NHS Greater Glasgow and Clyde

| NHS Greater Glasgow and Clyde | Paper No. 24/29 |
|---|---|
| Meeting: | NHSGGC Board Meeting |
| Meeting Date: | 30 April 2024 |
| Title: | Public Health Strategy 2018-2028: Turning the Tide through Prevention Update |
| Sponsoring Director/Manager | Dr Emilia Crighton, Director of Public Health |
| Report Author: | Anna Baxendale, Head of Health Improvement<br>Beatrix Von Wissman, Consultant Public Health Medicine<br>Marion O'Neill, General Manager |

## 1. Purpose

**The purpose of the attached paper is to:**

Provide an update on the health and wellbeing of the population, activities to improve health and refresh the strategic direction for public health in NHS Greater Glasgow and Clyde (originally outlined in the Turning the Tide through Prevention Strategy 2018-28).

## 2. Executive Summary

**The paper can be summarised as follows:**

Against the backdrop of the Covid-19 pandemic and cost of living crisis, work has been undertaken (framed by interviews with over 10,000 residents via NHSGGC's Health and Wellbeing Survey and updated epidemiology evidence) to develop a collective understanding of the health and wellbeing our communities and in order to review and refresh the public health strategy: Turning the Tide through Prevention.

Setting out the contemporary public health challenge, the strategy refresh recognises the role of wider determinants of health and focuses on mobilising the skills and expertise within the NHS and all of our partners to seize all available opportunities to improve health.

The Strategy Update provides details of NHSGGC activity against the agreed public health strategy priorities and shows the alignment between the calls to action in the Director of Public Health's report 2024 at the Board's corporate objectives and the 2024/25 Annual Delivery Plan

## 3. Recommendations

**The NHSGGC Board is asked to consider the following recommendations:**

Note the progress in meeting public health priorities; population health status and the actions to improve health in the refreshed public health strategy update.

Support further engagement and development of delivery plans for the calls to action via local delivery partners including IJBs and Community Planning Partnerships.

Reflect on the themes highlighted from the Board Seminar on 26 March 2024.

## 4. Response Required

**This paper is presented for assurance**

## 5. Impact Assessment

**The impact of this paper on NHSGGC's corporate aims, approach to equality and diversity and environmental impact are assessed as follows**:

- **Better Health** **Positive impact**
- **Better Care** **Positive impact**
- **Better Value** **Positive impact**
- **Better Workplace** **Positive impact**
- **Equality & Diversity** **Positive impact**
- **Environment** **Positive impact**

## 6. Engagement & Communications

**The issues addressed in this paper were subject to the following engagement and communications activity:**

The Health and Wellbeing survey Reports and Content of the DPH Report have been reviewed and developed in conjunction with local Health Improvement Representatives including Staff Side as part of the Public Health Inequalities Group.

A comprehensive communication plan has been developed with Corporate Communication Team to include IJBs and CPPs, following due governance.

Presentation of the DPH report content and discussion took place with HSCP Chief Operating Officers, Board Seminar, Glasgow City Council IJB

## 7. Governance Route

**The contents of this paper have been previously considered by the following groups as part of its development**:

Public Health Inequalities Group

Public Health SMT

Corporate Management Team

Population Health and Wellbeing Committee

## 8. Date Prepared & Issued

*Prepared on 17 April 2024*

*Issued on 23 April 2024*

NHS Greater Glasgow and Clyde

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## 1. Introduction

The Director of Public Health (DPH) report 2024 sets out the contemporary public health challenge, recognising the impact of the Covid-19 pandemic and general reduction in standards of living as a result of increased cost of living. It continues to endorse the approach outlined in the existing NHSGGC Public Health Strategy (Turning the Tide through Prevention) that population health remains everyone's business.

## 2. Background

The Covid-19 pandemic had a major impact on both population health and the public health priorities that were diverted to control its effect through Test and Protect and Population Immunisation amongst others.

## 3. Assessment

Following the remobilisation of services a number of public health priorities were agreed by NHSGGC:

- Ensuring the best start for life
- Enabling healthy weight through healthy eating and active living
- Boosting mental health and mental wellbeing

- Concerted action to reduce drug harms
- Building financial security for better health
- Broadening access to digital health
- Connecting people and health: affordable, accessible and sustainable transport
- Strengthening communities and places

Progress is presented in the Turning the Tide Strategy Implementation Update in Appendix 1.

The DPH report 2024, based on the health and wellbeing survey 2023 and epidemiology data presents the populations health post pandemic and identifies a number of priorities for action. These were endorsed by NHSGGC Population Health and Wellbeing Committee.

The DPH report 2024 is attached in Appendix 2.

## 4. Recommendations

The NHSGGC Board are asked to:

- Note the progress made against the approved Public Health priorities in appendix 1.
- Support further engagement and development of delivery plans for the calls to action in the DPH report 2024 (appendix 2) via local delivery partners including IJBs and community planning partnerships.

## 5. Appendices

Appendix One – Public Health Turning the Tide through Prevention 2018-2028 Strategy Annual Implementation Update

Appendix Two – Director of Public Health Report 2024: Working Together to Stem the Tide

# Appendix One - Public Health Turning the Tide through Prevention 2018-2028 Strategy Annual Implementation Update

The following report is the progress being made against the agreed priorities following the re-mobilisation of services.

| Ref | Key Strategy Deliverable | Planned Impact | Milestone Position | Resource & Finance Position | Risks to delivery | RAG | Mitigating Action Required | Lead(s) |
|---|---|---|---|---|---|---|---|---|
| OPBH 1.0a & OPBH1.0b | Ensuring the best start for life | Ensure the best start for children with a focus on developing good health and wellbeing in their early years through the Universal Health Visiting Pathway (UHVP) | The Revised Universal Pathway continues to provide an opportunity to assess the child and promote, support and safeguard the child's development and wellbeing. All 6 HSCP areas have approaches in place to support Health Visitors and families as part of the Children's Services Planning Partnerships and this includes the Universal Health Visitor Pathway. | On budget | Developmental concerns in children at the 27-30 months assessment are high in NHSGGC (with nearly 1 in 4 children having a developmental concern). Number of child development assessments completed on time for 4-5 year olds below target | Number of child development assessments completed within the assessment window Q3 2023/24 13-15 mnths | Collaborative work across NHSGGC is focusing on actions to address 'speech, language and communication' concerns, given the rise in these concerns. Work is also progressing to improve our completion rates for the 4-5 year visit to support identification of any new unmet need and action to address pre-school entry and lead to improved outcomes for children | DPH/Nurse Director |
| | | | | | | Number of child development assessments completed within the assessment window Q3 2023/24 27-30 mnths | | |
| | | | | | | Number of child development assessments completed within the assessment window Q3 2023/24 4-5 yrs | | |
| | | Enable oral health primary and secondary prevention (establishing tooth brushing in early years through child smile uptake, and increase dental registration of young children supporting the most vulnerable children and families via the UHVP). Reduce need for general anaesthetics in children requiring tooth extraction. | Sustained improvement in the proportion of schools participating in supervised tooth-brushing, despite challenges remobilising in some schools. The total at the end of the academic year 2022/23 was 71%, with 73% of schools reported to be brushing by the end of Q2 2023/24. | | Competing pressures on schools poses risk to uptake / sustaining toothbrushing | Proportion of schools reproted to be tooth brushing | Oral health improvement teams ensure all children targeted by the Childsmile tooth-brushing programme have access to a toothbrush and fluoride toothpaste, regardless of whether toothbrushing at school. Meeting with the Head of Health Improvement to identify additional actions to increase uptake of the programme beyond pre-Pandemic levels | |

| Ref | Key Strategy Deliverable | Planned Impact | Milestone Position | Resource & Finance Position | Risks to delivery | RAG | Mitigating Action Required | Lead(s) |
|---|---|---|---|---|---|---|---|---|
| OPBH 1.0c & OPBH 2.0 | Enabling Healthy Weight through healthy eating and active living | Expand healthy weight intervention through the UHVP. Expand community based 'Thrive under Five' Programme. Increase uptake of weight management interventions in line with national standards. Support increased detection and diagnosis, targeting most at risk groups e.g. pregnant women, the BAME communities. Increase the number of newly diagnosed patients who complete structured education and weight management programmes. | Development of Child Healthy Weight services ongoing. HENRY(Health Eating and Nutrition for the Really Young - An 8 – week course for parents and carers of children aged 0-11 giving support to develop a healthier lifestyle) training expanded to accommodate demand across HVs & Third Sector Organisations (TSOs). Commissioning exercise with procurement underway to secure TSO delivery of HENRY: Families Growing Up. SG bid for additional funding for Tu5 successful and local implementation groups established in 5 HSCPs. Weigh To Go fully operational with marketing & comms plan in development. Tier 2 Adult CWMS multi-supplier framework fully operational with service delivery across GGC. Increased volume of referrals and improved engagement associated with the new multisupplier contract. An upward trend in engagement and weight loss with Tier 2 services however, number of completers who achieved a 5% weight loss improved but behind target. Control It Plus (T2DM structured education) numbers have improved on the previous quarter. Work to implement evaluation service improvements ongoing. | On budget | Significant proportion of funding is ring fenced time limited SG funding. Late allocation of funding impact on ability to utilise full allocation within fiscal year. | Number of referrals to Adult Weight Management Services (AWMS) per quarter<br>Number of patients who engage with Tier 2 Services and achieved a 5% weight loss<br>Number of patients who engaged with Tier 2 Services: completed 12 week membership and achieved a 5% weight loss<br>Percentage of newly diagnosed Type 2 Diabetes patients who opt in to structured education programme | Ongoing contract management in place to identify performance challenges early and put remediation in place to improve 5% weight loss outcomes for completers in line with pre-covid outcomes | DPH |
| OPBH 13.0b | Boosting mental health and mental wellbeing | Refresh suicide prevention and self-harm action plans relating to children and young people in line with the new national strategies. Undertake further work to better understand increasing demand for CAMHS services for girls age 12-17, and presentations with eating disorders. | Continued delivery of a range of mental health training courses across the board. Suicide prevention training subgroup now established. Training for Trainers Applied Suicide Intervention Skills Training (ASIST) course completed to support roll out of suicide prevention training across NHSGGC. A LearnPro module dealing with Online Harms has been developed and launched for NHS staff working with young people (available Q3). An overall increase in the number of CYP accessing early intervention mental health services however the data shows a decrease in those accessing school counselling with the rise contributed to community support services | On budget | SAMH contract for delivering training ending March 2024 | Numbers accessing early intervention mental health services as part of CYP MH<br>Number of frontline public & voluntary sector workers trained in mental health & wellbeinf and suicide prevention | Identify potential sources of funding to extend SAMH contract and develop exit Strategy. Further work to understand reasons for reduced uptake of school counselling services in Glasgow City and use of alternative services. | DPH |

