GLASGOW'S HEALTHIER FUTURE FORUM 2

Wednesday 30 November 2005

REPORT

Glasgow Centre for Population Health

This report is a summary of the presentations and discussions from the GHFF2 event and does not necessarily represent the views of the GCPH

OVERVIEW

Following the first meeting of Glasgow's Healthier Future Forum on 15 June '05, the Forum met for a second time (GHFF2) on the morning of Wednesday 30 November '05, again at St Andrew's in the Square, Glasgow.

The Forum was aimed at a professional audience, with an open invitation attracting a diverse range of participants from a variety of backgrounds. Notably, the majority of the 140 participants at GHFF2 had also attended the first meeting of the Forum.

The format of the second meeting was slightly different to the first having taken into consideration feedback from participants at GHFF1. Maintaining the method of open debate at round tables, GHFF2 incorporated greater discussion time for participants, a synthesis of ideas discussed at the first event was provided, and the Centre offered all participants a method of joining the creation of a 'civic conversation' via the medium of 'learning journeys'[1].

The Glasgow Centre for Population Health has three steams of work:
1. Building a deeper and fuller understanding of health and its determinants.
2. Generating evidence of effects that current health strategies are having on health and health inequalities in our populations.
3. Fostering new thinking about how to create a healthier future.

Crucially, the Centre works through networks and partnerships with other organisations. The team leading on the first stream of work is the 'observatory function group' – a multi-agency, multi-disciplinary group sharing perspectives to generate new insights into Glasgow¹s health. The two key ingredients of the Forum are active participation of the attendees and injection of new material. The new material upon which discussion was based at GHFF2 was provided by the work of the Centre's observatory function group in the form of new analyses about changes in health in Glasgow, the West of Scotland and Scotland as a whole, the data being utilised as a resource for thought and ideas for action. Thus the focus of GHFF2 was what is getting better, what is getting worse and what is proving intractable in terms of health? The aims of GHFF2 were:
1. To present the data in such a way as to maximise recognition of its usefulness.
2. To convey the need for us to take stock based on the data.
3. To cause each participant to think about / discuss 'as an individual, what is my response to the data?'.
4. To secure feedback on the data and their implications in order to inform the observatory function report.

Short presentations were given by members of the observatory group, divided into two sections: 'Glasgow – past and present' and 'Glasgow – the future'. Discussion at round tables followed each section. See Appendix One for the full meeting programme.

This report provides an overview of GHFF2, including:
- summaries of the presentations;
- explanation of the review process; and
- summation of the feedback given by facilitators and participants.

[1] Learning journeys are a tool for insight and innovation. They usually involve a group of colleagues visiting a number of locations where activities of interest are taking place to see what happens and to hear from people there about what they are doing. See www.internationalfuturesforum.com for more.

PRESENTATIONS

Carol Tannahill opened the event, welcoming participants and introducing the Forum. Prof Phil Hanlon then set the scene before the data was presented.

GLASGOW – PAST AND PRESENT

SETTING THE SCENE – PROF PHIL HANLON

Phil welcomed participants and facilitated introductions before launching the second meeting of the Forum. As the lead of the observatory function group, Phil talked of the genuinely exciting new set of information produced by the group. He also introduced the theme of 'what's getting better; what's getting worse; what's proving intractable' and asked participants to look for these trends in the presentations. Phil went on to talk of the "extraordinary" Healthy Scotland Convention (HSC) which had taken place the week prior to the Forum. With an audience make-up similar to the Forum, attendees of the Convention affirmed their commitment to the principles and values of public health / health promotion / health improvement. Phil argued that it is crucial to stick to those principles to release energy in professionals and in people that have a real chance of making change in Scotland, and discussed taking the good work of the HSC and bringing it to the Forum. Phil set a challenge for the Forum participants to push themselves beyond those areas that there is consensus on and consider what will now, building on the consensus we have, really make a difference.

BIG TRENDS – JAMES ARNOTT

James presented an overview of long-term trends in Glasgow and the surrounding area between 1981 and 2001, arguing that the best way to understand where the city is at present is to consider where we have come from, which also gives us an insight into where we may be going to.

The 1971 Census included a broad description of Glasgow which was characterised by engineering, production and manufacturing. James argued that the changes that have taken place up to the last census in 2001 have been widespread and rapid, the degree of which may, at times, be underestimated. Historically, Glasgow City followed the trends seen in the surrounding conurbation. However, there are now signs of the city leading the rest of conurbation across a range of indicators and a range of developments.

Population

Loss of population has occurred with 100,000 fewer people in Glasgow in 2001 than in 1981 but this trend is not seen across all age groups. The 25-44 age-group has actually increased from 23% to 31% of the population which represents a 35% increase in just 20 years. Whilst this age-group is increasing generally, Glasgow has experienced at four times the increase of the surrounding area, three times that of Scotland as a whole, and more growth in this age group than any comparable UK city.

