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.

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