| Ref | Key Strategy Deliverable | Planned Impact | Milestone Position | Resource & Finance Position | Risks to delivery | RAG | Mitigating Action Required | Lead(s) |
|---|---|---|---|---|---|---|---|---|
| OPBH 3.0 | Concerted action to reduce drug harms | Develop NHS GGC Drugs Harms Framework. Continue to roll out Medication Assisted Treatment (MAT) Standards across the 6 HSCPs aiming to continue reduction in drug related death. Ensure public health input to the GGC-wide MAT Standards Implementation Group. Monitor drug use and drug harms through the Drug Trends Monitoring Group and inform any requirements for change. Lead the coordination of efforts to address blood-borne virus transmission in GGC. | track and has progressed to a degree that is equivale | On budget | | NHS GGC Drugs Harms Framework Developed<br>In agregate across GGC, implemetation of the MAT standards is on track and has progressed to a degree that is equivalent to or greater than in Scotland as a whole, based on assessments from the annual national benchmarking process. | | DPH/CO's |
| | Building financial security for better health | Local Child Poverty Action Reports. Develop NHSGGC Strategic Anchors Plan, Develop Performance management framework to meet SG metrics, Identify and deliver year 1 priority actions | NHSGGC continue to support LCPAR development and implementation. Corporate NHSGGC actions to support child poverty are reported via the PHWBC assurance framework. NHSGGC Anchors Strategic Delivery Plan 2023-26 completed and approved at November CMT. Performance Management framework not included in Plan as SG benchmarking metrics delayed from June 23 to October 23. GGC benchmarking exercise now underway and Anchor plan with completed metrics will be submitted to SG in line with revised timeline 29th March 2024. Theme leads have identified & submitted year 1 actions via the agreed governance of the Sustainability Governance Group. Delivery will be reported via the Sustainability Governance Group. | On budget | Delivery of Financial Inclusion support is dependent on multi agency partnerships to provide funding and service capacity. | On targt - see milestone position narrative | Continued partnership working / joint funding applications to support matrix funding arrangements. Ongoing engagement with Children's Services Planning to support move to sustainability and continued partnership working. | DPH, Director of HR, Director of Estates and Facilities |
| | Broadening access to digital health | Design, test and evaluate approaches to improve digital access to healthcare services and develop 'best practice' to mitigate digital barriers | Health and Wellbeing Survey results provide up to date intelligence on digital access. Public Health digital group and eHealth developing solutions to increase digital access in the community. | On budget | Cost of living crises as additional barrier to affordability of digital access | On targt - see milestone position narrative | PEPI, EHRT and eHealth team agreed mainstreaming action for 2024/25 to develop best practice to mitigate digital barriers | DPH/Director of eHealth |

| Ref | Key Strategy Deliverable | Planned Impact | Milestone Position | Resource & Finance Position | Risks to delivery | RAG | Mitigating Action Required | Lead(s) |
|---|---|---|---|---|---|---|---|---|
| | Connecting people and health: affordable, accessible and sustainable transport | Complete scoping exercise into travel re-imbursement systems with local authority and travel partnership input | In preparation for work to commence in Q4, a scoping exercise has been completed looking at the current transport re-imbursement and cash-first approaches in place to support hospital attendance. A planning session will be held with a transport working group in Q4 to identify additional actions. Wider Transport issues and associated health care access are highlighted in the Director of Public Health Report and will inform discussions with the Transport working group. | On budget | | On targt - see milestone position narrative | | DPH/HI Lead Glasgow City |
| | Strengthening communities and places | Director of Public Health report and Health and Wellbeing Survey results: Complete dissemination and strategic engagement with partners. Deliver a programme of community engagement with local HI Teams, Third Sector Interface organisations and partners. Develop a joint delivery framework with partners aligned with IJB Local Strategic Plans and CPP Local Improvement Outcome Plans. | Local Health and Wellbeing Survey results were shared (pre publication) with HSCPs via Health Improvement leads and are being considered by respective Senior Exec teams. Dates for formal dissemination via IJBs and other fora (CPPs) being identified. HSCP Chief Officers confirmed support to use the HWB survey as a joint strategic needs assessment and embed findings and proposed calls to action within their local planning infrastructure (CO meeting 10 Jan 2024). Health and Wellbeing Survey results launched at PHWBC Jan 2024. Programme of community engagement with local HI Teams, Third Sector Interface organisations and partners being planned. | On budget | | On targt - see milestone position narrative | | DPH/CO's |

| RAG Status | |
|---|---|
| (blue) | Complete |
| (green) | On Schedule |
| (amber) | At Risk |
| (red) | Overdue |

BOARD OFFICAL

NHS Greater Glasgow and Clyde

# Working together to stem the tide

January 2024

# DPH Report Forward

I am delighted to introduce the new Director of Public Health (DPH) Report; providing an update on the health and wellbeing of the population of NHS Greater Glasgow and Clyde (NHSGGC) against the backdrop of the Covid-19 pandemic and the current cost of living crisis. Whilst this has meant the NHS, our partners, and the community we serve has been through significant challenge and change, it has also served as a reminder of the importance and necessity for population health. The purpose of this report, therefore, is to re-mobilise and re-focus efforts on population health in order to reduce health inequalities and accelerate health improvement.

As in previous years, our understanding of the challenges experienced in our community is framed by the most recent NHSGGC Health and Wellbeing (HWB) Survey. Featuring interviews with over 10,000 patients, it represents the biggest single source of data about current health behaviours and perceptions of health and wellbeing across our population and provides valuable intelligence on where we need to work with partners and local communities to improve health.

The report shows, post pandemic, an overall worsening of health (particularly mental health and wellbeing) and persistent inequalities, but we know that concerted action at all levels can make a difference. There is further need for immediate and focused action for the most vulnerable in our population.

The successful delivery against the public health priorities within this report cannot be delivered in isolation or solely by one team; nor can they be delivered by continuing to do things the same way they have always been done. Our concerted efforts must be focused on innovating together, quickly and at scale, to support design and adoption of interventions that we know will make a difference to our community.

While the population health post pandemic shows significant challenge, together we can create a ‘can do’ attitude to mobilise efforts across population and wider partners. Public health remains everyone’s business. We need to seize all available opportunities to improve health. This report therefore aims to share and create understanding of the post pandemic health challenge and to create wide dialogue to strengthen effective action to address challenge, including enabling individual’s role in self-care and accessing healthcare in the virtual world.

I hope you find the public health priorities and actions identified in the report useful to inform the joint planning that is undertaken to improve the health of the population with a continued focus on addressing inequalities. I would like to extend my thanks to

all of those that contributed to this report. I look forward to further discussions with you all over the coming months as we work together to improve the lives of those living in NHSGGC.

**Dr Emilia Crighton**
Director of Public Health
NHS Greater Glasgow and Clyde

# Executive Summary

This Director of Public Health (DPH) report sets out the contemporary public health challenge, recognising the impact of the Covid-19 pandemic and general reduction in standards of living as a result of increased cost of living. It continues to endorse the approach outlined in the existing NHSGGC Public Health Strategy (Turning the Tide through Prevention) that population health remains everyone's business.

It develops a collective understanding of our communities and demographic changes using population statistics (Chapter 2) before summarising factors which describe or influence health including life expectancy, burden of disease, self-reported health, and infectious disease incidence (Chapter 3). The main focus of the report is around the opportunities to work collectively to improve health, in relation to established public health priorities reconfirmed by the new evidence (Chapter 4 – children and young people, healthy weight, mental health, drug harms) and in relation to priorities emerging from the current health challenges (Chapter 5 – financial security, trauma informed response, access to digital health, transport, strengthening communities and places).

Against the background of the Covid-19 pandemic and the current cost of living crisis, this report sets out a stark reality of worsening health, with a particularly steep decline in mental health and wellbeing. It shows that those already worst off in our society are also worst affected by austerity and the pandemic. Any narrowing of inequalities in health and wellbeing were due to a 'levelling down effect', i.e. those formerly doing better seeing a steeper rate of decline in health, but those most disadvantaged still being pushed into further deterioration.

Addressing the priority areas (which are closely aligned to those set out in the Marmot report[2]) will require strong and coordinated collective action rooted in a human rights based approach, with a focus on equality of health and wellbeing. The application of proportionate universalism (providing the strongest support to those with the greatest needs) will improve equality in outcomes.

In summary, we call for:

### Giving every child the best start in life

- The foundations for our physical and mental health, relationships, abilities and habits including diet and activity are laid in childhood. Our commitment to prevention and reduction in inequalities needs to have children's outcomes at its core.

### Enabling all people to maximise their capabilities and have control over their lives and strengthening the role and impact of ill health prevention.

- Strengthen the factors that boost positive mental wellbeing, address root causes of poor mental health and ensure swift mental health support for those in distress.

- Enable all people to eat healthily, be physically active in their daily lives and maintain a healthy weight.
- Tackle the conditions that can give rise to or exacerbate drug use and drug harms, such as stigma, trauma, deprivation and homelessness and reduce the health impact of drug use through prevention, harm reduction, treatment and recovery services.

**Ensuring a healthy standard of living for all, creating fair employment and good work for all, creating and developing healthy and sustainable places and communities**

- Enable all people to access the financial support they need, ensure that all services contribute to mitigating the impacts of poverty, create fair employment and good work opportunities for all and ensure that all organisations and services contribute positively to their local communities.
- Tackle the conditions that can give rise to or exacerbate trauma, including gender based violence, stigma, deprivation and homelessness and ensure that all people who have experienced trauma are supported through trauma sensitive practice to access all services they need.
- Enable all people to gain the benefit of digital access and optimise digital opportunities for better health, whilst ensuring those who cannot or chose not to have digital access receive equally good services and support.
- Enable all people to use affordable, accessible and sustainable transport in a way that maximises health, environmental and economic benefits for individuals and communities.
- Bolster our communities and the places in which we live (with opportunities for children and young people at their heart), build on the strengths and assets of communities and organisations by working together to design support around the needs of those who are most vulnerable and ensure that all organisations and services contribute positively to their local communities, including through fair employment and work.

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# 1. Introduction

The Director of Public Health (DPH) report is an important vehicle for the DPH to fulfil their role as independent advocate for the health of the population and to provide system leadership for its improvement and protection[1]. It is intended to provide advice and recommendations on population health to both professionals and the public.

The existing NHSGGC Public Health Strategy 2018-2028, Turning the Tide through Prevention, emphasises that achieving improved and equitable population health is everyone's business. The strategy established a clear direction of travel for a whole system approach to public health, working together across legislative, social, community and individual change programmes.

This DPH report underpinned by the 2022/23 HWB Survey results, provides an update on the health challenges for NHSGGC. It serves simultaneously as a review of the Public Health Strategy in the context of these health challenges, as a joint strategic needs assessment to inform planning across partnerships, and to mobilise efforts across the population and wider partners, by setting out the rationale for priorities for action.

Greater Glasgow and Clyde has had longstanding experience of deprivation, with poverty, discrimination and exclusion impacting on both overall population health and inequalities in health. This has been further intensified by a series of recent shocks, with the current cost of living crises and the impact of the Covid-19 pandemic compounding the adverse effects of austerity. These have resulted in a significant impact on the health of our population, with increases in premature mortality, chronic illness and many more residents experiencing difficulties in meeting essential costs.

Health inequalities remain unacceptable with the most vulnerable in our society affected the worst by the succession of recent crises. This report highlights priority areas for partnership action to help mitigate this impact and slow and reverse trends of increasing inequalities in the longer term. Human rights and equality need to be the guiding principles of this work. The priority areas for action are closely aligned to those set out in the Marmot report[2], which have been adopted as the conceptual foundation for health inequalities work within Scottish Government[3,4]:

- Giving every child the best start in life
- Enabling all people to maximise their capabilities and have control over their lives
- Ensuring a healthy standard of living for all
- Creating fair employment and good work for all
- Creating and developing healthy and sustainable places and communities
- Strengthening the role and impact of ill health prevention.

# 2. Understanding our communities

## 2.1 Current population and changes over time

The size and composition of any population is a fundamental indicator of need for health and other services in a community. Detailed profiles are available via ScotPHO[5].

