Kinship care in recent years which is expected to rise further.

We need to:

- Get the views of kinship carers and foster carers on the parenting support that would be of most value as the NHSGGC parenting framework is being revised.
- Raise awareness of the importance of 'One Good Adult' for LACYP with our statutory and third sector partners.
- Support parenting programmes for both parents and carers.

Chapter 5: Improving health in NHSGGC's prison settings

Scotland has one of the highest rates of imprisonment in Europe and a rising prison population (Scottish Government 2011a). Most offenders are re-offenders, 78% have previously been on remand and 70% have served a prison sentence (Scottish Prison Service 2011). Most offenders come from areas of deprivation; the Greater Glasgow and Clyde region is disproportionately affected. 80% of prisoners are unemployed at the time of sentencing and under 10% gain employment after liberation (Marshall et al 2001). Females comprise 5% of the prison population but the female population has doubled in the past decade (Commission on Women Offenders 2012).

Prisoner health

Physical and mental illness in the prison population is disproportionately high compared to the general population. This is due to socio-economic disadvantage, lifestyle and behavioural factors such as substance misuse, smoking and poor nutrition (SEU 2002; Graham 2007). Many of the prison population are a product of the care system and at some points in their lives have experienced physical, emotional or sexual abuse. Levels of educational attainment are low and unemployment levels are high amongst offenders. Imprisonment can contribute to poor health and exacerbate social exclusion (SEU 2002; Bradley 2009). Many prisoners experience mental illness (predominantly anxiety and depression) following incarceration, lose contact with families and are homeless, unemployed and socially isolated on liberation (Bradley 2009). The Better Health, Better Lives report (Brutus et al 2012) provides a national analysis of prisoner health needs. A more detailed regional health needs assessment for Greater Glasgow and Clyde (Gillies et al 2012) highlights several concerns:

- **Alcohol** misuse is linked to violent crime (MacLeod et al 2009). Half of prisoners were drunk whilst offending (Scottish Prison Service 2011). Prisoners with alcohol problems have complex needs including dual diagnoses (mental illness, substance misuse, physical health problems) and problems with housing,

employment and relationships. Overall, 44% of men and 48% of women in prison were found to have an alcohol problem compared to 13% of men and 9% of women in the general population and this is especially problematic amongst remand prisoners (Parkes et al 2010).

- **Drug misuse** is associated with psychiatric morbidity, alcohol dependence, blood borne viruses (BBV) and social exclusion including homelessness, unemployment and relationship breakdown (ISD 2012a). Problem drug users are at risk of premature death because these factors have a negative impact on life expectancy. The rate of drug related death in Scotland in 2010 was 9 per 100,000 population (GRO 2011). 70% of prisoners report use of illegal drugs in the 12 months before being in prison; over 40% said that they were under the influence of drugs at the time of their offence, often committed to get money for drugs (Scottish Prison Service 2011). Over ten thousand new clients access drug treatment services in Scotland each year and 20% funded their drug use by crime and 20% had been in prison (ISD 2012a).
- **Smoking** prevalence overall is 76% in the 2011 Scottish Prisoners Survey compared to a Scottish population reported rate of 26% men and 25% women. Local data suggest that the rate for females in HMP Greenock is over 90% (Scottish Government 2011b; ISD 2012b). Tobacco is used as a coping mechanism and also a currency in prisons, but many offenders do want to quit.
- **Oral health** is very poor compared to the general population. Whilst current data is not readily available, a major study in 2002 noted that 76% of men and 89% of women had unmet dental care needs (Jones et al 2004). It may not be viewed as a priority by prisoners who live complex and difficult lives (Bradnock et al 2001). Prisoners are less likely to engage with preventative health care and are less likely to attend a dentist unless they are experiencing dental pain (Bradnock et al 2001; Graham 2007).