Social class

James used social class as a proxy for quality of employment. There has been an obvious decline in manufacturing employment over time but, in addition, there has been an increase in social class I and II jobs, from 18% of jobs in 1981 to 38% in 2001. In general, social class I and II jobs are more prevalent throughout the economy but, again, the growth in Glasgow has been greater than the rest of the area and Scotland. James argued that this is a key point about what's happening in the city: for people who are in work there has been a fundamental change in the quality of that work and the way in which it has been rewarded.

Housing

Lastly James talked of the number of residents who live in owner-occupied housing, which has more than doubled in the 20 year period 1981-2001 to one in every two households. While this rate is still lower than in the rest of the surrounding conurbation and the rest of Scotland, the rate of increase was marginally greater in Glasgow than in either area.

To conclude, James argued that there has been rapid change since the 1980s involving a major period of adjustment with some people having been able to take advantage of the opportunities the city has been able to offer whilst many others have not. This may be one of the clues as to why we have continuing problems with deprivation in many areas of the city. We are closing the gap between Glasgow and the rest of Scotland but why have these changes taken place? What have been the drivers and how might it continue?

FROM INDICATORS TO INSIGHTS – DR ANNE SCOULAR

Anne discussed use of indicators in one area of Glasgow (Parkhead) as a starting point for generating insights into the pathways between Glasgow's environment and its health outcomes. Anne argued that Parkhead is a relatively understudied area in comparison to peripheral estates such as Drumchapel. Parkhead was the industrial heartland of Glasgow and Parkhead Forge drove Glasgow as an industrial centre for a century and a half. However, since the 1950s there has been a massive decline in heavy industry. There has now been half a century of regeneration effort but Parkhead continues to have a large number of challenges.

Anne's work centred on trying to understand indicators in a social context. An initial task was to develop an understanding of what is meant by the community known as 'Parkhead'. Instead of drawing lines on a map along a postcode sector, this piece of work involved asking local people 'where do you think Parkhead is and what kind of a place is it? Show us on a map'.

The resulting map is a synthesis of 36 local residents' ideas of where they think Parkhead is and confirms that the social understanding of space on the ground is very much more complex than simple lines on a map. The community defined area of Parkhead is messy in that is does not fit into postcode areas i.e. administratively defined areas. The community defined profile cuts across most of the administrative boundaries and thus a great deal of work went in to piecing together what the area represented. However, having done so it was found that the population of the community defined area has fallen by 18% over the last 20 years with the falling numbers largely in the over-45 age-group whilst relatively static population trends were found in the under-45 age-groups.

The end result of this study of space and health outcomes revealed that all-cause mortality in Parkhead, particularly for men, shows a substantial and increasing gap when compared to Glasgow and to Scotland. For women the position is rather less clear. However, overall the gap is widening and there is no convincing evidence of a decline in death rates for this community compared with Glasgow as a whole. This presents some evidence of this community falling behind. Further, ischemic heart disease mortality shows a similar picture, with no evidence of a decline in contrast to Glasgow. For incidence of all cancers there is a suggestion that the rate is increasing in both men and women in Parkhead. A health gap between this community and the rest of Glasgow is evident.

Anne went on to discuss how looking at numerous determinants of health could be the starting point for exploring what local people think the connections might be and for generating some hypotheses on the connections between health determinants and health outcomes. Glasgow City Council provided a breakdown of different types of activity taking place in the community defined area of Parkhead and this was combined with data from a recent survey which took place at Parkhead Cross. The synthesis revealed an apparently encouraging picture. However, the retail environment behind what was seen on paper represents a considerable challenge to living a healthy life in Parkhead. Trends in vacant and derelict land over the last decade also appear encouraging in terms of the conversion of derelict land into vacant green space. However, green space may reflect environments that are not entirely conducive to health e.g. rubbish dumping, graffiti, etc. Anne discussed the need to look beyond the indicators to achieve an understanding of how people use environments and which aspects of an environment are conducive to health.

To conclude, routine data can be applied to a socially defined space, as opposed to an administratively defined space. Determinants of health are also available using a rich array of sources. Health outcome data clearly show that Parkhead's trajectory differs from other areas of Glasgow. This piece of work will continue with local people, particularly Parkhead Housing Association, to generate new insight into the pathways and interactions between the determinants to attempt to really understand the lived experience of people in Parkhead and, most importantly, to generate information for action in terms of health improvement.

INTEGRATED PUBLIC HEALTH PICTURE – BRUCE WHYTE AND DAVID WALSH

Bruce and David outlined some of the patterns of health trends in Glasgow and the West of Scotland, sub-divided into the topics below.