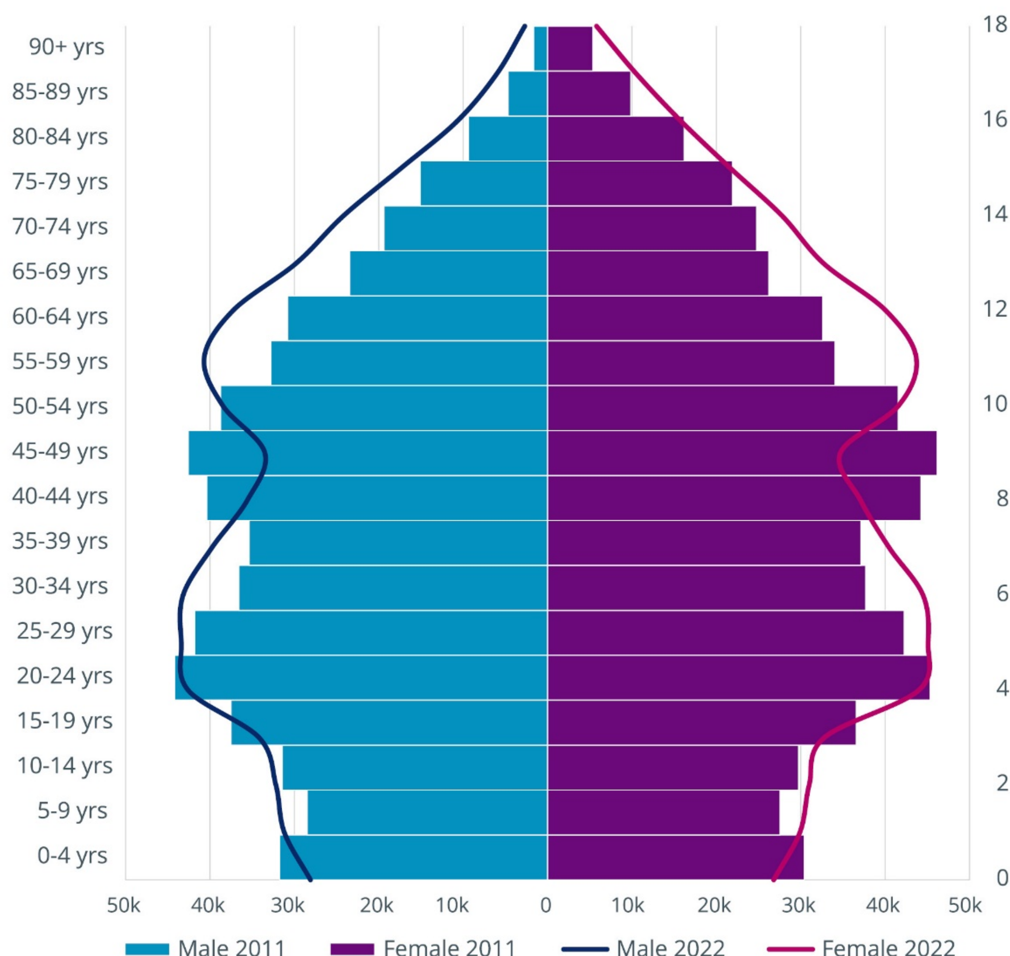
### Size of the population

NHSGGC has the largest population of Scotland's Health Boards, accounting for over a fifth (21.7%) of the population. This is distributed across six Local Authorities (LAs), with wide demographic variations both between and within these areas. According to preliminary 2022 census data, the total population of NHSGGC comprised of 1,177,100 people - increasing faster than Scotland as a whole (3.6% since the previous census in 2011 compared to 2.7% for Scotland). Different patterns of change occurred across LAs. Population increases were seen in East Renfrewshire (6.9%), Renfrewshire (5.1%), Glasgow City (4.6%) and East Dunbartonshire (3.8%), whilst declines were seen in Inverclyde (3.8%) and West Dunbartonshire (2.6%)[6].

### Age-structure

The age-structure of a population is an important indicator of population need, as the prevalence of chronic illness and the demand on health and social care services increases with age. The population of Scotland is ageing i.e. the number and proportion of the NHSGGC population who are in older age groups has increased over time (Figure 1). In 2022, 17.4% (205,100) people in NHSGGC were aged 65 years or older compared to 15.7% in 2011. Of these, 2.1% (25,100) were 85 years or older in 2022, compared to 1.9% in 2011. The proportion of the population in NHSGGC aged 65 years and older was lower than for Scotland overall (20.1%). However, there were marked differences in age structure by LA across NHSGGC, with the highest proportion of the population aged 65 years or older in East Dunbartonshire (24.0%), and the lowest in Glasgow City (14.0%)[6].

**Figure 1**: Population pyramid: population of NHSGGC by 5 year age band and sex, based on census data in 2011 and 2022.



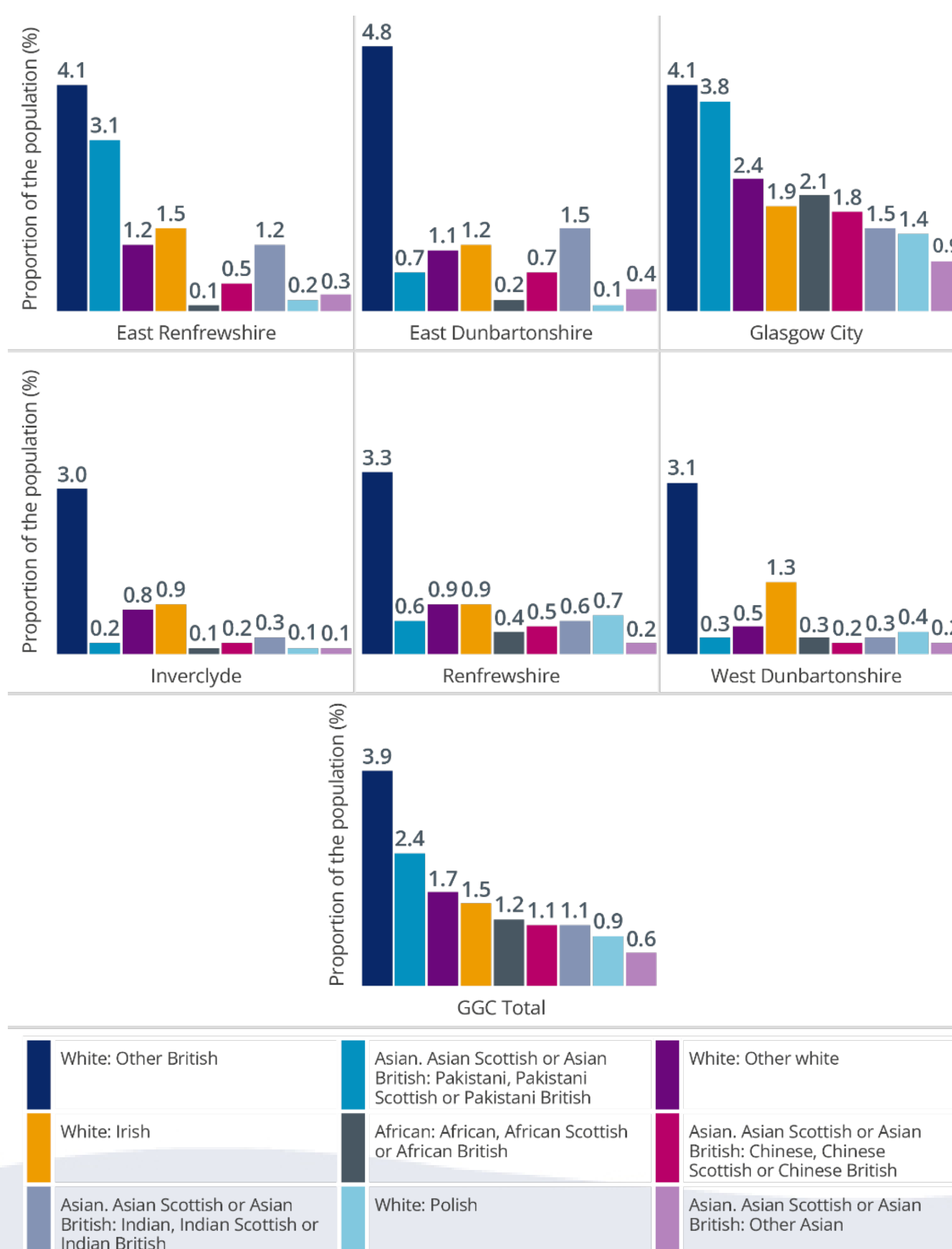

## Material deprivation

Closely associated with population need, material deprivation is measured using the Scottish Index of Multiple Deprivation (SIMD) system, which allocates deprivation rankings to data zones. (A data zone is a small unit of population of approximately 1,000 people. The deprivation ranking of data zones is commonly grouped into quintiles, Quintile 1 represents the most deprived fifth of the population and Quintile 5 the least deprived fifth of the population). In 2021, more than one third (34.3%) of the total population of NHSGGC resided in the most deprived Scottish data zones (Quintile 1), compared with 19.7% across Scotland. Within NHSGGC, the proportion resident in the most deprived data zones (Quintile 1) varied from 4.0% in East Dunbartonshire to 44.9% in Glasgow City[7].

## Ethnicity

Ethnicity is also an important indicator, as there are significant inequalities in health needs and outcomes between ethnic groups in Scotland. According to the 2011 Scottish census estimates, 84.4% of the NHSGGC population identified as white Scottish (ranging from 78.6% in Glasgow City to 93% in West Dunbartonshire)[8]. Figure 2 shows the distribution by LA over ethnic groups. The ethnic diversity of the population is likely to have increased since 2011, with international inward migration the main driver of population increase for NHSGGC and in particular for Glasgow City between 2011 and 2021[9].

**Figure 2**: Proportion of the population by LA, for ethnic groups accounting for 0.5% or more of the NHSGGC population (excluding white: Scottish), based on census 2011 results.



## 2.2 Demographic changes

Changes in size and structure of the population are determined by three fundamental demographic processes; birth rate, mortality rate and migration.

### Births

There were 10,966 live births to residents of NHSGGC in 2022, a 16% decrease from 2011 (compared to a 20% decrease in births across Scotland over the same period). The birth rate in NHSGGC declined from 11.5 per 1,000 in 2011 to 9.3 per 1,000 in 2022. Whilst birth rates recovered again slightly since the low rate seen in the first year of the Covid-19 pandemic (8.8 per 1000 population in NHSGGC in 2020), the longstanding decline in birth rates is likely to persist for the foreseeable future.

### Mortality

There were 13,092 deaths in residents of NHSGGC in 2022, an increase of 8% from 2011 (compared to a 17% increase across Scotland).

Mortality rates are one of the most commonly-used indicators of general health status. As mortality rates differ by age and sex, the standardised mortality rate (SMR) takes account for differences in age-structure and sex to allow comparison between different populations and changes over time. Reflecting the decline in mortality for some specific diseases, including vascular diseases, the SMR (all causes) was declining in most western countries until the middle of the last decade. The SMR in NHSGGC declined to 11.3 per 1,000 population in 2013 and 2014, after which it started to increase. This dramatic reversal in mortality trends, particularly associated with an increase in premature mortality in the most deprived areas, has been linked to the impacts of austerity[10].

A further large increase in mortality rate from 11.7 per 1,000 population in 2019 to 13.6 per 1,000 population in 2020 reflected the impact of Covid-19 on mortality before vaccination had become available. In 2021 and 2022, the SMR in NHSGGC declined to 12.9 and 12.5 per 1,000 population respectively, but this was still higher than observed in the ten years from 2004-2014. In 2022, the SMR ranged from 8.6 per 1,000 population in East Renfrewshire to 14.0 per 1,000 population in Glasgow City.

### Migration

The latest available migration statistics (2021)[11] show the total net inward migration into NHSGGC as 2,740. This was almost sufficient to cover the demographic loss arising from the number of deaths in residents of NHSGGC exceeding the number of births by 2,934. This underlines the importance of inward migration as a mechanism of sustaining the Board's population. Net inward migration was high in the middle of the last decade but has declined in the last few years e.g. net migration to NHSGGC was 11,340 in year 2015-16. The probable reasons for this decline include the departure of the UK from the European Union and the Covid-19 pandemic.