- **Chronic diseases:** Although over 90% of those incarcerated are under 50 years of age (Scottish Government 2011a), prisoners are at increased risk of chronic disease due to the high prevalence of risk factors for poor health among this group. In the 2011 Scottish Prisoners Survey 29% of participants in HMP Barlinnie and 28% in HMP Greenock reported having one or more long-term illness (Graham 2007; NHS Scotland 2010; Scottish Prison Service 2011).
- **Mental health problems** and co-morbidity of mental health and substance misuse problems are common. A 1998 Office of National Statistics study of 1437 prisoners in England and Wales found 90% of prisoners had one or more psychiatric disorder (Sirdifield et al 2009) and 80% of prisoners had two or more psychiatric disorders, most commonly a psychiatric illness and substance misuse. Around 15% of the prison population had severe and enduring mental illness. The Commission on Women Offenders (2012) reports a rate of 80% mental illness among female offenders in Scotland.
- **Blood borne viruses:** Offenders are at risk of BBV through high-risk sexual behaviour, drug and alcohol misuse (Green et al 2003a; Graham 2007). Prisoners and young offenders are more likely to have more lifetime sexual partners, higher risk partners (sex workers and/or intravenous drug users), and unprotected sex than the general population (Green et al 2003b; Buston 2008). Hepatitis C (HCV) is most commonly associated with a history of injecting drug use and approximately 90% of intravenous drug users have been imprisoned at some point during their injecting careers (Ball 1995). The prevalence of HIV and Hepatitis B is low in Scottish prisons but a significant proportion of prisoners are infected with HCV (Green et al 2003a; Champion et al 2004). A national study of HCV prevalence among Scottish prisoners found a prevalence of 24% in HMP Greenock and 29% in HMP Barlinnie (Taylor et al 2012) compared to 1% in the general population, and many of these infections remain undiagnosed.

Female offenders

Female offenders are an especially disadvantaged group. Many women have complex needs related to social circumstances, histories of abuse and gender based violence as well as addictions problems. Most women in prison have mental health problems. Their children have greater risk of physical and mental health problems and of becoming offenders. Prison is expensive for men and women and has little impact upon offending with 70% of women given short term sentences being reconvicted within 2 years (Commission on Women Offenders 2012).

Prisoner families

Offending and incarceration affect the health of prisoners' families, creating inter-generational health inequalities. In the 2011 Scottish Prisoners Survey, 48% of those participating reported having one or more dependent child (Scottish Prison Service 2011). A third were caring for their children before being incarcerated and 42% will be caring for their children on liberation. This is greater for female offenders. Prisoner families can be victims of crime and frequently experience stigma, loss of income and housing uncertainty. Children are at greater risk of poor health. Approximately 30% of children with imprisoned parents go on to develop physical health, mental health and addictions problems and have substantially greater chance of offending (Commission on Women Offenders 2012).

National policy

The health and welfare of prisoners and their families is highly linked to poverty. It has been a policy concern historically, through the prisons reform movements and, internationally, through the World Health Organisation (Moller et al 2007). Criminal justice policies developed by the Scottish Government focus upon reducing (re)offending and the personal, social and economic harm it creates, acknowledging the relationship between offending and health.

The strategic link between national and local policy is provided by Community Justice Authorities who include amongst their objectives the improvement of health and welfare of offenders in and leaving prison and their families in partnership with

the NHS. Several linked policies have shaped the public health approach to prisons and offenders:

- The transfer of responsibility for healthcare (including the employment of staff) from the Scottish Prison Service to NHS boards in 2011 to enhance provision and through-care connections with community health services. NHSGGC have taken responsibility for healthcare in HMP Barlinnie, HMP Greenock and HMP Low Moss. We currently have between 40 and 50 female offenders in HMP Greenock but will be responsible for delivering healthcare in the new national female prison that is being built in the NHSGGC area.
- The Scottish Government's Reducing Reoffending Programme (RRP) has several goals including reform of sentencing policy and an explicit aim of ensuring effective reintegration into the community by ensuring that employment, health, accommodation and other needs are met. This places a health focus upon through-care and rehabilitation.
- The Commission on Women Offenders (2012) has profoundly shaped Scottish Government policy. The NHS has an ongoing role in supporting the refocusing of provision to community justice centres with multi-disciplinary teams as alternatives to custody: appropriate health services in the new female prison and a series of community mental health initiatives.
- Better Health, Better Lives (Brutus et al 2012), the national framework for public health in prisons, builds upon substantial Scottish Prison Service (SPS) health promotion policies in areas ranging from nutrition to suicide prevention, and provides a framework for regional action in prisons.

