Glasgow City Community Health Partnership

NHS
Greater Glasgow and Clyde

Strategic Direction for the GCHP Health Improvement Workforce, 2013

1.   Purpose

1.1   This paper proposes the strategic direction for the health improvement workforce within Glasgow Community Health Partnership (GCHP) over the next 3-5years.

1.2   This recognises that the GCHP health improvement workforce is part of a much wider health improvement endeavour within the city. This paper should be seen as the first phase in the development of a clear strategic direction for all working to improve health within Glasgow. To this end strategic clarity for the health improvement workforce is a critical marker, recognising that these staff are often the local champions that will generate debate with the wider GCHP workforce and partners to determine this broader strategic direction.

1.3   This paper is the result of a process started at an event with health improvement staff in May, 2011 where the need for a clear strategic direction within GCHP was raised. Since then a process of developing and discussing the strategic direction has taken place, using an approach of consultation based on saturation criterion (grounded theory), where dialogue continues until views and concepts are regularly repeating.

1.4   Over 360 people have engaged in these discussions, 43% from out with the NHS, with the bulk of discrete views emerging by May 2012. This paper is the result of comments and views expressed on the original discussion paper, and further work undertaken to clarify and determine the core strategic elements required.

2.   Context

2.1   Health is a resource for living, a consequence of who we are, where we live and how we live. Within this context health improvement works on a collective (groups, communities and populace) level to affect aspects of the 'where' and 'how' we live on our health experiences.

2.2   The Scheme of Establishment articulates the ambitions of the NHS for the Community Health Partnership in driving forward health improvement with and for our population. Within GCHP health improvement takes place in the daily interactions between staff and patients and through our specialist health improvement workforce.

2.3   GCHP invests around £9 million in health improvement staff and services annually (1.7% of our budget); with almost a quarter of this direct Scottish Government funding for specified programmes. As well as the GCHP specialist health improvement workforce specialist staff within Public Health, hosted teams and the Public Health Resource Unit (PHRU) provide collectively nearly a third of the specialist activity in the City.

2.4   There is a strong national drive for prevention across Scotland. This has lead to clear health improvement targets articulated within all policy and national strategic frameworks, both for community planning and the NHS. Organisationally half of our HEAT targets relate to health improvement activity. This challenges us on where effort can most productively be focused in a way that redresses the existing and anticipated inequalities gap.

2.5   In almost all population risk measures Glasgow fairs very poorly. We are the local authority area that contributes most to the poor international health statistics that Scotland is known for. Male life expectancy in Glasgow has increased by nearly 3 years over the last two decades; however the improving trend in Glasgow has not kept pace with improvements other parts of Scotland. Within Glasgow there is now a 16 year gap in male life expectancy between the least and most deprived areas. Appallingly the gap is two years greater than it was two decades ago, reflecting that the improvements we have seen have by-passed our poorest residents and contributed to widening the gap.

2.6   Our healthy life expectancy is equally poor. A quarter of young people at secondary school in Glasgow City (Youth Health Survey, 2010) already have a long term condition. This has increased significantly since the last school survey in 2006/7. Likewise the rates are higher in our most deprived schools where a third of pupils report having a long term condition. This means that the burden of illness starts early and the consequences of illness extend further for our population, and that the gap in healthy life expectancy starts very early indeed. Our challenge is in determining where to focus our health improvement specialist's efforts in a city with such considerable and stark need.

2.7   During the process of the development of the strategic direction for health improvement GGC NHS Board have been developing Planning Guidance for 2013-16. This incorporates the Health Improvement Policy Framework and health improvement components for each of the service planning frameworks. Within the planning guidance for GGC NHS 49 health improvement priorities/strategies across the eleven planning frameworks are articulated, for which our existing health improvement workforce are supporting action on many of these.

2.8   This paper is set within the backdrop of these demand and financial challenges and an updated understanding of how the health of the city has, and is, changing. Having a set of strategic priorities for the specialist health improvement workforce will not ease the complexity of the agenda to generate better health alone. Our workforce will need to generate and strengthen endeavours with partners and the wider CHP workforce to generate significant change.

3.   Informing the strategic direction : Evidence and Policy direction

The understanding of health determinants, health inequalities and the evidence base for health improvement has dramatically improved over the last decade. The key insights from

this evidence base have been considered alongside recent information on the state of health of Glaswegians, and the policy direction that our specialist health improvement workforce needs to respond to. This section provides a brief résumé of these influencing factors;

3.1 Sir Michael Marmot produced a landmark government review in 2010 into how wealth affects health (http://www.marmotreview.org/) . The key determinants of health, he argued, relate to a host of issues including employment, the welfare state and child development. The report gave a high priority to mothers, children and families. Marmot cautioned that *'the existing drive for health improvement can produce an 'inverse care law' effect where the benefits of such programmes accrue to the more advantaged groups who have awareness and knowledge of how to use the system'*. In concluding the review Marmot indicated that

> 'there is convincing evidence that, provided an appropriate agenda of policies can be defined and given priority, many of these inequalities are remediable."