## 2.3 Projections for the population of NHSGGC

Projected populations for NHSGGC and the individual LAs can be made by applying demographic processes to recent estimates of the populations. The most recent projections available for local areas (2018 based) show that to the year 2036, the overall population of NHSGGC is projected to increase by 2.5%[12]. The projections show different trends across LAs (largely reflective of historical trends). Projected population increases are expected in Glasgow City (3.3%), East Renfrewshire (8.9%), East Dunbartonshire (5.5%) and Renfrewshire (2.4%); whereas projected population declines are expected in Inverclyde (9.6%) and in West Dunbartonshire (3.3%).

Further ageing of the population is also projected. The number and proportion of people aged 65 years or older in NHSGGC are expected to increase substantially making up 21.3% of the population by the year 2036.

# 3. Identifying factors which influence health

## 3.1 Life expectancy and healthy life expectancy

Life expectancy at birth and healthy life expectancy are common indicators used to describe the overall health status in populations.

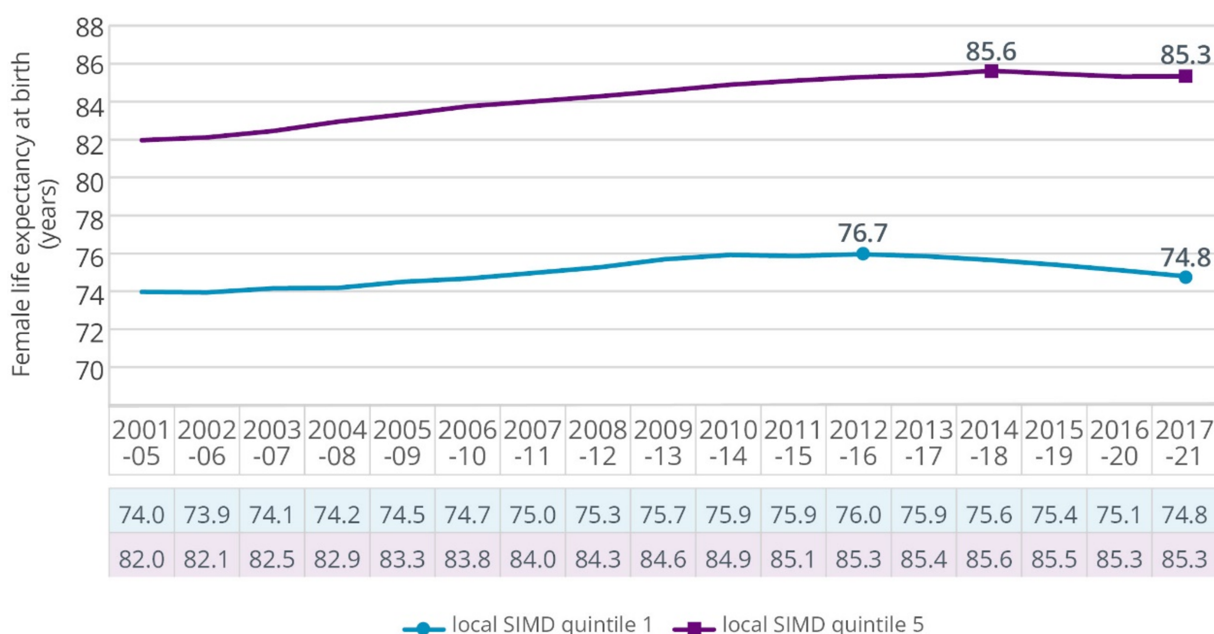
### Life Expectancy

Life expectancy at birth is the number of years that a person born into a particular population might be expected to live, based on current mortality rates.

Life expectancy for male residents in NHSGGC, born in the years 2019-2021, was 74.8 years and for females, 79.5 years. The life expectancy for both males and females was less than that in Scotland generally - 76.6 years in males and 80.8 years in females. Life expectancy varied considerably by area of residence across NHSGGC, ranging from 79.4 years in males and 83.8 years in females in East Renfrewshire, to 72.9 years in males and 78.0 years in females in Glasgow City[13], reflecting differences in life expectancy associated with experience of deprivation.

Trends in life expectancy show that the long-standing increase in life expectancy in Scotland slowed and then reversed in the middle of the last decade. In NHSGGC, life expectancy increased to a maximum value of 75.4 in males (2014-16) and to 80.1 years in females (2013-15). Such a stagnation in trends for life expectancy was unprecedented outwith times of war or previous pandemics, and there is strong evidence that this was associated with the severe impacts of austerity on health[10]. For people living in the most deprived fifth of NHSGGC (local SIMD quintiles), a decline in life expectancy was already observed from the period estimates for 2012-2016, illustrating that the impacts were worst for those already most disadvantaged (data shown for females in Figure 3). Life expectancy at birth for both males and females for NHSGGC overall has fallen in more recent years. Covid-19 mortality contributed to an increase in mortality across the whole population, but caused significantly worse mortality in the more deprived areas, thus driving further exacerbation of inequalities in life expectancy.

**Figure 3**: Trends in female life expectancy at birth in NHSGGC for the most deprived local SIMD quintile (Q1) and the least deprived local SIMD quintile (Q5) by 5 year period, data labels for period of highest life expectancy, and for the most recent period.




| | 2001-05 | 2002-06 | 2003-07 | 2004-08 | 2005-09 | 2006-10 | 2007-11 | 2008-12 | 2009-13 | 2010-14 | 2011-15 | 2012-16 | 2013-17 | 2014-18 | 2015-19 | 2016-20 | 2017-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| local SIMD quintile 1 | 74.0 | 73.9 | 74.1 | 74.2 | 74.5 | 74.7 | 75.0 | 75.3 | 75.7 | 75.9 | 75.9 | 76.0 | 75.9 | 75.6 | 75.4 | 75.1 | 74.8 |
| local SIMD quintile 5 | 82.0 | 82.1 | 82.5 | 82.9 | 83.3 | 83.8 | 84.0 | 84.3 | 84.6 | 84.9 | 85.1 | 85.3 | 85.4 | 85.6 | 85.5 | 85.3 | 85.3 |

## Healthy Life Expectancy

Healthy life expectancy is the number of years from birth that a person could expect to live in a state of self-assessed good health.

Healthy life expectancy for males living in NHSGGC born in 2019-2021 was 58 years and for females, 58.7 years, lower than in Scotland generally (60.4 years in males and 61.1 years in females). Healthy life expectancy varied considerably by area of residence, ranging from 66.7 years in males and 67.2 years in females in East Renfrewshire, to 54.8 years in male and 56.0 years in females in Glasgow City, reflecting differences in health associated with deprivation.

The difference between life expectancy and healthy life expectancy underlines that many years of life are spent in states of poor health. Public health measures should thus not only consider effects on life expectancy, but also on closing the gap between life expectancy and healthy life expectancy.

# 3.2 Burden of disease

The Scottish Burden of Disease (SBoD) study[14] provides a summary about which diseases and injuries have the greatest impact on population health and wellbeing.

The most recent estimates (2019) illustrated stark inequalities in health. National data revealed the disease burden per person to be twice as high in the most deprived areas compared to the least deprived areas. This was largely driven by inequalities in premature mortality15. Many of the leading causes of disease burden in NHSGGC in 2019 – including heart disease, drug use disorders, lung cancer and

COPD – were also the leading drivers of absolute and relative inequalities in the disease burden at the national level (Table 1).

**Table 1**: Five leading causes of health loss for males and females in NHSGGC in 2019 (Scottish Burden of Disease Study).

| | Males | | Females |
|---|---|---|---|
| 1 | Ischaemic heart disease | 1 | Alzheimer's and Dementia |
| 2 | Drug use | 2 | Ischaemic heart disease |
| 3 | Lung cancer | 3 | Lung cancer |
| 4 | Depression | 4 | COPD |
| 5 | Cerebrovascular disease | 5 | Drug use |

There is a shift with age in the conditions most influential for health losses. For males and females who are 15–64 years of age, the top 5 causes of health loss include substance misuse (drugs and alcohol) and mental health conditions (depression/ anxiety), and also self-harm and violence in young people and younger working age males (males and females 15-24 years of age; males 25-44 years of age).

Cancers and circulatory diseases enter the top 5 causes of health loss for adults 45 years or older, and Alzheimer and Dementia enter the top 5 causes of health loss in those aged 65 years and older.

The total burden of disease for people aged 85 years or older is small compared to other age groups in NHSGGC, but there is a large burden per person. This means that the total burden will increase substantially, with an increase in the number of older people, as anticipated from population projections.

The burden of disease estimates confirm drug harms and mental health as priorities for public health. There is also a large overlap in the modifiable risk factors for cardiovascular diseases, COPD, cancers as well as dementia, including healthy diet and weight, physical activity, living smoke free, limiting alcohol consumption, and being able to avoid air pollution. Healthy and sustainable places are important to enable good physical and mental health. Increasing and retaining cognitive reserve, including through educational attainment and maintaining frequent social contact, are further important protective factors reducing the risk of dementia, reinforcing both the importance of supporting early years' development, as well as strong communities that reduce social isolation.

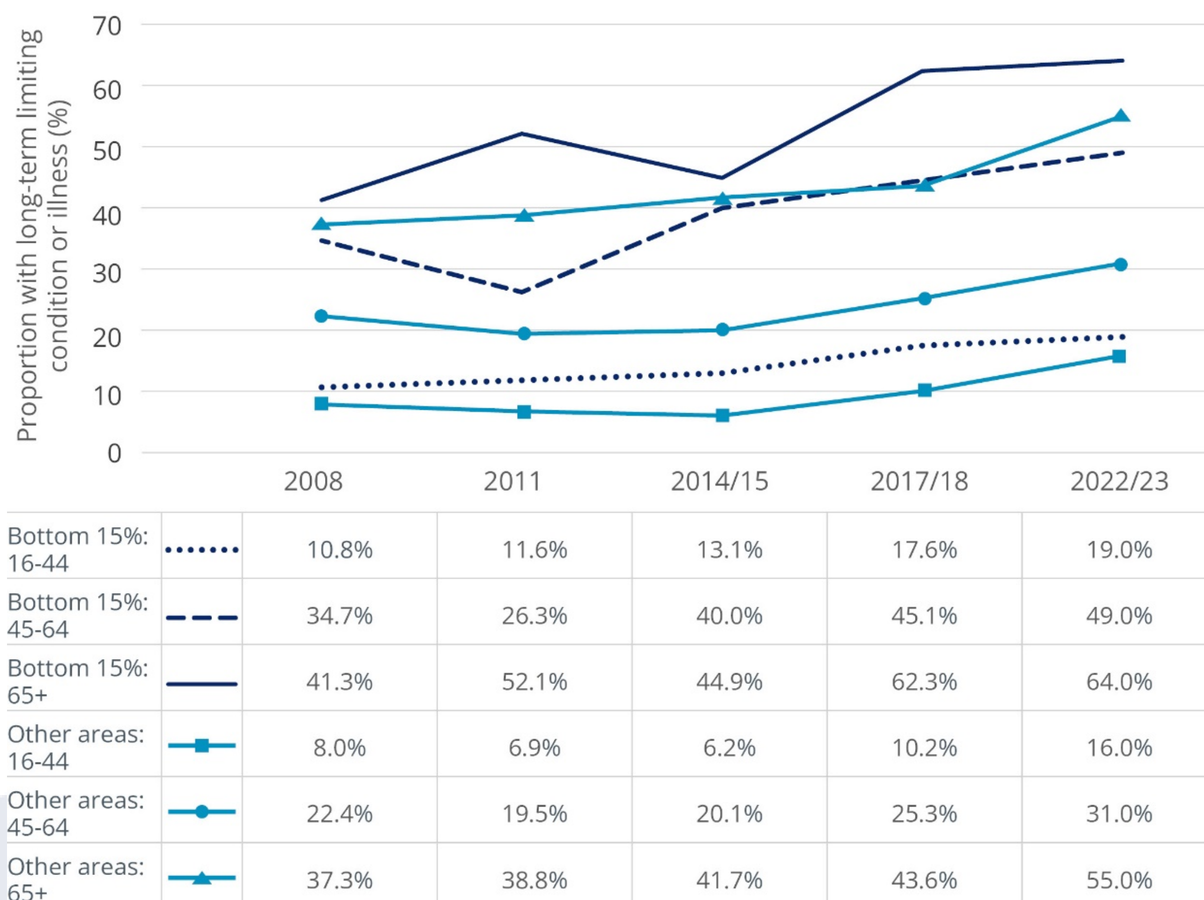
## 3.3 Long term condition or illness that substantially limits day to day activities

Conducted in the aftermath of Covid-19, the 2022/23 NHSGGC HWB Survey provides important insights into self-perceived health and ill-health of our population.