Wider national health and social policies have also prioritised offending and prisons, for example, The Same as You Review (Scottish Government 2012a) focuses upon the needs of people with learning disabilities; The Mental Health Strategy (Scottish Government 2012b) focuses upon female offenders; The Road to Recovery (Scottish Government 2008) provides direction for addictions policy; and prisoners and ex-offenders are an important element of equalities in anticipatory care in the national Keep Well programme.

Local Implementation and Practice

NHSGGC has responded to the national policy agenda with a robust strategy and programme in partnership with a number of statutory and community partner agencies. An Offenders and Prisons Health Improvement Group manage our strategic system-wide approaches and ensure that all parts of the system take account of the needs of prisoners and offenders. Some important actions to date include:

- Completing a health needs assessment (Gillies et al 2012) with the prisons that has informed the development of an evidence-based public health programme.
- Developing an ambitious health improvement programme with each prison for 2013-15. The programme has 30 objectives in health areas including mental health, drugs and alcohol, smoking cessation, physical activity, sexual health, BBV, parenting, health at work, anticipatory care and long term conditions, oral health and through-care.
- Ensuring strong strategic connections between policy and practice regionally and nationally. Our Glasgow City CHP Director chairs the national health and prisons network (HIS) and our Director of Public Health chairs the Glasgow Women's Justice Centre initiative.

NHSGGC support several multi-agency initiatives which aim to improve health in community settings that link closely to offending. This includes supporting policies to reduce offending and the health problems it creates, for example, violence reduction schemes. In addition, NHSGGC are a partner in the One Glasgow initiative with Strathclyde Police to reduce offending amongst young people whilst addressing health needs. We support the process to develop a pilot community justice centre for female offenders in Glasgow. We are reviewing through-care for those leaving prisons in line with a current national development framework. Core partners in developing our strategic approach are North Strathclyde and Glasgow City Community Justice Authorities. Together we are jointly developing a model to inform our public health beyond the prisons walls to: support the health of victims of crime; support the families of those sent to prison; prevent crime; intervene early for those at risk; and support health through-care and rehabilitation for those leaving prisons.

Local Practice

In partnership with our colleagues in SPS, we are enhancing the delivery of health services and public health interventions in our prisons and key achievements are:

- A prison-based team are delivering the Keep Well programme of anticipatory health care checks in each prison. They have completed over 300 health checks this year. In addition, prison-based NHS staff have continued to deliver broad based health checks called well man and well woman to prisoners of all ages.
- We are training and mentoring staff in each prison in smoking cessation approaches that match our community services and are working to increase significantly the provision of smoking cessation groups to meet need.
- We are piloting an activity on referral project for the most vulnerable prisoners including those with disabilities, mental health problems and older prisoners. This scheme builds upon the live active programme in the community and offers a range of physical activities and health education sessions. Prisoners are referred through our Keep Well health reviews based upon need.
- We are supporting the implementation of parenting programmes for offenders and their families in HMP Barlinnie and we are developing plans to scale up parenting programmes across the three prisons in partnership with SPS staff in prisons and at SPS HQ.
- We are developing a health education programme to cover key health issues including mental wellbeing and relationships. We will explore the role of peer educators.
- We are supporting prisons to complete health promotion initiatives and policy developments to retain or achieve Healthy Working Lives Awards. HMP Barlinnie and HMP Greenock undertake health activities for both staff and prisoners as part of their schemes.
- We are reviewing the sexual health and blood borne virus pathways for all prisoners with the Sandyford Initiative and the Brownlee Centre for Infectious Diseases which provides a range of adult treatment services. We have improved the sexual health service provision for female offenders through the development of an in reach service at HMP Greenock.

- The healthcare team is developing a new recovery-focused model of provision to support those offenders with addictions problems. This is supplemented by the recruitment of dedicated staffing resource to identify and support those with alcohol problems, including those on remand.
- We are increased the capacity to deliver alcohol brief interventions in the prison setting by training NHS and SPS staff and we have recently recruited alcohol brief intervention nurses to support offenders including those on remand sentences.
- We have invested in improved facilities for dental services and recruited more dentists to meet need. We are currently developing an approach to improve oral health promotion.
- We have contributed to a national work stream which is proposing the development a stepped model of care for mental health incorporating mental health promotion, prevention and early intervention. This model will include staff training in mental health.
- We are undertaking a project to establish the levels of learning disabilities amongst our prison population and to identify their health needs.
- We are supporting the development and evaluation of a pilot Women's Justice Centre in Glasgow.