Historical context

Population trends show that rapid growth occurred in the 19th century, with a period of stability in the 1930s and 1940s and decline thereafter. There are a number of reasons for Glasgow's population increase including the city's development into an industrial powerhouse / trading and business centre and attracting population for that reason. Also, health improved, particularly over the latter half of 19th century and finally, the city boundary was extended a number of times. There are historical links between population size and pride in the city.

Births peaked in the 1920s and have in general declined since then, reflecting social and cultural changes prevalent across Scotland and the UK. Birth and death rates have both declined over the last 150 years, with deaths exceeding births in the last 20 years. Therefore, unless Glasgow's fertility rate increases or more people come into the city, Glasgow is going to experience a prolonged period of population decline.

Infant deaths show a positive picture over the last 150 years. In 1855 one in five children died in the first year of life. In 2003, seven children died in their first year of life; a figure that is one third of that even in 1972.

Inequalities

The pattern of crude death rates across Glasgow's sanitary districts in 1901 shows a five-fold variation between the areas with the highest and lowest rate. A hundred years later inequalities continue to exist with a two-fold variation in standardised mortality across the West of Scotland. Small area level analysis (e.g. by postcode sector), shows even greater variation in rates with a four-fold difference across the West of Scotland.

Life expectancy

Over the last 100 years life expectancy for men and for women has doubled. However, over more recent periods there has been an increase in the gap in life expectancy for males. In 1991-93 the gap between the highest and lowest Council areas was six and a half years: it is now at eight years.

There is a 12 year gap in healthy life expectancy[2] across the West of Scotland with the average male likely to live for 20 years with a limiting long-term illness.

Economy

The number of children in workless households (a proxy for children living in poverty) shows wide variation across the West of Scotland from 6-7% up to 50%. At smaller area level there are even bigger differences – up to 60% of children are living in workless households in the most deprived areas of Glasgow.

Unemployment has shown a downward trend in last ten years. However, those areas that had high unemployment relative to other areas still do. Glasgow and West Dunbartonshire continue to have the highest rates of unemployment although they are coming down. Income support (as a proxy for low income) shows variation across the West of Scotland Councils. Glasgow has a rate of 20% which is double the Scottish rate. A similar indicator, free school meals, is double the Scottish rate in Glasgow at 42% of pupils.

In terms of housing, prices are increasing as Glasgow is seen as an attractive place to live but issues of affordability are becoming key.

Social environment

Lone parents as a percentage of all households with dependent children varies from 13-14% to nearly 50% and looking at smaller areas reveals greater variation.

Education

There are some communities in Glasgow where the student participation rate in further education is less than 20% whilst in others it is above 60%. The trend for Scotland is upwards, as it is for the majority of areas, but there remains a huge gap between areas of low participation and communities with a high participation rate.

Crime

Recorded crime levels have been 50% above the Scottish level in recent years but the pattern is different for different crime types. Domestic housebreaking and motor

[2] The estimated average number of years that a new born baby could be expected to live in 'good health'. The discrepancy between healthy and total life expectancy, therefore, indicates the average number of years likely to be spent in 'poor health'.

vehicle crime are down significantly but serious violent crime, fire raising and vandalism, and drug related crime have increased.

At a data zone level (6-700 people per data zone), in one particular area (Kingston) one in ten people have committed a serious violent crime in the last three years. The pattern of victims of violent crime is remarkably similar: the areas with highest rates show one in ten people have been a victim of violent crime. In terms of perceptions of safety, 33% of people in Glasgow do not feel safe walking around alone after dark.

Physical environment

Overcrowding has come down a lot over the last 20 years but a number of Glasgow communities have rates of overcrowding that are double the Scottish average so clearly this continues to be an issue. Housing conditions have improved greatly but damp, poor heating efficiency and mould are still an issue for a significant number of households in Greater Glasgow. Further, a number of areas have 50% of people living within half a kilometre of derelict land with those in deprived areas a lot more likely to live close to derelict land.

Behaviour

For alcohol related deaths, between 1980 and 1991 the trend is reasonably flat but from 1992 the numbers have increased by four-fold. Most of the deaths relate to males but the total number of deaths among females have more than doubled in the period. Admissions to hospital for alcohol related and attributable conditions show the same pattern. At a small area level (postcode sectors) the ten areas with the lowest rates of admission (all relatively affluent) all show a fairly flat trend, compared to the ten areas with the highest rates of admission (all relatively deprived), revealing a clear gap emerging between the two sets of localities.

Focusing on liver cirrhosis mortality for European countries, from the 1950s to 1990 Scotland had consistently lower rates of death compared to the European average. However, Scotland's rates have increased in the last 15 years to the highest rate in Europe. Greater Glasgow (highest rate in Scotland) stands out in a European context, as the figure for the area is around three times the European average rate.

Smoking has come down significantly over the last 30 or 40 years. This has flattened out somewhat but has continued to decrease from 35% of adults to 33% in the last few years.