3.2 The Director of Public Health Report (2011-13) was published in February 2012 (http://www.nhsggc.org.uk/content/default.asp?page=home_dphreport) . This report sets priorities for action by life stage required by all public services to improve mental health and well-being. Within this context the levels of depression, anxiety, isolation, alcohol and drug use are considered. 'No Health Without Mental Health' (2011-13) emphasises that good mental health and wellbeing are the cornerstones to enabling and optimising improvement in population health.

3.3 The Centre for Population Health undertook a comparative analysis of Glasgow City with Manchester and Liverpool to add to our understanding around the impact of poverty on health outcomes (http://www.gcph.co.uk/publications/61_investigating_a_glasgow_effect) . This 'Glasgow Effect' analysis found that Glasgow has experienced considerably more deaths than those comparably poor cities. Of concern are the proportions of these additional deaths that relate to alcohol and drug consumption, which together account for half of the observed differences. Not unexpectedly the majority of the additional deaths were observed in younger adults (15-44 years). This analysis has lead to recommendations that we must focus on early years and what's happening to our young people, and we must change the pattern of alcohol and drug use within the city, which tackling poverty alone will not solely address.

3.4 The GGC NHS anticipatory care framework articulates clearly that known risk factors are only part of the picture e.g. 20% of CHD patients have no known risk factors at all. Conversely not everyone exposed to risks have poor health outcomes. In the last decade research has focused on what protective factors moderate risk and has identified resilience factors as significant mediators in health outcomes (social and emotional). This suggests rethinking our lifestyle related programmes to better address resilience.

3.5 The health experiences of the people of Glasgow are also much better understood and tracked now than in previous decades. Community Health profiles (2008), the Understanding Glasgow Indicators project (www.understandingGlasgow.com) and the new Mental Health Profiles (2011) have provided rich data sources on the patterns and differences in health experienced within and across Glasgow City. The profiles are exceptionally stark, your health is extremely related to where you live in this city, and in our poorest neighbourhoods life expectancy is lower than the national retirement age.

3.6 The Scottish Overview; Child and Young Health Profiles (2010) (http://www.scotpho.org.uk/comparative-health/profiles/2010-chp-profiles) used 38 indicators to present a comprehensive picture of the health and well-being of children and young people at local levels throughout Scotland. They concluded that the patterning of poverty in Scotland explains much of the inequality in health outcomes observed. The overview found 8 key indicators; child poverty, and then smoking during pregnancy, breastfeeding, dental decay, obesity, school leavers achieving positive and sustained destinations, admissions to hospital following assault, and alcohol related admissions to hospital as defining characteristics for the health of Scottish children. Only a small portion of these are current HEAT targets, with activity in other areas stemming from local motivation rather than organisational drive.

3.7 Alongside these rich data sources on health experiences the strategic direction for health improvement needs to respond to the changing population within the city. Although the city population has increased over recent years the indigenous white population has decreased, both absolutely and in relative terms. In 2004 it was estimated that 5.4% of Glasgow's population were from other ethnic groups. More recent analysis by Glasgow City Council in 2008 concluded that 11.4% of Glasgow's population could be determined to be of Asian, Black, Mixed or other ethnic backgrounds. This work has not only highlighted that the ethnic diversity of our population has more than doubled in the last decade but also how neighbourhood composition has also changed during this period.

3.8 In considering the strategic direction consideration has also been given to the positive changes in the city that are taking place. Within the last five years health improvement activity has been considerably enhanced, with affect. Early signs of population shifts are very encouraging, the more recent successes are seen as a reflection of the scale of action that has been possible with investment and, on occasion, legislation.

- Falling smoking rate
- Reduced use of alcohol & drugs by school aged pupils, and alcohol related deaths
- Improvements in dental health in P1 pupils
- Reductions in heart disease
- Smaller improvements in breastfeeding rates
- Reduction in suicide

Therefore some programmes are leading to change, and indeed there is still more change that can be generated, however this change is not bringing a shift in healthy life expectancy in our poorest communities.

3.9 In his most recent annual report , 'Health in Scotland 2009: Time for Change' (Scottish Government, 2010), http://www.scotland.gov.uk/Publications/2010/11/12104010/0) the Chief Medical Officer for Scotland asked whether 'it is time to consider a change' in the methods we currently use to improve health and to move to more upstream asset approaches. He proposes that this may provide the necessary step change in health creation which Scotland needs to accelerate gains in healthy life expectancy. Asset approaches are concerned with identifying the protective factors that support health and well-being, and enhancing these. Evidence of the impact of parenting, developing emotional resilience, having people to rely on, being involved and occupied suggest a

network of programmes for such a focus. This is not the principal way we have organised and discharged our health improvement programmes to date.