Three in ten adults in NHSGGC (31%) reported a long-term condition or illness that interfered with their day to day activities[16]. This increased with age, affecting nearly two thirds (61%) of those aged 75 years and over. Health inequalities remained large, with 37% of people living in the 15% most deprived data zones affected by a limiting condition, compared to 29% of people living in other areas.

The proportion of adults in NHSGGC with a long term limiting condition increased substantially over the last 15 years from just under a quarter (23.3%) in 2008, to over a third (35.8%) in 2022/23. This increase varied across age groups. For the middle aged (45-64 years) and older age (65 years and over) groups, the increase was steeper for those living in the 15% most deprived data zones, compare to other areas. However, a narrowing in inequalities was seen between 2017/18 and 2022/23, with a steeper increase in those living in less deprived data areas. This narrowing was least pronounced in the 45-64 year old age group.

**Figure 4**: Trends in proportion of the population with a long-term condition or illness limiting daily activities by deprivation (bottom 15% most deprived versus other areas) and age group (16-44 years, 45-64 years, 65 years or older) 2008 to 2022/23.




| | 2008 | 2011 | 2014/15 | 2017/18 | 2022/23 |
|---|---|---|---|---|---|
| Bottom 15%: 16-44 | 10.8% | 11.6% | 13.1% | 17.6% | 19.0% |
| Bottom 15%: 45-64 | 34.7% | 26.3% | 40.0% | 45.1% | 49.0% |
| Bottom 15%: 65+ | 41.3% | 52.1% | 44.9% | 62.3% | 64.0% |
| Other areas: 16-44 | 8.0% | 6.9% | 6.2% | 10.2% | 16.0% |
| Other areas: 45-64 | 22.4% | 19.5% | 20.1% | 25.3% | 31.0% |
| Other areas: 65+ | 37.3% | 38.8% | 41.7% | 43.6% | 55.0% |

The proportion of NHSGGC adults receiving treatment for at least one condition (not necessarily conditions affecting daily activities) also increased by nearly 10% over the last 15 years (36.5% to 45.9%), with the steepest increase seen between 2017/18 (39.2%) and 2022/23 (45.9%).

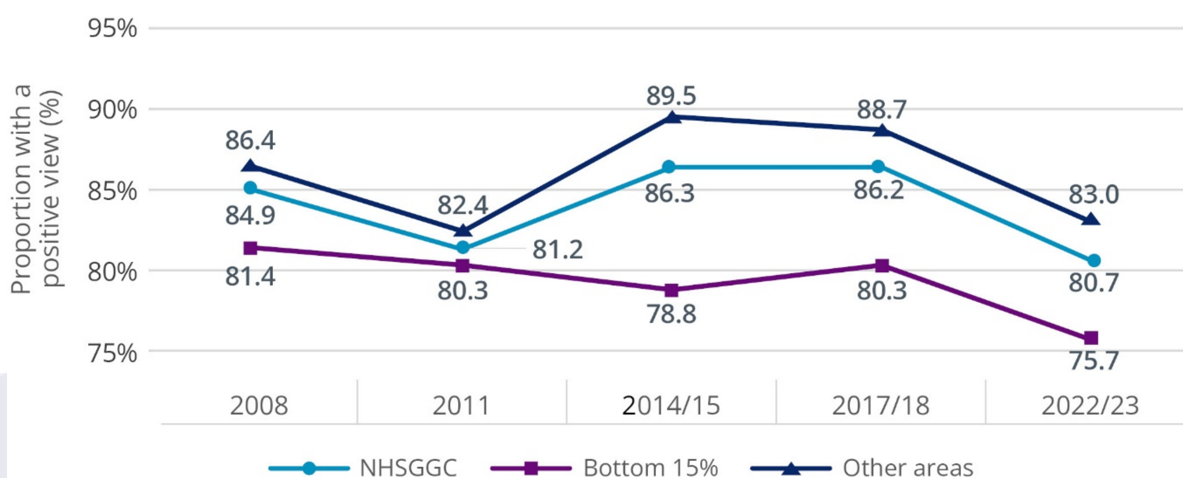
These stark trends in ill health over time, accelerated over the last 5 years since the last survey, represent an increasing need for health and social care, with a clear requirement for enabling self-management to support the substantial increase in people whose health directly impacts on the activities they carry out in their daily lives (which may include work and or caring commitments).

## 3.4 Positive views of mental and emotional wellbeing

Based on the most recent HWB Survey (2022/23), four out of five adults in NHSGGC (81%) had a positive view of their mental and emotional wellbeing, though this was lower in those living in the most deprived 15% data zones (75% compared to 83% for those living in other data zones). A much lower proportion of adults with a long term condition limiting their day to day activity rated their mental and emotional wellbeing positively (62%), compared to those without a limiting condition (89%). There was no clear trend by age group, though the proportion with positive views was generally higher in those groups under the age of 45 (range 82% to 84%), compared to older age groups (range 76% to 81%) with the lowest proportion rating their mental and emotional wellbeing positively those aged 45-54 years (76%).

Over the last 15 years, the proportion of adults reporting a positive view of their mental and emotional wellbeing fluctuated, with a previous fall in the 2011 survey. A steep decrease (by 5.5%) was seen since the most recent survey pre-pandemic (2017/18 versus 2022/23). This decrease was steeper in those living in the less deprived data zones (Figure 5). Young adults aged 16-24 year had the steepest decline in reporting a positive view of their mental and emotional wellbeing, decreasing by 12% (94% in 2017/18 to 82% in 2022/23). This compares to a decrease in positive views of 3%-6% for the other age groups.

**Figure 5**: Trends in positive view of mental and emotional wellbeing by deprivation, 2008 to 2022/23.



# 3.5 Infectious diseases in the context of the Covid-19 pandemic

## 3.5.1 Covid-19

The last three years have been dominated by the Covid-19 pandemic, the most significant health event worldwide since the 1919 influenza pandemic. The response to Covid-19 was a societal effort, requiring strong partnership working. The NHS worked together with a multitude of partners, including LAs, police, fire, and many other statutory and voluntary organisations, through resilience partnerships. Two areas of partnership work particularly deserve to be highlighted – work undertaken to deliver the largest mass vaccination drive in living memory, and the design, set up and running of community testing services.

The epidemiology of Covid-19 is described in detail elsewhere through national surveillance outputs, and dashboards that allow tracking of local trends[17]. The impact of Covid-19 has touched every aspect of our lives – individual and community health, delivery of services, education and economic growth. It has more severely affected the lives and health (higher morbidity and higher mortality) of older people, those living in more deprived areas, ethnic minorities, disabled people and those with underlying chronic conditions.

In the 2022/23 HWB survey 47% of respondents reported that the impact of the Covid-19 pandemic led to deterioration of at least one measure of their wellbeing (32% quality of life; 29% general mental or emotional wellbeing; 25% general physical wellbeing). These effects were disproportionally felt by those with limiting conditions, as well as women and older people.

Between 2% and 3% of the population are currently thought to be affected by long Covid, the syndrome when ongoing symptoms associated with Covid infection continue for at least 4 weeks after the start of infection[18,19]. This equates to approximately 20,000 individuals in NHSGGC (although this is likely to be an underestimation). Symptoms of long Covid can include fatigue, breathlessness, brain fog and limited capacity to engage in Activities of Daily Living. Referrals received by the NHSGGC long Covid service (a multidisciplinary service offering group and individual support) reflect findings around those most affected, with two-thirds female, and those being referred predominantly aged 30-64.

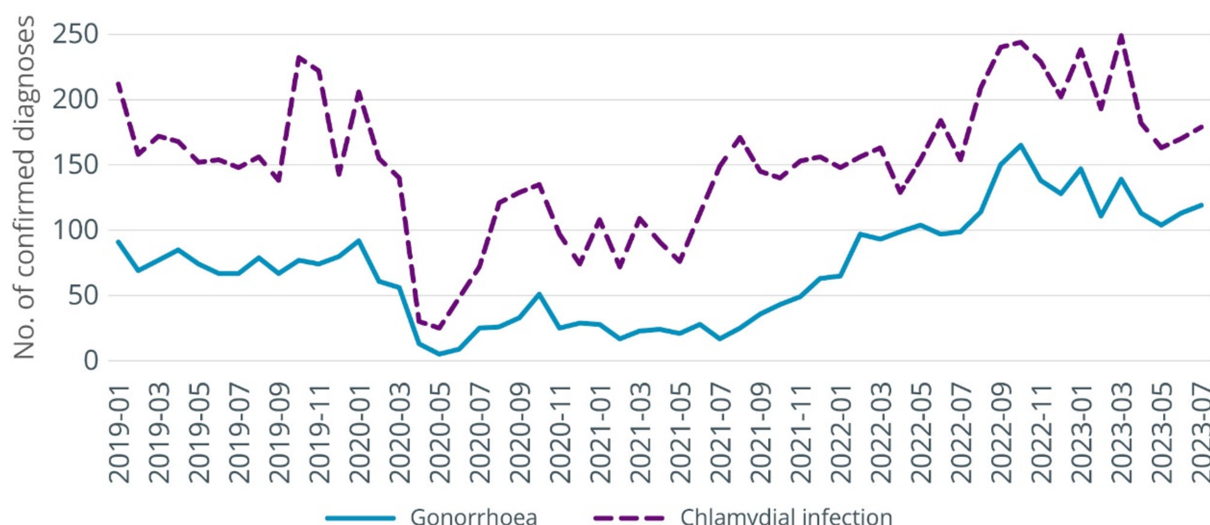
## 3.5.2 Sexual health including sexually transmitted Infections and blood-borne viruses

### Sexually Transmitted Infections (STIs)

NHSGGC has seen changes in the number of sexually transmitted infections (STIs) since the start of the Covid-19 pandemic, likely to be a result of changing societal restrictions and behavioural changes during the pandemic. In the first year of the Covid-19 pandemic, both the numbers of tests for gonorrhoea and chlamydia, and the proportion of positive results fell, suggesting a reduction in STIs in our population

at that time. However, during 2021, newly diagnosed cases of chlamydia and gonorrhoea began to increase again, at first returning to pre-pandemic levels, and then continuing to rise to higher levels in 2022. Number of tests carried out had not recovered to pre-pandemic levels, suggesting that the increased diagnoses were due to a true rise in the number of these STIs, rather than due to increased testing. A national response was mounted including a Scotland-wide communication campaign focussing on social media channels and promoting behavioural change to reduce STI transmission risk.

**Figure 6**: Number of gonorrhoea and chlamydial infection diagnoses by month, NHSGGC, January 2019 – July 2023 (National Sexual Health System data).