Key Issues

A number of key issues make this public health topic especially important and will shape our work in future years:

- Potential restrictions on public finances, welfare benefits and employment opportunities, combined with relatively high socio-economic disparities in NHSGGC, may result in an increase in offending with consequent impact on health of offenders, families and victims. This makes public health interventions especially important.
- National policy is recognising that incarceration generally does not achieve the objective of reducing reoffending and the health service has an important role, with partners, in supporting alternatives to prison.

- Public health has a role in upstream prevention of offending through our work on social conditions and circumstances. For example, given that most offenders come from and return to areas of deprivation, an increasing focus upon these areas in partnership with community planning, may reduce offending and health inequalities. Equally, public health has an important role in supporting legislation and policy that reduces crime, for example, policies on minimum alcohol pricing.
- The increasing recognition of the needs of female offenders. By adopting an inequalities lens, we know most of these women are extremely vulnerable. The NHS has a role in creating a paradigm shift in the way we view and respond to female offenders.
- Short-term prisoners and remand prisoners can often miss out on health and social care interventions. Yet these are very often the individuals with high and complex needs and they should be a priority group for public health.
- A major barrier to re-integration for many offenders is not just addiction and poverty but wider social stigma. This can be a barrier to developing supportive social networks and relationships and to gaining employment and income. NHSGGC has experience of addressing stigma and discrimination, and promoting recovery, peer support models and citizenship for those with addictions and mental health issues and can assist in promoting wider social changes in the longer term.
- The prison population is changing. It is slowly becoming older overall (Graham 2007) and there has been a significant increase in female prisoners over 30 years (Commission on Women Offenders 2012). It is therefore necessary to plan ahead to meet the needs of older prisoners who will have greater levels of physical illness, disability and chronic conditions. It is also important to more clearly establish the levels of learning disabilities and of mental illness amongst our offenders in order to shape services and through-care more effectively for them.

Priorities for Action

Priority 1: Develop a 'whole prison' approach to health improvement

We need to:

- Implement and evaluate the agreed programme of service development and health improvement objectives in Low Moss, Barlinnie and Greenock Prisons between 2013 and 2015.

Priority 2: Reduce potential for adverse impact of imprisonment on the health of prisoners and their families

We need to:

- Work with partners including the Community Justice Authorities, Scottish Prison Service, nationally funded project by Sacro and Wise group to promote health in through-care and social inclusion of those leaving prison.
- Support prisoners' families, alongside Families Outside, by increasing their access to support services and parenting programmes in the community, by increasing the number of health and parenting programmes for those in prison, and by developing practitioners training.
- Evidence based-parenting programmes should be more widely available in Barlinnie, Greenock and Low Moss prisons, building on the successful use of Triple P in Barlinnie and linked to enablement of family contact.

Priority 3: Ensure that the needs of specific subgroups of prisoners are understood and met

We need to:

- Work with partners to address the physical health, mental health and addictions needs of female offenders and their families within the new national prison service in NHSGGC and through the new Community Justice Centre, in line with recommendations from the Commission on Women Offenders (2012).