4. Strategic Principles

These are the set of underlying value drivers for the Health Improvement specialist workforce in Glasgow City.

4.1   Reducing Health Inequalities. The burden of poor health and health inequalities continues to be a major issue for Glasgow. Narrowing the health gap is complex and there is an inherent risk of widening the health divide in the provision of universal programmes which are often adopted earlier by residents at least risk.   Recent evidence demonstrates that inequalities in mortality are increasing, partly due to increases in diseases relating to alcohol and drug use in deprived areas and, at the same time, reductions in ischemic heart disease in affluent areas. Research suggests that different strategies are required to reduce health inequalities from those to improve health more generally. Health inequalities arise from reduced opportunities for access to resources for health such as good quality commodities (housing, employment, education, goods). Therefore, strategies to improve health require improvements on the causal factors: poverty, discrimination and lack of access to resources, in so doing contributing to both direct e.g. teenage pregnancy and indirect health targets.

4.2   To reduce health inequalities we need to focus on those that die earliest, a failure to do this would mean that we would be actively working to increase the existing inequalities. The old saying holds true, the better your start in life the better and longer the rest of your life is likely to be. There is a need to reframe our activity to be more closely aligned to affecting the lives of families, more closely touching the lives of today's and tomorrows children.

4.3   Scale is relevant. By scale we mean the number of lives we impact upon and the intensity and duration of that impact. Some of our greatest gains have resulted from the system wide scale of interventions applied in the last four years e.g. oral health, smoking. Doing a little bit of everything is not feasible and indeed is unlikely to lead to the population shifts required. We should seek to consider scale in relation to what we deliver locally, more clearly building local work into citywide outcomes or concentrating local activity in key areas to elicit sufficient impact on defined populations over a meaningful duration. In our neighbourhood work we would look firstly at a ten year timescale for our programmes.

4.4   Partnership focused. In order to tackle the health inequalities in the city, Glasgow Community Health Partnership has continued to work in partnership with a range of professionals, organisations, the third sector and communities with a focus on the needs of the most disadvantaged communities. Working across a wide range of partners enables us to engage residents beyond the context of health care provision and achieve more with less reliance on NHS resources. However this means that sometimes health improvement programmes and staff may seem invisible to clinical services and we need to work better to connect these agenda's together.

4.5   Holistic programmes. There is a mass of evidence that articulates the contributory factors to poor health in the city. Traditionally this has lead to discrete programmes that act to mitigate against an identified risk.   As we move forward we need to find ways of

contributing to multiple risks within programme delivery, Keep Well is a good example of this, with the Keep Well check acting as a mechanism to consider lifestyle and life circumstances issues in a holistic way. In developing holistic programmes further analysis and programme design based on strengthening protective factors becomes critical. This will require flexibility within our workforce, funder's and outcomes.

4.6   Evidence. Health improvement programmes are about implementing evidence based practice however the 'wicked' nature of how to improve population health means that the interplay between discrete evidence based programmes, and the net effect of these are still emerging. In this regard we have a need to work to assist the establishment of the evidence base. This means that we must also develop and create different ways of affecting change, some of which will not be pre determined and for others that the evidence base is still emerging.

4.7   To improve healthy life expectancy in Glasgow, particularly in our poorest neighbourhoods we have a significant advocacy role, assisting partners, colleagues and communities to consider what is happening to health and how this can be altered. Our specialist health improvement workforce can support this through focusing on supporting system changes including;

- Fostering collaborative processes for change – as there are not single internal solutions to the health problems of the city we need an effective network of partnerships to generate multi-agency engagement and change. Partnerships at a neighbourhood, sector and city level.
- Strategically Influencing for health gain –; supporting staff, partners and communities to be informed about what we can and should be doing to improve the health of Glaswegians, enabling wise consideration and decision making across and beyond our organisation.
- Establishing delivery mechanisms (mostly in partnership) to affect the 'where' and 'how' we live – internally, with partners, communities and through contracting processes to ensure a network of health improving opportunities are available and utilised.
- Building capacity by providing the 'know what' and 'know how' components across organisations and communities within the city.

5.   Strategic Priorities

5.1   Using the research base, alongside the views of staff, CHP colleagues, partners and the third sector the key priority areas for the health improvement specialist workforce are defined in this section. Within each of the three priority areas work will happen in one or more of three levels;

- Population : priorities for cultural change across the city that require universal action across the population at various life stages. The priorities will be tailored across the life course with an emphasis on affecting change within families and for children and young people.

