Greater Glasgow and Clyde NHS Board

Board Meeting
17 December 2013   **Board Paper No: 13/54**

Director of Public Health

BUILDING MOMENTUM FOR CHANGE

**Biennial report on population health in NHS Greater Glasgow and Clyde
2013-2015**

RECOMMENDATIONS:

The NHS Board is asked to receive the draft report of the Director of Public Health
on population health in NHS Greater Glasgow and Clyde (NHSGGC) 2013-15 and
to:

1. Endorse the central importance of poverty and disadvantage in shaping the health
   of the NHSGGC population across the life course

2. Support the recommendations for action by NHSGGC to reduce the adverse
   health impact of poverty and disadvantage

Background

This is the fourth biennial report of the Director of Public Health. Covering the period
2013 to 2015, it highlights the pivotal importance of poverty and disadvantage in
shaping health at three key life stages (early years, adolescence and mature adults)
and in two priority groups (Looked After and Accommodated Young People and
Prisoners). The report also includes a description of progress made since the
previous report: 'With Health in Mind'.

Dissemination

The report will be formally launched this afternoon (17th December 2013) at an event
at which Sir Harry Burns, Scotland's Chief Medical Officer will respond to the report.
All Board members are cordially invited to this launch event at the Heart of
Scotstoun. The intended audiences for this report include, in addition to our own
organisation, wider public agencies and Community Planning partners, who are
urged to reflect carefully about potential impact on population health on all decisions
about services and priorities in a time of constrained public sector budgets. As in
previous years, the report will be disseminated in electronic form only, for reasons of
environmental sustainability, accessibility and cost. I will also present the report at a
range of local events, to CH(C)P and local authority staff and to a wide range of
community groups.

Ensuring that the DPH Report leads to change

It is vital that the priority actions identified in this report translate systematically and coherently into action on the ground. Accordingly, the Public Health Directorate will use its existing inputs into the relevant internal and joint planning groups to oversee implementation of these actions. Progress on implementation of the recommendations will be reported at the December 2014 Board meeting.

BUILDING MOMENTUM FOR CHANGE

**Biennial report on population health in NHS Greater Glasgow and Clyde
2013-2015**

Introduction – personal reflections from the Director of Public Health

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.

Priorities for Action, Chapter 1: Supporting our most disadvantaged families

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.

Priorities for Action, Chapter 2: The transitions of adolescence

Priority 1: Address the needs of young people who are exposed to persistent poverty

We need to:

- Influence local Community Planning partners to address the needs of young people who are exposed to persistent poverty.
- Increase the range of opportunities that will enable young people to improve their wellbeing and resilience.
- Support young people to develop the life skills necessary for future employment and/or positive destinations.

Priority 2: Develop clearer focus on youth health as a priority

We need to:

- 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 NHSGGC.

Priority 3: Strengthen evaluation, innovation and improvement activities

We need to:

- Review youth health services in NHSGGC 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 for important groups.

Priority 4: 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.

Priorities for Action, Chapter 3: Promoting healthy ageing

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.

Priorities for Action, Chapter 4: "Getting it Right" for looked after and accommodated children and young people

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 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: Develop 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.
- Utilise second tier organisations such as SCIF and GCVS.
- 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.

Priorities for Action, Chapter 5: Improving health in NHSGGC's prison settings

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. Also 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 on 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 NHSGGC. 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)
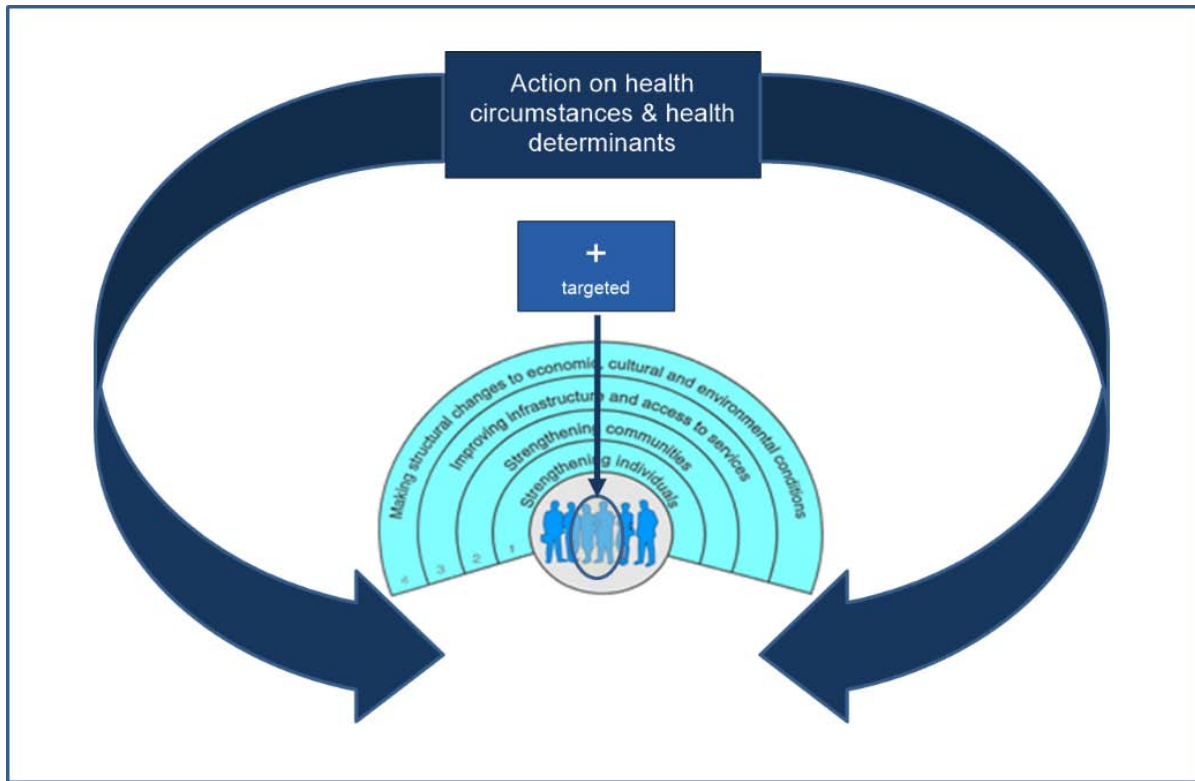
NHSGGC has an exceptionally strong track record of developing new initiatives for improving services to patients and to our wider population. This report describes just a fraction of the innovation which has taken place since the last biennial DPH report. However, some of this innovation is fragmented, 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.