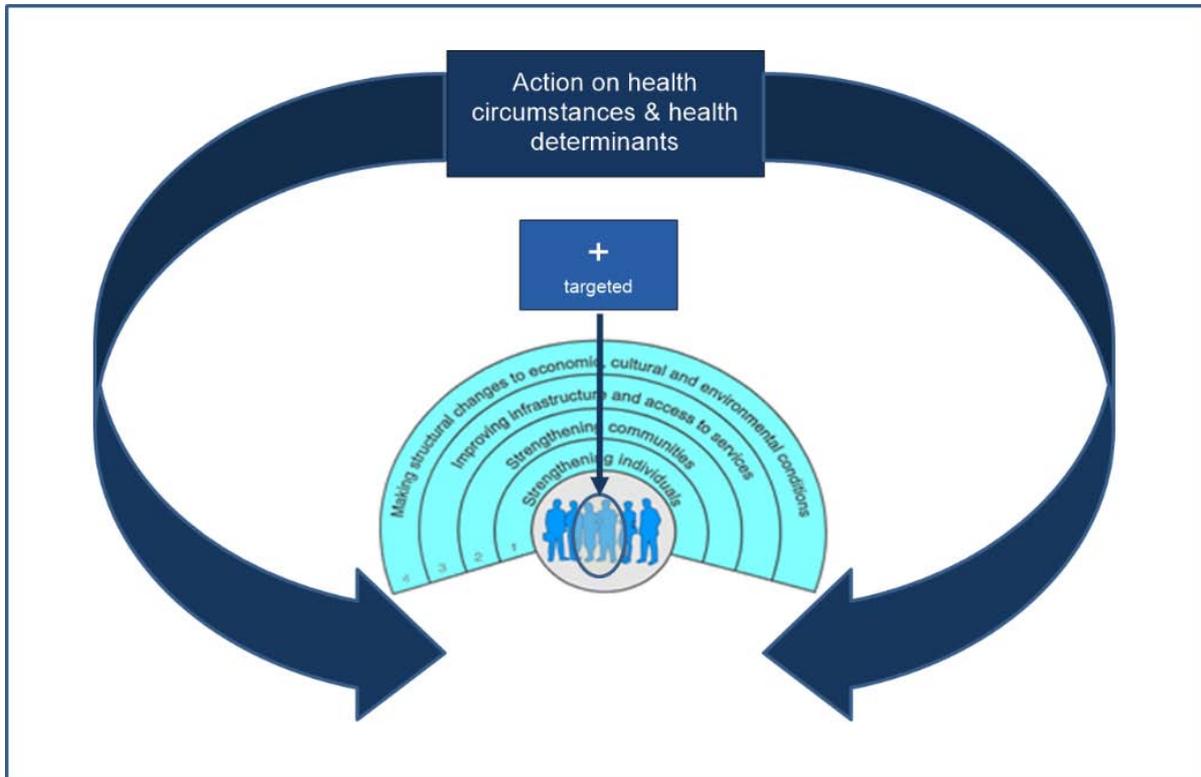
- Focus upon providing evidence-based supports to those with alcohol addiction, as prison provides an opportunity to support abstinence. This includes alcohol screening and brief interventions.
- Ensure consistent approaches to BBV vaccination, testing and treatment are in place across local prisons, reduce the number of undiagnosed HCV infections, and increase the proportion of diagnosed cases accessing in-reach treatment.

Putting it all together

As well as presenting data, this report is about celebrating achievements and showcasing examples of best practice in public health. We hope that it will inspire others to get involved in this collective movement for change to mitigate some of the health effects of poverty and disadvantage. The scale of transformational change required to achieve a step change in the health of our population will need clear, courageous action that is fully joined up on a reduced number of priorities which go beyond the short term and well beyond the boundaries of our own organisation. At present, we are asked to respond to a plethora of policies, performance frameworks and initiatives that do not sufficiently impact on public health. This report contains many calls for reviews, evidence, strategies and information. Arguably the greater priority is for population needs to be translated more systematically and coherently into action.

Clarity and focus are becoming ever more vital as we respond to the increasing external challenges we face as an organisation. Increasing demands on services and public sector budget challenges mean that financial pressures are intensifying. Public health can help shape a response to these challenges by: providing an objective analysis of population needs; advising on evidence based health and social care systems; and supporting an evaluative perspective on evolving services and strategies. As we enter yet another phase of major structural change in health and social care services in Scotland, we will need to focus even more strongly on cost effective actions for the most important drivers of health in our population. This will require an explicit framework of clearly defined interventions, based on need, co-production approaches and balancing individual level interventions with effective action on the determinants of population health in NHS GGC. Figure 1 shows the requirement to balance individual level healthcare with wider preventive action.