- Place : priorities that affect a selection of neighbourhoods within the city and a more select number of priority neighbourhoods for which there are so many health

inequalities that we will make a longer term commitment for an asset approach to change. The neighbourhood approach is defined in the accompanying paper

- People : working with identified groups of people who experience events/circumstances which challenge their ability to remain well e.g. those experiencing discrimination, and key groups of people who experience multiple vulnerabilities resulting in considerably lower healthy life expectancy e.g. the mean age of death for someone experiencing homelessness is 41 years for men and 37 years for women, for people experiencing extreme life events place is not the defining characteristic.

5.2 **Building mental well-being and resilience**. At an individual level, there are protective factors that mitigate against risk e.g. there is a clear gradient in the relationship between emotional adjustment in children and subsequent crime rates, misuse of drugs and alcohol, smoking and suicide rates. The health improvement specialist workforce are well placed to support programmes enhancing emotional resilience – for which parenting is crucial but also emotional literacy which can be developed at any stage in life to 'buffer' negative life events. Resilience is also strongly related to isolation i.e. individuals who are socially isolated are between two and five times more likely than those who have strong social ties to die prematurely. In focusing on promoting mental well-being and resilience the health improvement staff will work towards building resilience and supporting social resilience programmes.

> "it is not so much that social networks stop you from getting ill, but that they help you to recover when you do get ill" Marmot (2010) Fair Society Healthy Lives Final Report.

5.3 **Building structurally and socially resilient communities (reducing poverty and growing aspiration)**. These are the pre-requisites identified in the Marmot Review and the Persistent Poverty analysis – including employment, income and infrastructure through which purpose and support are built and found. The heavy reliance on welfare within Glasgow means welfare reform will bring very significant change for our residents. This alongside the changing economic landscape is expected to generate further differences in health outcomes for our population. This requires a focused intervention with existing community infrastructures e.g. anchor organisations. Health improvement capacity will be realigned to work with the identified neighbourhoods to contribute to social change and seek to influence partners to work with us in this way.

However poverty stretches well beyond a few key neighbourhoods in the city. Although there will be a focus on raising aspiration and regeneration within the identified neighbourhoods further action will be taken to contribute to the tackling poverty requirements of the city further, particularly around employability, financial inclusion, volunteering and aspiration.

5.4 **Creating a culture for health in the city** (alcohol, drugs, smoking, and obesity). Glasgow has a particular concentration of the range of issues that contribute to an unhealthy culture. In the context of Glasgow city, tackling these deep seated issues goes beyond changing individual behaviours, rather there needs to be a focus on changing the perceived cultural norms. Health improvement alone will not determine the culture of the city however we should work towards addressing key public health issues with the strongest evidence base as contributors to the gap in life expectancy.

- **Alcohol**. The Ripple Effect research (2007) found that 99% of communities in the city reported alcohol significantly affected their community, with 95% reporting this issue as having a negative impact on where they live. Health Improvement should work to create a City less reliant and associated with drinking alcohol.

- **Drugs.** Glasgow City has more than double the rate of drug users than the next nearest local authority area in Scotland. Drugs prevention programmes are crucial in an environment of continual growth in the number of people directly and indirectly affected by drugs. The Glasgow Effect work has clearly identified drug deaths as a very significant contributor to the state of health in the city.

- **Smoking**. Tobacco remains the number one cause of preventable death and ill health in Glasgow city, again concentrated in the most deprived areas. Cessation services are well established and have been a notable success in health improvement. Targeting particular sectors of the city's population, for example expectant mothers and fathers, children and young people to quit or prevent addiction to tobacco will be a key focus.

- **Obesity**. Our populations weight is drifting upwards, health improvement have a role to support a culture of healthy weight, reducing the drift over time and the drift upward with age.

6.   **Next steps**

6.1   The impact of this strategic direction on health improvement staff will take place over time, through consideration of the existing work programmes of the staff in each sector. This will result in some programmes being revised and some capacity being realigned.

6.2   Work will also commence on establishing a set of targets and outcomes for each priority theme to enable progress and impact to be tracked over time. Some of the targets are already in place e.g. smoking cessation targets, and for others development work is required to establish suitable measures.

6.3   The work of the Centre for Population Health has proved invaluable in this process. Their experience of GoWell and Equally Well neighbourhood based programmes offers opportunities for further collaborations on the more innovative asset based approaches within identified neighbourhoods. This will be progressed.

6.4   In discussions with others within and beyond GCHP the issue of a health improvement strategy for Glasgow City was raised. Ideally there should be a vision for the city that then influences the action of partners, the action of CHP staff beyond the health improvement team and the discrete health improvement workforce. The health improvement workforce will use this paper as a starting point to work with others to develop this wider strategic coherence and report back to Committee in the summer of 2013 on this.