## Blood-Borne Viruses (BBVs)

NHSGGC accounts for over a third of cases of blood borne virus (BBV) infections diagnosed in Scotland. BBVs can affect anyone, but they disproportionately affect people who inject drugs (>90% of hepatitis C diagnoses in Scotland are linked to injecting drug use), gay and bisexual men, and men who have sex with men (who account for 45% of HIV diagnoses in Scotland).

There has been a fall in the number of new diagnoses of HIV in recent years and there are signs that the outbreak of HIV among people who inject drugs in NHSGGC (first identified in 2015) has stabilised. In addition, the prevalence of hepatitis C in NHSGGC fell by 60% between 2015-2016 and 2019-2020. These developments are likely to be the result of the scaling up of testing and treatment as well as outreach models to improve initiation and retention in care.

The Covid-19 pandemic, however, had a major and lasting impact on BBV prevention, diagnosis and treatment in NHSGGC, and progress towards the elimination of hepatitis C has slowed. Higher rates of testing and treatment as well as expansion of other control measures, including: injecting equipment provision (IEP); provision and promotion of condoms; HIV Pre Exposure Prophylaxis and Post Exposure Prophylaxis, vaccination for hepatitis B and outreach services to support

individuals into care will all be required if NHSGGC is to make further progress on BBVs and achieve elimination of hepatitis C and HIV transmission.

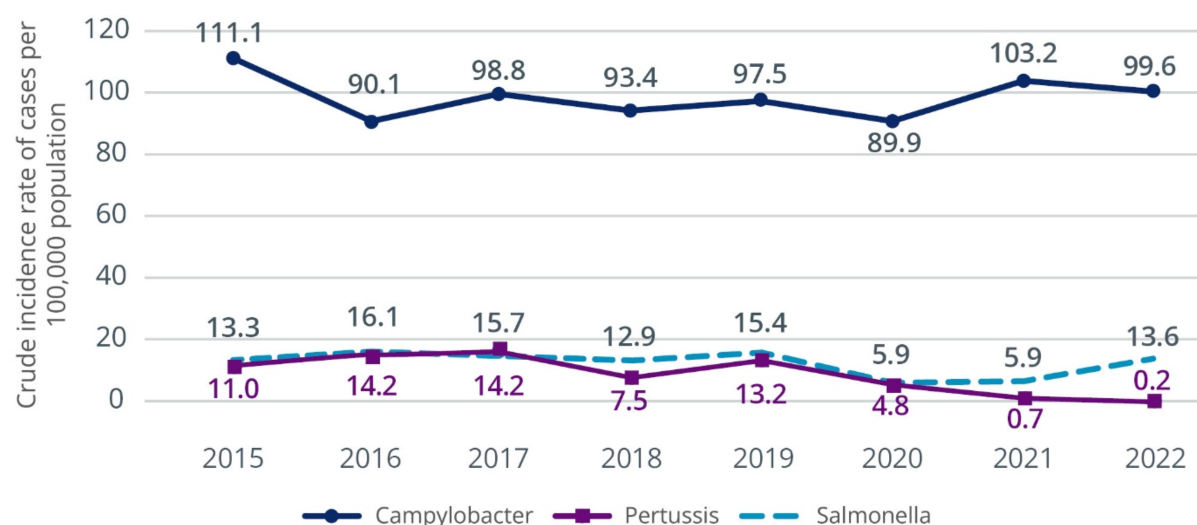
### 3.5.3 Changes in selected notifiable communicable diseases

The Covid-19 pandemic has greatly impacted the pattern of many communicable diseases. The countermeasures against Covid-19 and lifestyle changes encouraged by the pandemic response, might have contributed to this, but did not have the same effects across all diseases. This is illustrated here with reference to three specific pathogens – pertussis (whooping cough), salmonella and campylobacter.

There has been a strong and persistent reduction in pertussis cases compared to before the pandemic (Figure 7). Whilst a similar substantial decrease was recorded for salmonella in that time period, the number of salmonella cases has now returned to near pre-pandemic levels (Figure 7). This is likely to be due to resumption of travel patterns (with a significant proportion of all salmonella cases in NHSGGC residents are associated with foreign travel).

An example of a disease with levels remaining similar before, during and after the pandemic is campylobacter, which is the most common bacterial cause of gastrointestinal illness (Figure 7). Campylobacter is most associated with ingestion of undercooked poultry or other meat products, particularly with summer BBQ season and other holiday periods, which were less affected by the pandemic restrictions.

**Figure 7**: Crude incidence rate of Campylobacter/pertussis cases per 100,000 population by year, NHSGGC, 2015-2021 (HPZone).




The workload of the Public Health Protection Unit (PHPU) is a further indicator of the changes in burden of infectious diseases. PHPU is a multidisciplinary team of public health specialists, responsible for fulfilling the Health Board's obligations under the Public Health Act. For example, in 2022 there were 941 incidents or outbreaks managed by PHPU; a 779% increase compared to 2017.

### 3.5.4 Vaccine preventable diseases

After clean water, vaccinations are considered the single most important intervention for improving health and preventing disease. The NHSGGC vaccination programme is the largest NHS public health intervention in Scotland.

Due to the high vaccination rate, measles is rare (last confirmed measles cases in NHSGGC were in 2019) however, there is an ongoing resurgence of measles across Europe and the rest of the UK. Whilst measles, mumps and rubella (MMR) vaccination uptake is close to the WHO target of 95%, Public Health Scotland estimate that 9.4% of NHSGGC residents aged 19 and under remain susceptible to measles.

Other routine vaccination rates are comparable to rest of Scotland and close to or over the WHO targets. This includes the Human Papillomavirus (HPV) schools vaccination where NHSGGC has the highest coverage by S4 of all mainland Boards and is the only Board to achieve coverage above 90% across all five SIMD quintiles.

# 4. Opportunities to improve health

The burden of disease is projected to increase in coming years. Combined with the likely long term health impacts of the Covid-19 pandemic and the cost of living crisis, the urgency of concerted action for prevention and reduction in health inequalities is greater than ever. In line with the objectives outlined in the Marmot review, this requires **strengthening the role and impact of ill health prevention** (including mental health, drug harms, overweight, obesity and diabetes) whilst **enabling all people to maximise their capabilities and have control over their lives.** It also means **giving every child the best start in life**. Health and development in childhood influence a person's health over the rest of their life, and a commitment to prevention and reduction in inequalities needs to have children's outcomes at its core.

## 4.1 Ensuring the best start for life

The foundations for our physical and mental health, relationships, abilities and habits, including diet, are laid in childhood. The first 1,000 days from conception to age 2 is a critical period of body and brain development. Positive and negative impacts at this time directly influence future mental and physical health (including oral health and healthy weight) and life chances. These impacts include our nutrition, the 'emotional environment' and learning stimuli.

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**"The highest rate of economic returns comes from the earliest investments in children"** (Heckman, Nobel Prize winning economist).[20]

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Adolescence brings a further important stage in brain development. It is a time of rapid learning and vulnerability and important for developing resilience and mental wellbeing.

Childhood and adolescence is not just a route to adulthood, however, it is approximately a quarter of our lives. A fifth of our community are children and young people and they make a large contribution to that community, including in the role of carers. Public health outcomes for children are multifaceted and are not well represented by the 'need for healthcare', or measures such as life expectancy and burden of disease.

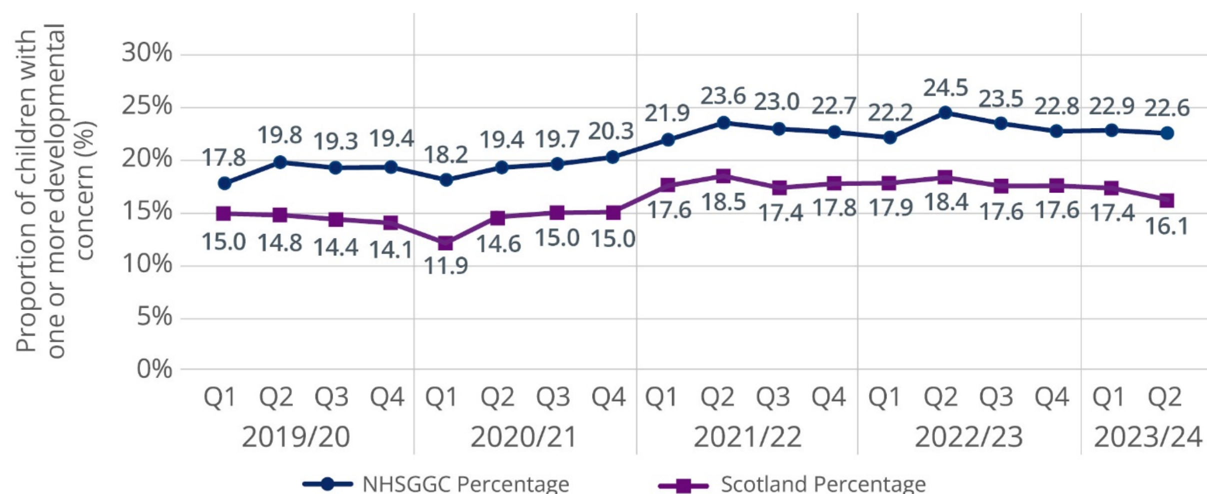
### 4.1.1 Child development – why immediate action is needed

The proportion of children with developmental concerns has remained high and has increased since Covid-19 (Figure 8). A proportion of these developmental concerns are preventable, whilst outcomes can be improved in others if there is early intervention. Without this, more children will require more support and have more challenges to overcome throughout life.

Children residing in deprived areas and children who have experience of care are more likely to have developmental concerns. Pre-Covid, there was some evidence

that the gap associated with deprivation was reducing, however this is widening again. Narrowing the gap in health outcomes must begin at this stage.

**Figure 8**: Percentage of children with one or more developmental concerns recorded at the 27-30 month review, NHSGGC and Scotland, quarter one (Q1) 2019/20 to quarter two (Q2) 2023/24.