Turning to sexual health, there has been a 70% rise in acute sexually transmitted infection (STI) rates for Scotland over the last ten years and almost a doubling for Glasgow. Although some of the increase may be related to an increase in screening, this is clearly an issue.

For obesity, the 2003 Scottish Health Survey results show that over a fifth of adult male Glaswegians and almost a quarter of females are classed as obese.

In terms of travel, nationally over half travel by car and a quarter by bike or foot whilst in Glasgow 40% travel by car and more than a quarter do so by bike or foot. The trend in car ownership has increased in Glasgow over the last ten years which has led to huge increases in traffic volume.

Pregnancy and childbirth

Nationally, 25% of pregnant women are recorded as smokers at their first hospital visit but in the West of Scotland the figure varies from 10% to about 40%. At small area levels, the figure varies from under 7% to about 60%. The trend is downwards

in all population groupings – since 1995 rates have fallen from about 33% to the current level of 25%. Rates have fallen at a similar rate so the gap between the least and most deprived remains much the same.

The proportion of babies being breastfed at 6-8 weeks is about a third at a national level but in the West of Scotland figures range from under 20% to almost 60%. At a small area level, there is greater variation from 70-80% down to below 10%. The trend is positive though and has risen in recent years from 32 to 35% in the Greater Glasgow area, although it is not improving rapidly. Over the last ten to twelve years in Glasgow City Council area, although teenage pregnancy rates remain high, they have fallen by 20%.

Children

The proportion of children looked after by a local authority is around 2% in Glasgow City which translates as 2,500 children, which proportionally is twice the national rate. As a trend this is not improving but is increasing slightly year by year.

In terms of smoking, alcohol and drug use by 13 and 15 year olds in Greater Glasgow, a national survey in 2002 found that 7% of boys and 11% of girls where classed as regular smokers, just under a third were regular drinkers and 15% and 12% of boys and girls respectively had taken drugs in the month prior to the survey.

Since the late 1980s that trend in the proportion of primary one children who have no decayed, missing or filled teeth has risen from about 36% to 42% in the Greater Glasgow area. The converse is that 60% of primary one children have "obvious or advanced decayed teeth" and across the city the range is 37% up to 75% of five year olds.

Health and function

In 2000, 10% of the Scottish working age population were 'unable to work due to illness or disability' and in Greater Glasgow the figure was double that i.e. a fifth of all adults. Across the West of Scotland communities the figure ranged from about 5% in 2000 to almost a quarter of the working age population. At a smaller area level there are areas where half of the working age population fall into this category. Nationally the figure has been static and in Glasgow it has fallen slightly from 19% to 17%.

Illness and disease

The fall seen in rates of heart disease deaths is one of the successes of the last few years. Rates have halved in Greater Glasgow over the last 25 years. However, in the mid 1970s rates of heart disease in Glasgow were similar to Scotland but over time a gap has emerged so that over the last 15 to 20 years Glasgow consistently has higher rates of death.

Admissions to hospital for diabetes over the last ten years or so show a 100% rise nationally which is matched or even higher in some Glasgow communities. This rise is linked importantly to the rise in obesity in the population.

Admissions to hospital for deliberate self harm show a five-fold variation across the city.

In summing up, David and Bruce highlighted what is getting better, what is getting worse, and what is proving resistant to change. Life expectancy has increased, although it is increasing at faster rate for the more affluent. Trends are moving in the right direction for smoking, unemployment and teenage pregnancies, some crimes, breastfeeding, dental health of children, some deaths, many aspects of housing and

housing conditions. More people are going into higher education. Dental health and breastfeeding have shown very slow rates of increase. Life circumstances of the population e.g. the proportion of people living in poverty and on low incomes are fairly stagnant as is the trend in looked after children. Levels of disability and healthy life expectancy are also proving resistant to change. Finally, what is getting worse – alcohol, obesity, aspects of sexual health, traffic volume, violent crime and inequalities in many areas clearly widening.

GLASGOW – THE FUTURE

GLASGOW'S HEALTHIER FUTURE – PROF PHIL HANLON

Phil wrapped up the event by making the point that institutions find it hard to be brave but individuals can be. He argued that we need to appeal to individual citizens to tap into the intrinsic motivation that exists. Phil argued that a challenge emerging from the Forum (and also from the Healthy Scotland Convention) is how to mobilise that force. He felt there was a strong echo of the Healthy Scotland Convention's conclusions at the Forum: there is a body of practice; and there are many motivated members of the public and professionals who have quite a strong consensus amongst them about much of what might be done. But at the same time there are trends that could blow this away – if we can't mobilise some of these forces quickly the lives of many of us will become worse. He said that we are at a difficult position as to come back in another ten years time and say we need to re-commit again to that set of principles would be to fail ourselves and those that we seek to serve. For that reason, Phil urged that the 'civic conversation' needs to continue and we need to enlarge the circle of that conversation and to tap into some of that courage. The truth of the matter is that these trends are not going to bend on their own and unless we can come up with something that's different they will continue to worsen. We need to get this message across without doing so in an alarmist or victim blaming way. There are people who have the inner resource to make a difference. He concluded by saying that this is unfinished business in a sense and we really need to think hard about how to create the tipping point, the social epidemic, that would make a difference with respect to some of these issues.