**Figure 1: Balancing individual level healthcare with wider preventive action
(Modified from Dahlgren & Whitehead)**



NHSGGC has an exceptionally strong track record of developing new initiatives for improving services to patients and to our wider population. This report describes just a fraction of the innovation which has taken place since the last biennial DPH report. However, some of this innovation is fragmented, localised and risks ‘withering on the vine’ if not understood, supported and embedded in the wider organisation. There is an urgent need to accelerate evidence-based redesign of services and get real energy behind the transfer of knowledge and experience about what works best for our local health system. The work underway in redesign of our future clinical strategy provides an important opportunity to deliver transformational change, by integrating evidence based prevention into all of our clinical systems in ways that reflect the experience, capacity and learning of real people in our communities and those at the front line of service delivery.

We also continue to have a duty to assess the health needs of population groups and communities who are adversely affected by welfare changes, lack of employment opportunities and in-work poverty, in order to advocate for changes in national policy, local responses and social attitudes.

Glossary of Terms

BBV	Blood Borne Virus
Brief Intervention	A brief intervention is the provision of information, advice and encouragement to a person to consider the positive and negative impact of their behaviour. Help is then provided if the person decides to make changes
CAMHS	Child and Adolescent Health Services
CfE	Curriculum for Excellence
CHI	Community Health Index or CHI Number is the national unique number for any health communication related to a given patient.
Chronic Disease	A disease that persists for a long time
Community Health Partnership (CHP) and Community Health and Care Partnership (CH(C)P)	Community Health Partnerships are organisations that have been developed across Scotland to manage a wide range of community based health services. In some parts of NHS Greater Glasgow and Clyde, these

	new partnerships will also be responsible for many local social care services and are called Community Health and Care Partnerships, CH(C)Ps
Community Planning Partnership	A range of partners in the public and voluntary sectors working together to better plan, resource and deliver quality services that meet the needs of local people
CORE10	Clinical Outcomes in Routine Evaluation Questionnaire
CSWS	Children's Social Work Statistics
CVD	Cardio Vascular Disease
DAS	Differential Ability Scale
Data zones	Data zones are aggregates of unit postcodes and census output areas and nest within Local Authority boundaries. They are the building blocks of the Scottish Neighbourhood Statistics programme which is intended to make available small area data of many different kinds across Scotland

Deprivation Quintiles	Deprivation quintiles divide areas in fifths according to some measure of deprivation, and can be used to analyse variations in health between the most and the least deprived sections of the population regardless of where they live
EHRC	Equality and Human Rights Commission
GCPH	Glasgow Centre for Population Health
GCVS	Glasgow Council for Voluntary Services
GIRFEC	Getting it Right for Every Child
GP	General Practitioner
GRO(S)	General Records of Scotland
HCV	Hepatitis C Virus

Health Inequalities	The gap between the health of different population groups such as the well-off compared to poorer communities or people with different ethnic backgrounds
Health Life Expectancy	An estimate of how many years they are expected to live in a healthy state, free from morbidity
Healthy Working Lives Award	The Healthy Working Lives Award programme supports employers and employees to develop health promotion and safety themes in the workplace in a practical and logical way, that's beneficial to all
HIV	Human Immunodeficiency Virus
HMP	Her Majesty's Prison Service
HWB	Health and Wellbeing
ISD	Information Services Division, part of NHS National Services Scotland

LAC	Looked After Children
LACYP	Looked After and Accommodated Children and Young People
Life Expectancy	An estimate of how long the average person might be expected to live
Long Term Condition (LTC)	A condition that requires ongoing medical care, limits what one can do, and is likely to last longer than one year
Morbidity	The presence of disease or medical conditions
Needs Assessment	A formal process undertaken to assess the health and social care needs of a given population
NHSGGC	NHS Greater Glasgow and Clyde
NRS	National Records of Scotland
SAPE	Scottish Area Population Estimates
SCIF	Social Care Ideas Factory

ScotPHN	Scottish Public Health Network
SDPH	Scottish Directors of Public Health group
SDQ	Strengths and Difficulties Questionnaire
SIMD	Scottish Index of Multiple Deprivation (SIMD) identifies small area concentrations of multiple deprivation across all of Scotland in a fair way. It provides a wealth of information to help improve the understanding about the outcomes and circumstances of people living in the most deprived areas in Scotland
Socio-economic	Involving a combination of social and economic matters
Social Exclusion	A situation in which some members of a society do not feel part of that society because they are poor or do not have a job
SPS	Scottish Prison Service

WHO

World Health Organisation

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Chapter 1: Supporting our most disadvantaged families

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