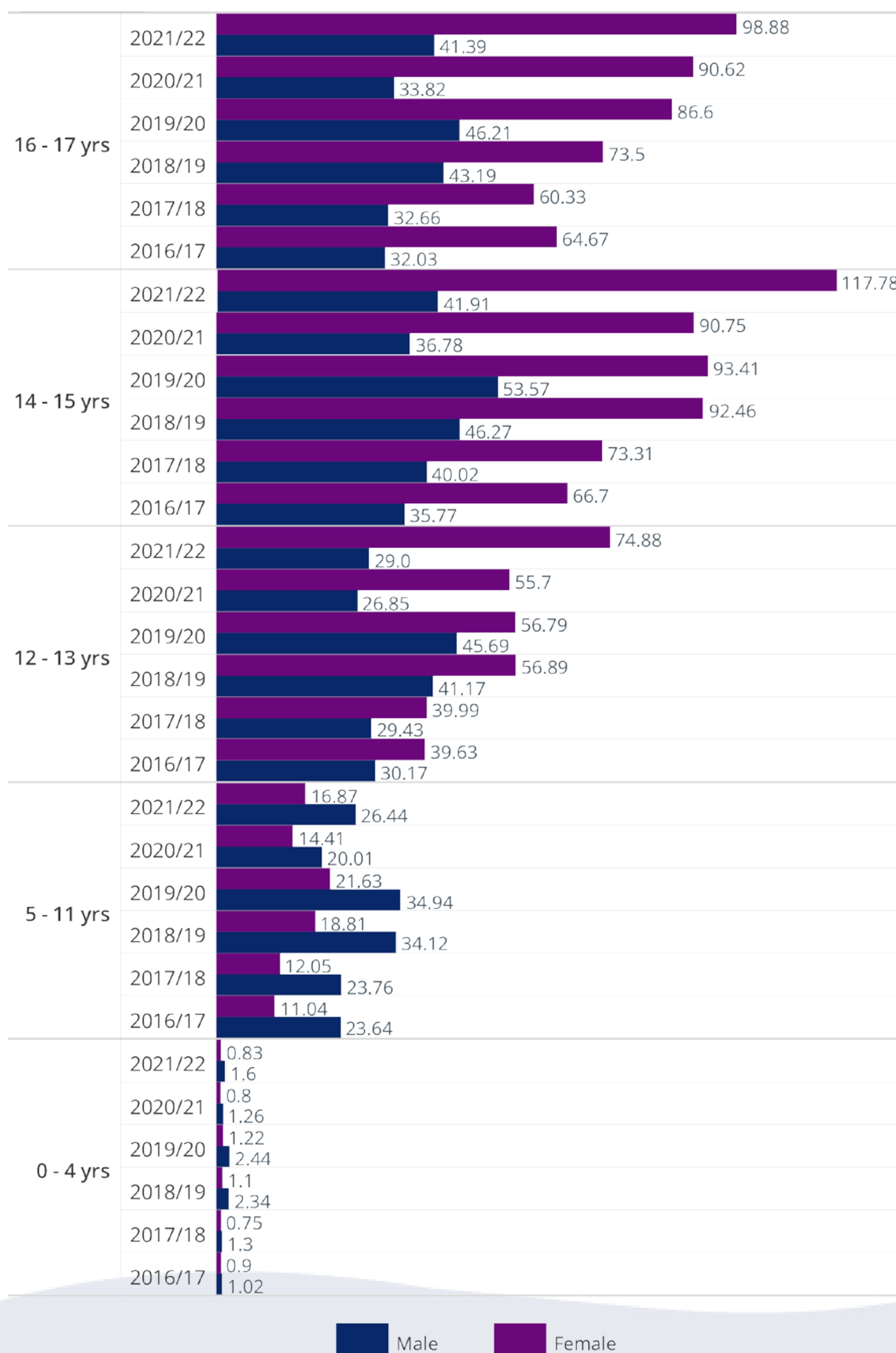



### 4.1.2 Children and young people's mental health – why immediate action is needed

The mental health and wellbeing of children and young people is deteriorating. This is reflected by increased referrals to Child and Adolescent Mental Health Services, increased presentations with self-harm to hospital and primary care and an increase in eating disorders. This is predominantly seen in females aged 12-17 (Figure 9). Conducted in 2021/22, the most recent Scottish Schools Health and Wellbeing Census[21] highlighted 3 in 10 secondary age/S2-S6 pupils with probable clinical depression and a similar proportion with a high level of emotional and behavioural difficulties (from local analysis of Glasgow City data). 14% often or always felt lonely, 30% had been bullied in the last year, 27% were not happy with their body or the way they looked, and around 7% had a social media disorder (problematic social media use). Suicide is the leading cause of death in children and young people.

Mental health and wellbeing is worse in particular groups including LGBTQ+ people, those from deprived areas and those with neurodevelopmental concerns. There are links with developmental concerns including increased risk of mental health problems in children with neurodevelopmental disorders, particularly if they are not supported early and provided with the environment and techniques to support them to thrive.

**Figure 9**: Accepted CAMHS referrals over time by gender and age (rates per 1,000 population)



### 4.1.3 Child oral health – why immediate action is needed

Dental decay is a preventable condition but remains the most common reason for a child to be admitted to hospital for a General Anaesthetic (GA) across the UK. Despite child oral health improving in Scotland and NHSGGC since 2005, there are persistent oral health inequalities. Just under 30% of Primary 1 and Primary 7 children were noted to have obvious decay, with higher levels in children living in more deprived areas. The impact of the Covid-19 pandemic is not fully understood, but the available data from the National Dental Inspection Programme conducted in 2022[22] suggests that those children who had decay were more likely to need urgent dental treatment (i.e. they were experiencing more severe disease) compared to previous years.

The Childsmile programme, a flagship programme which includes toothbrushing in schools, was severely disrupted by the pandemic. Whilst the proportion of schools engaging has improved (71% in June 2023 compared to 38% in November 2022), it is still lower than pre-pandemic levels (around 80% uptake). Toothbrushing with fluoride toothpaste remains the most effective and cost effective intervention to reduce tooth decay.

### 4.1.4 Ensuring the best start for life - Calls to action

As a society, in order to improve health and wellbeing, we need to significantly reduce child poverty and financial distress, drive out gender based violence and support families to flourish if we are to make the biggest impacts on children's outcomes. We know that a consistent drive to improve the first 1,000 days of life - from conception into the early years - including maintaining investment in this period, will give us the best return for the health and wellbeing of our population.

- Through maternity care, recognise and address the individual needs of women and families during pregnancy, including risk behaviour such as alcohol, preparation for parenting, mental health and financial challenges and risks of gender based violence.
- Maximise the role of the Universal Health Visiting Programme, providing support to all families, recognising children and families who need additional support to thrive and those with developmental problems. Intervene quickly and connect vulnerable children and families to effective, evidence based, preventative services and support programmes, building pathways of care centred around the needs of children and families.
- Strengthen support for early child development through strong early years learning; social opportunities supportive environments for play and early years child care providers.
- Protect the mental health of children and young people and promote development of resilience, recognising the impacts of sleep, social media, diet and exercise in mental wellbeing. This includes embedding children's rights within decision making, supportive learning and home environments, with

resilient youth services and opportunities for children and young people within our communities.

- Use our joint resources to build supportive and easy-to-navigate tiers of mental health support which prioritise early intervention when needed.
- Improve children's oral health by promoting dental registration and delivering new and innovative approaches to school/community based tooth brushing programmes (such as Childsmile).

## 4.2 Enabling Healthy Weight through healthy eating and active living

The proportion of the population who are overweight or obese continues to rise across Scotland. In NHSGGC, 67% of adults and 23% of children entering P1 are now overweight and/or obese[23]. Being overweight or obese increases the risk of developing conditions such as type 2 diabetes (T2DM), as well as cardiovascular disease, many types of cancers, liver and respiratory disease[24]. It can also impact on mental health[25]. The annual costs of overweight and obesity across Scotland is estimated to be £5.3 billion, which corresponds to 3% of Scotland's 2022 GDP[26].

Overweight, obesity and T2DM contribute to health inequalities, disproportionately impacting on people living in the more deprived areas (SIMD 1 and 2) and people from an Asian or Black ethnic origin.

### 4.2.1 Enabling healthy weight – why immediate action is needed

During the pandemic, childhood levels of obesity relative to overweight have increased in our most deprived communities[27]. Overweight and obesity is the single most important modifiable risk factor for T2DM and increasing prevalence is driving an alarming rise in the number of people being diagnosed with T2DM. In 2022, 66,677 patients had T2DM; this is a rise of 4,687 cases from the previous year. It represents 5.5% of the NHSGGC population, with approximately 150 new diagnoses every week.

The pandemic (where lockdown measures increased sedentary behaviours) followed by the cost of living crisis (increased food costs) exacerbated drivers of overweight and obesity[28]. Healthy foods now cost almost three times as much as unhealthy foods that are high in fats, salts and sugars[29]. The increase in levels of food insecurity described in chapter 5 are mirrored by the use of foodbanks. 1 in 20 of the NHSGGC population use foodbanks regularly, rising to 1 in 5 in the most deprived areas.

Recent HWB Survey data showed that eating habits are changing. Fruit and vegetable consumption is a reliable indicator of nutritional quality of the diet, but across all socio-economic groups, the proportion who ate the recommended daily amounts has decreased since the last survey. Those living in the most deprived areas were also less likely to consume nutritious and more expensive foods such as

lean meat or fish and more likely to consume cheaper processed convenience foods such as pies, pastries and chips.

**Figure 10**: Proportion of children in primary 1 of school in NHSGGC who were overweight or obese by Local Authority, 2021/22.

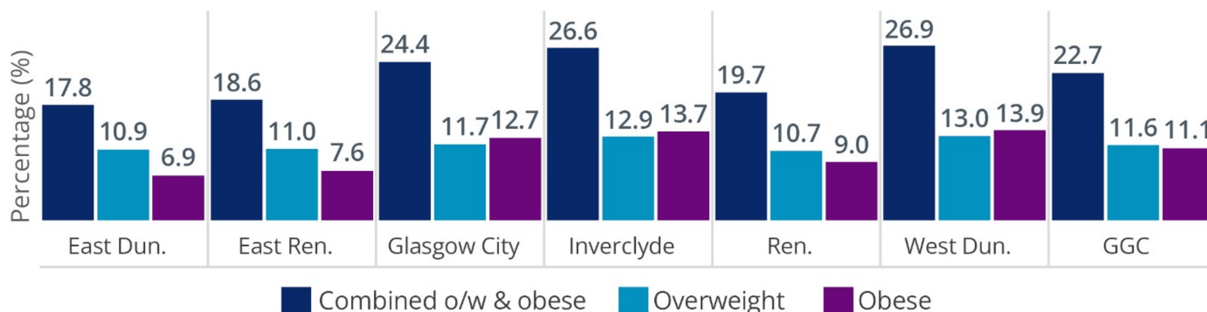
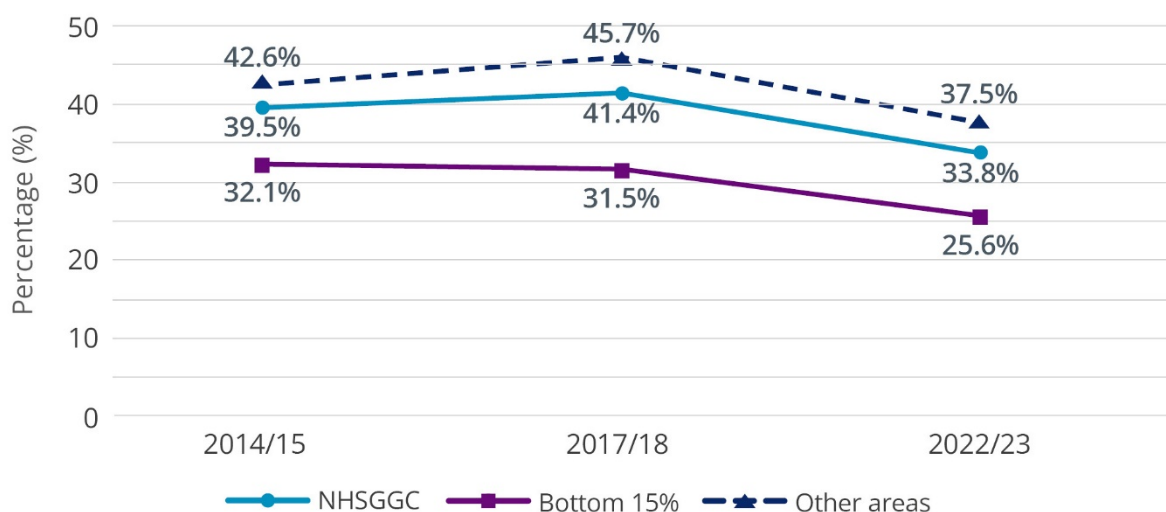



**Figure 11**: Trends for proportion meeting the target of consuming five or more portions of fruit/vegetables per day 2014/15 to 2022/23.




Food purchased outwith the home is more likely to be higher in fat, salt and sugars than home cooked options. However, 40% of the wider population did not eat home-made food daily (higher in deprived areas). The increased cost of healthy food coupled with the reduction in cooking from scratch and the associated loss of practical cooking skills[30], is undoubtedly having an impact on nutrition related health inequalities[31].

Additionally, HWB Survey data highlighted that those living in the most deprived circumstances, those over the age of 65 and those with a long term limiting condition were all less likely to be physically active. The recent schools census highlighted that less than a third of young people are active every day.