THEMES OF PARTICIPANTS' DISCUSSION AND FEEDBACK

Feedback was gathered in two ways. All participants were given a notes sheet to complete, which had a carbon copy attachment. Participants therefore completed the sheet for their own record, leaving behind the carbon copy to allow the Centre to gather and present their views. Each notes sheet was pre-printed with the following questions:

- What are your reactions to the data you have seen this morning?
- Bringing your own experience and insights to bear alongside this morning's analyses, what do you think our health improvement priorities should be?
- Where do you think current thinking and approaches will deliver what we want, and where not?
- What would be the most useful next steps to take in your own practice and what actions could the Centre most usefully take?

Further feedback was provided by table facilitators, each of whom submitted a short written update on the main points of discussion at their table. Feedback from the participants, as gathered from both these sources, is summarised under the emergent themes as set out below.

What are your reactions to the data you have seen this morning?

Confirmation

- reinforced the view of Glasgow as a divided city even more so than an unhealthy city;
- confirmation that in deprived areas circumstances have not changed;
- good evidence to support anecdotal observations of the complex needs of Glasgow's communities;
- highlights virtuous circles (e.g. West End, East Renfrewshire etc.) and vicious cycle (more deprived communities);
- overwhelming evidence of continuing failure to resolve issues in historically deprived areas and development of new social issues in wealthier areas - frustrating;
- familiar but shocking;
- mixed reactions: fear, anger, depression, alarm, desire to strengthen efforts to change some of trends.

Usefulness of data

- terrific that having known it for so long we are now documenting it and proving it;
- good baseline information;
- useful to have the problems clear to set the agenda for the future and to provide basis for planning for health improvement and the development of primary care services;

> "*Getting all the data together and presenting it is an excellent step."*

- very important to have data – enables informed debate;
- encouraging that there is so much data available;
- would be useful to have some more qualitative indicators like current participation in local activities;

Optimism

- some good news in long term trends;
- encouraged by gains made in CHD rates;
- some positives which we should be focusing on;
- Glasgow has a great future – how can we ensure it is everyone in Glasgow's future?

Inequality

- gap between health experiences of different areas reflects the continuing inequalities;
- shocking divergence between Scotland and Glasgow rates;
- picture of two cities with opportunity gap widening;
- huge pockets where subcultures exist in specific areas.

Alcohol

- surprised / shocked / disturbed by alcohol data – needs to be addressed due to links to mental health, disease and crime levels;
- given impact on behaviour and health, can our society afford to allow this? Why haven't we learned from past experience?
- alcohol figures hardly surprising given that alcohol is the normative drug in western societies;

- worry around alcohol related illness and consumption, drug use, mental illness; we've created a dependency culture – professionalisation of poverty (we are the gatekeepers and we are not listening);
- do our organisations make people dependent?
- worrying given amount of money already going into city, agencies, etc;
- worried that the millions being targeted at communities living in deprived areas is not having a significant enough impact on their lives.

Employment
- clear correlation between economic factors and poor health, life expectancy and self harm;
- fact that a lot of long-term sickness really represents disguised unemployment needs to be highlighted;
- link between male worklessness and family breakdown and in turn the impact on children's, men's and women's health needs highlighted;
- alarming to see the gap and number of working age group living on incapacity benefit.

Parkhead
- study very interesting;
- keen on Parkhead model especially definition of community by local people.

Questions
- What can we do to change the trends?
- What is the story behind this?
- What trends 'bucks the trend' and why?
- How do we compare with other areas with same socio-demographic make-up?
- Should we try to shift the average or focus on the worst health? And should this vary by issue, e.g. alcohol, mental health?

Actions
- We are becoming more aware of interdependencies and need to turn this into intelligence, allowing for differential interpretations depending on perspectives and then use that perspective to take action.
- Have to draw the right conclusions from what we gather and then lobby for resources to effect change.

Bringing your own experience and insights to bear alongside this morning's analyses, what do you think our health improvement priorities should be?

Take stock
- have courage to give up things that are not working;
- be brave – will do nothing if wait for somebody to create policy;
- Executive should be honest about what is and isn't working;
- be prepared to trust and take risks.

Funding / resources
- shift of funding from acute services to health improvement;
- movement of health resources from affluent areas to deprived areas which requires political support;
- need sustained long-term funding.

Prevention and early intervention

- target the well and encourage them to stay that way with early intervention programmes;
- prioritise the earliest possible generations (early years) to improve health i.e. children and young people (especially 0 – 5 years) where life trajectories are set
- shift from tackling the symptoms to the underlying causes;
- better alcohol awareness for younger people beginning in education setting and provide interventions to work with people who are drinking hazardously to prevent onset;
- emotional literacy training / investment in young people to help make choices and improve mental health;
- focus on young people with view that change will be generational;
- press hard on preventative measures especially on issues including alcohol, obesity, CHD;
- support parents and parenting;
- control critical points – early years and positive parenting;
- educate children because they can influence parents;
- target youth – need to change the attitudes and aspirations of the young people to really change the future.

Environment

- we now have a better understanding of the relationship between human 'animal' and the ecosystem it inhabits – focus on how can environment contribute to change?
- built environment needs to be improved as directed by communities themselves (shops, greenspaces, etc);
- local authority needs to do Health Impact Assessments of planning, trading licenses, etc.;
- town planners need to recognise enormous effect they have on health – legislation must help them to make 'healthy' recommendations.

Housing

- availability of better quality housing in deprived areas;
- housing of right size, quality and price;
- concern that increasing house prices will further impact on inequality.

Mental health

- mental and emotional wellbeing and closely associated issues of addictions, violence fear, aspiration and hope, stigma and prejudices;
- work with communities and families to ensure mental health and wellbeing mainstreamed into social inclusion work;
- finding out how people can improve their wellbeing and happiness as a means of tackling aspirational poverty;
- issues around stress and mental health and wellbeing;
- mental health and wellbeing targeting areas with high self harm rates;
- schools need greater focus on pupil wellbeing.

Culture

- need to engender a culture where maintaining and improving health is seen as everyone's personal long term responsibility and use patient centred approaches to explore beliefs and understanding of health and illness;
- address entrenched cultures to hopefully break the cycle for the next generation;

- culture change required to create ambition and to overcome poverty of aspiration and lack of educational attainment.

Aspiration

- motivational programmes;
- improving self esteem;
- improving aspirations and life chances;
- brief intervention training in motivational interviewing techniques;
- address poverty of aspiration;
- equipping people with the practical and cognitive tools to realise aspirations – health will follow;
- ask people why they lack hope.

Community development

- continued, proper community development / participation in order to support and help families to have aspirations and be able to effect change themselves;
- community engagement process needs to clearly tackle areas and people who have least aspiration (long term process);

> *"Some of Glasgow's tapestry is very frayed indeed. We can't keep patching it up."*

- resources targeted at an area, go into the local economy and capacity is left behind in the community to propagate positives that were begun during the intense investment period (link local economy to local health);
- focus on communities of interest as well as geographic communities; need to unpick and re-knit excluded areas into mainstream culture.

Employment

Change in mindset at policy level to facilitate socially excluded groups to participate in employment; importance of male employment – scope to make employment growth in Glasgow more balanced by sector and geographically; life opportunities for local people e.g. volunteering, running voluntary organisations, establishing local enterprises, local jobs and training for jobs; addressing employment issues – focus on the value of people; benefits system which encourages people back into employment; ascertain whether benefit culture contributed to formation of subcultures and get radical (Westminster remit – how do we influence this?); refer those in long-term receipt of benefits for assessment followed by therapy, training, guidance and on-going support; the data would suggest that health improvement only occurs with economic improvement.

> *"The growth of type I and II jobs is bringing new people to Glasgow but residents are being left behind due to poor education and socioeconomic factors."*
>
> *"It is time to admit that there are many people who have been dependent on services / benefits all of their life – sometimes taught and encouraged by the long-standing systems in place."*

Policy (alcohol, smoking, school meals, etc)

- change of policy with regard to sale of alcohol, licensing laws, etc;

> *"Free, nutritious school meals is an area where significant improvements across a population over a lifetime can be made."*

- major public health legislation such as banning smoking in public places, increasing tax on alcohol;
- put up the price of alcohol and promote alternatives;

- policy to introduce free, healthy school meals;
- implementation of strategies akin to and as dramatic as the Scottish Executive smoking in public places ban required (alcohol, obesity, mental health, etc);

Behaviour
- target key behaviours – alcohol consumption, crime, teenage pregnancy, food choice / obesity – at structural / political level;
- approach to examining why people are indulging in behaviours that negatively affect their health; continue to tackle smoking;
- training to deal with addictive behaviours;
- alcohol related issues seem to be paramount BUT simply seeking to tackle this on its own without looking to tackle underlying and inter-related issues (housing, inter-generational cultures, etc) is not going to be enough.

"Our health improvement priorities should be combining transformational structural change such as national and local policies on alcohol, food cost and availability alongside fostering conditions for people living in difficult circumstances to make changes that will enable them to achieve potential."

Working together
- require more joined up thinking amongst health professionals;
- encourage integration of communities and learning from each other;
- strategic approach.

Inequality
- real challenge is engaging extreme areas of deprivation with poorest levels of improvement;
- need to focus on deprived areas empowering people, planning services, working on enterprise and employment;
- equitable distribution of and access to health improvement opportunities;
- fully explore impact of gender inequalities on health.

Where do you think current thinking and approaches will deliver what we want, and where not?

WILL DELIVER

Structures and partnerships

New Learning Communities have massive potential for health improvement; Community Planning Partnerships should work – commitment to making them work but communities must shape agenda rather than representative agencies; direct and focused strategies are the most likely to succeed (effective evaluation is always necessary); joined up work in local areas working; integration of health, social services, community planning (roads, housing); could achieve real shift in joined up public services directly accountable to communities; fora like this need to be maintained and expanded to overcome working in disparate units with little knowledge of each other and to allow a concerted approach to providing solutions.

Individuals and communities

Community economic regeneration but must be sustained long term and carried out in partnership with communities; 'proper' community development approach should deliver but individual work required to increase self esteem and confidence to allow individuals to engage in this process; Parkhead approach – professionals handing over power to community; communities usually have the solutions – listen to them;

focusing on rights and responsibilities of individuals and communities; success will be delivered at a local level where local people are listened to and services delivered which serve local need; a focused approach, targeting individuals, families and communities to assess their needs and wants and supporting them to achieve their aspirations / fulfil their potential; communities defining their own community instead of administrative boundaries being imposed; approaches based on increasing individual and family capacity will improve lives.

Policy change
Ban on smoking in public places will benefit working class people whereas previous initiatives have benefited the middle classes most; where politicians and political will has been strong like the smoking ban; radical approach to changing the benefits culture.

Education and employment
Executive's explicit stress on employability has the potential to have significant impacts upon health and wellbeing if done properly, in terms of self-esteem, confidence, disposable income, etc (but employment not going to be enough without community regeneration, better housing, better service provision, etc which the Executive's short-termism is failing to address); focus on benefits of being in work, not just the financial rewards of employment; emphasis on young people and education is the right direction; holistic education (not just in school); education focused on practical skills (German model) will allow lower academic achievers to flourish.

Inequalities
In deprived areas where we have informed and committed staff working in all the sectors; movement of health resources away from affluent areas.

"Current approaches can probably improve persistent poor health outcomes but not close the gap between best and worst which are caused by much wider social influences."

WILL NOT DELIVER

Alcohol
Alcohol related areas – increase price of alcohol and radical overhaul in education; current approaches re. licensing laws cannot help reverse the trends in alcohol consumption; efforts on alcohol hampered by fiscal regime – need higher taxation and restricted availability.

Policy
Local / small scale approaches will not be especially successful – should aim to target Executive policy to close off licences, increase the cost of alcohol, etc; where politicians bow down to anti-health forces and unpopular decisions; when local work is undermined by Scottish Executive policy as three streams (communities, services and government) all must work in tandem.

Structures
We are too internally focussed (social work, looked-after children, health visiting, community development); professional boundaries militate against progress.

Stage of intervention
Focusing too late in a person's life-cycle to raise the issue of employment or training and the potential that this will have on health outcomes; need more work on how to prevent policies widening inequalities.

Empowerment
Without confidence in individuals, community development will fail; local people need control and power over resources; need to encourage more community spirit through housing policy; schools, education, teachers need to radically change – currently disempower young people and their families.

Education
Need more effective ways of improving people's knowledge about health and what supports are available; education for the up and coming generation needs to look at more innovative learning e.g. lifestyle, confidence raising and expectation to work; must get people to internalise health messages and reach own decisions.

Funding
Thinking around the importance of health promotion / prevention is great but all the money is in curative care; current approaches are not economically sustainable; identify areas where we can disinvest as interventions lack evidence of effectiveness.

Employment
Equal access to employment – needs much more support; not enough emphasis on increasing labour demand in Glasgow through economic development – need a Glasgow Local Employment Plan; efforts to increase employment hampered by UK benefits system.

What would be the most useful next steps to take in your own practice and what actions could the Centre most usefully take?

OWN PRACTICE

- More work on public mental health and links to underlying causes – resilience
- Environmental health – moving towards topical issues, extending out of hours, dealing with ASBOs, noise, new smoking legislation – intention to expand the unit
- I'd like to speak to the Centre about health and non-white ethnic groups in Glasgow
- Practice to be focused on personalisation of public service provision
- Willingness to give up power and decision making focus – accept mistakes will be made before results can be delivered
- Own practice has already changed with increasing client consultation but is prevented by financial support to meet the individual or community need identified
- Recognise that working in communities, with communities is incredibly resource and people intensive and that success cannot be measured in terms of months – takes years to gain confidence => promote this idea
- Work with other local initiatives to pool resources to overcome 'bitty' nature of work i.e. too many services in small communities attempting to improve health

FOR GCPH

Communication

Work with GCC, education, media etc to raise awareness of health agenda and promote involvement in it; ensure positive messages communicated; highlight good practice; showcase local initiatives; media campaign on work of the Centre; disseminate the findings / data presented today to colleagues and peers and use the info as a basis for planning for the next ten years; take debate to and inform others via the web; inform and disseminate the data presented especially to politicians and civil service; communicate evidence of approaches that have had some success and assess their relevance to Glasgow and Scotland; media advocacy – positive stats and people's stories.

GHFF

Continue providing excellent events to keep communication flowing; have similar meeting and 'civic conversation' with the people who are actually the statistics and listen to them; bring politicians in (Minister and / or Glasgow MSPs should be attending GHFF); bring in the deprived communities – why is GHFF just for professionals? Centre should continue the Forum – important to hear people's good / bad experience in tackling health issues and Forum is very good place for experience sharing and learning from others.

"Continue to give us inspiration at meetings like this"

Health Impact Assessment

Further research into health impact assessments and their role in evaluating environmental decision making at a city scale and at a local level; really need to tackle Health Impact Assessments of policies and strategies seriously rather than leaving it as a matter of preference; Centre should assist, cajole, support and make necessary HIAs that include those who stand to win and those who stand to lose due to a policy / strategy divide – measurable outcomes should be incorporated into community planning initiatives and to the work of the Centre. Centre could help with tracing the connections between the interdependent variables of social, economic and environmental strands as they impact health and wellbeing

Communities

Acknowledge the achievement of surviving in a disadvantaged community and the skill base within communities; improve knowledge of what individuals in the community actually want

Research

Should definitely take on further research into public health issues and share outputs; assess if 25-40 group are coming from outside Glasgow (if external then failing the Glasgow population who are educationally poor) – incomers, asylum seekers? Continue to provide observatory function; assess numbers of young people on income support where their parents receive incapacity benefit – culture of dependency

Key words / phrases

Aspiration / aspirational poverty
Prevention
Education
Divided city
Employment
Community / community development
Change
Funding / resources
Equality / equity
Health impact assessment
Alcohol
Smoking

COMMENTS

Included within the delegate packs was a page entitled 'Comments' and asking participants for any general comments about Glasgow's Healthier Future Forum. A very small number of these sheets were completed and handed in (4) and the comments received were:

"Involve the people that these statistics affect. Seems that we have a forum which is considering possible future decisions e.g. decision makers whom none of these issues directly affect. Therefore, without direct insight and lack of representation from the people involved e.g. Parkhead, how can we know the way forward alone?"
The Centre has taken this comment on board and will consider how best to involve local people in the Forum.

"In future put the contact details of individual delegates for ease of networking."
Whilst we would like to do this, data protection guidance means that we cannot freely distribute contact information. Instead we include a delegate list with the names and organisations of the participants and provide name badges for all to aid networking between participants. Further, we are happy to make introductions having received consent from each person involved.

"Papers could be sent out in advance along with key questions to be addressed - would be useful for pre-event thinking and reflection."
This is an idea for consideration although we must always be conscious that even if information is sent out before an event, not all in attendance will have had the opportunity to familiarise themselves with it and thus we cannot conduct a Forum event on the assumption that all participants have the same level of knowledge on the subject at hand.

"Very good way of engaging with multidisciplinary professionals."
We will certainly continue to invite a wide range of individuals from diverse backgrounds to the Forum events.

Appendix One: Programme

09:00 – 12:30
30 November 2005
St Andrew's in the Square,
1 St Andrew's Square, Glasgow G1 5PP

PROGRAMME

09:00	Registration and coffee	
09:30	Welcome and introduction	*Dr Carol Tannahill, Director, Glasgow Centre for Population Health*
Session One: Glasgow - past and present		
09:50	Setting the scene	*Prof Phil Hanlon, Professor of Public Health, University of Glasgow*
10:00	Big trends	*James Arnott, Senior Economic Development Officer, Glasgow City Council*
10:05	From indicators to insights	*Dr Anne Scoular, Clinical Research Fellow, MRC Social and Public Health Sciences Unit*
10:10	Integrated public health picture	*Bruce Whyte and David Walsh, Public Health Information Managers, NHS Health Scotland*
10:30	Round table discussion and feedback	
11:00	Coffee break	

Session Two : Glasgow - the future		
11:30	Glasgow's healthier future	*Prof Phil Hanlon, Professor of Public Health, University of Glasgow*
11:40	Round table discussion and feedback	
12.20	Conclusion	*GHFF participants*
12:30	Closing remarks	*Prof Sir John Arbuthnott, Chair, Greater Glasgow NHS Board*
Lunch