### 4.2.2 Enabling healthy weight - Calls to action

- Work across agencies to build a comprehensive universal approach to child healthy weight based on the HENRY programme32, which promotes holistic child development and wellbeing in a way which builds meaningful reductions overweight and obesity from a young age.
- Continue to develop weight management services to meet the needs of the NHSGGC population.
- Strengthen work with the national pantry network, Third Sector Organisations and partners to identify supply chains and distribution networks to widen access to affordable healthy food for those experiencing food insecurity. Collaborate to develop robust asset-based initiatives such as Thrive Under Five and local Community Food Networks to build community capacity, cookery skills and food literacy and reduce food insecurity.
- Strengthen partnerships with Third Sector Organisations, leisure and land services to incorporate safe, green spaces and play areas within existing communities and new developments to promote play and activity and community cohesion and offer a range of free and low-cost physical activity opportunities.

## 4.3 Boosting mental health and mental wellbeing

Good mental health and wellbeing are important foundations for positive general health, relationships, development and resilience. Our mental health is shaped by the social, physical and economic environments in which we are born, grow, live, work and age[33]. Therefore, good mental health is not experienced equally across society. Those who are experiencing the most disadvantage in life are also at highest risk of poor mental health.

### 4.3.1 Boosting mental health and wellbeing - why immediate action is needed

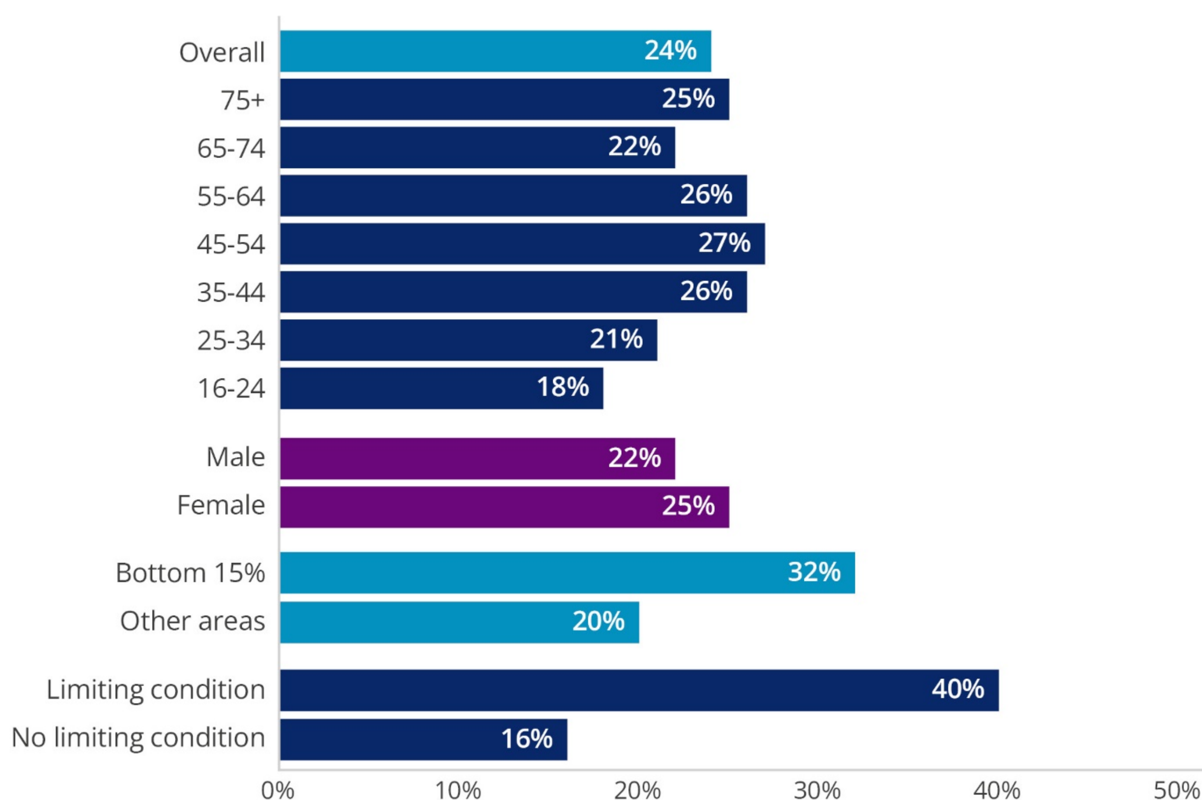
The pandemic lockdowns and cost of living crisis have, on the whole, negatively impacted on mental health and have disproportionately affected those who were already struggling. Overall trends show mental health and wellbeing has declined steeply across NHSGGC since the last HWB Survey in 2017/18 (see section 3.4).

Within the NHSGGC HWB Survey, participants were asked about the impact of the Covid-19 pandemic on various aspects of wellbeing. Whilst 64% stated that their general mental or emotional wellbeing had remained the same, 29% stated it had deteriorated. For all indicators of wellbeing, 67% of those with a limiting condition reporting deterioration of at least one wellbeing indicator due to the Covid-19 pandemic compared to 37% of those with no limiting condition.

The 2022/23 survey used the validated tool Warwick-Edinburgh Mental Well-being Scale (WEMWBS) to measure mental health and wellbeing. Using a score of 41 or below as an indicator of likely depression, significant inequalities were seen with

females, those living in the 15% most deprived areas and those with a limiting condition, more likely to have a score indicative of depression (Figure 12).

**Figure 12**: Proportion with a WEMWBS Score Indicating Depression by Age, Gender, Deprivation and Limiting Conditions. Source: NHSGGC Adult Health and Wellbeing Survey 2022/2023.




Other groups known to be disproportionately affected by poor mental health include people with disabilities, LGBTQ+ people, Black & Minority Ethnic (BME) people and those with a mental illness. Recent reports have identified issues such as high suicidal ideation, discrimination, micro-aggressions towards individuals in these groups, stigma and challenges seeking and accessing the support needed[33,34,35,36,37].

### 4.3.2 Boosting mental health and mental wellbeing – Calls to action

- Build on a 'public mental health' approach across NHSGGC, which means taking a systematic approach to addressing both the root causes of poor mental health and the factors that boost positive mental wellbeing, working in active partnership with relevant communities to achieve the best possible mental health for all, with a particular focus on groups disproportionately affected including disabled people, ethnic minorities, LGBTQ+ people and people with a mental illness.

- Learn from lived experience in our communities to drive improvements in relation to wellbeing support, finding the right support at the right time, suicide prevention and responding to those in most distress.

- Identify and spread innovative practice and service development across partnership structures, working closely with statutory partners and Third Sector Organisations to build capacity.

## 4.4 Concerted action to reduce drug harms

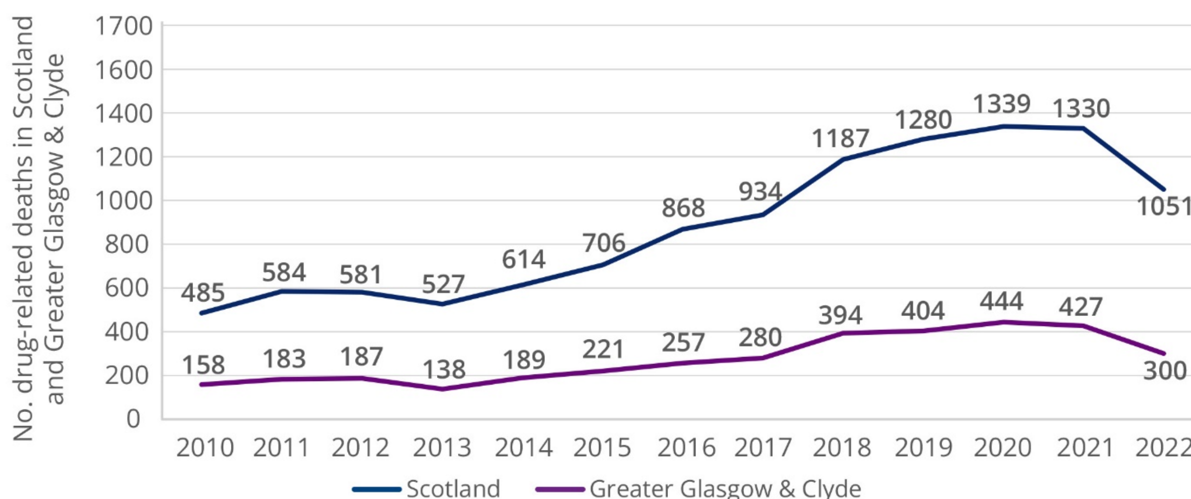
NHSGGC has a high prevalence of drug use and experiences a considerable burden of associated health harms. Those harms disproportionately affect those living in areas of greatest deprivation and include: drug-related deaths and non-fatal overdoses; injecting wound infections; blood-borne virus (BBV) transmission (see section 3.5.2), exacerbation of mental health conditions and other co-existing health problems and reduced access to services to meet health and wider needs (such as financial inclusion and housing) that in their own right have a bearing upon health.

Drug use also has the potential to harm the physical and mental health of not just the individual using drugs, but also their friends and family, including children. Stigma is commonly experienced by people who use drugs and their families and is both harmful in its own right as well as a powerful factor in generating other forms of harm such as impaired access to services.

### 4.4.1 Concerted action to reduce drug harms - why immediate action is needed

Drug-related deaths are the most extreme form of drug harms. For many years, the number of drug-related deaths has been steadily rising across Scotland, with NHSGGC consistently accounting for about a third of the deaths. In 2021 and 2022, the number of deaths fell for the first time in nearly a decade, with NHSGGC experiencing 30% fewer deaths in 2022 than in the previous year. Whilst this is encouraging, the number of deaths remains far too high, and there are no certainties that this recent decrease will be sustained into the coming years. Interventions on BBV were severely disrupted by the Covid-19 pandemic (see section 3.5.2). Ongoing efforts to prevent drug-related deaths and other drug harms are therefore as important as ever.

**Figure 13**: Number of drug-related deaths in Scotland and Greater Glasgow and Clyde by year, 2010-2022 (Source: National Records of Scotland).




## 4.4.2 Concerted action to reduce drug harms - Calls to action

The complexity of drug harms requires broad action to reduce the extent of drug use in our population and to prevent or mitigate the harms that can arise from it.

- Continue to deliver a comprehensive range of prevention, harm reduction and treatment services which meet Medication Assisted Treatment (MAT) Standards.

- Strengthen collaborative efforts to tackle the conditions that can give rise to or exacerbate drug use and drug harms, such as stigma, deprivation and homelessness.

- Facilitate a co-ordinated approach to reducing drug harm through the implementation of NHSGGC Framework for Addressing the Health Harms Associated with Drug Use, which reflects key national and local policies and strategies for tackling drug harms.

- Following the Lord Advocate's statement in September 2023, support the opening of a Safer Drug Consumption Facility in Glasgow City, and ensure robust evaluation to demonstrate this as a key component of a comprehensive approach to addressing drug harms in our population.

# 5. Shaping a better future, today

Following the Covid-19 pandemic, the remobilisation of public services is focussed on the immediate health and social needs of our society. Responding to the public health challenges is equally as time critical. As set out in the Marmot objectives, this will require both immediate and ongoing actions to achieve **a healthy standard of living for all, fair employment and good work for all, and healthy and sustainable places and communities**. Working closely with our communities, building financial security, and shaping local services to minimise the impact of further inequalities from trauma, digital exclusion and transport for health, are important to pave the way.

## 5.1 Building financial security for better health

The link between health and wealth is indisputable. Poverty makes leading a healthy lifestyle more difficult and can make prioritising health impossible. Being in ill health can both push people into poverty and make it harder to escape it.

Across Scotland, just over one in five adults and almost one in four children are living in poverty[38]. People most at risk of poverty include single parents, younger households, households with larger families (with three or more children), disabled people, Black and Minority Ethnic people, people experiencing homelessness and people that are unemployed and on low incomes.

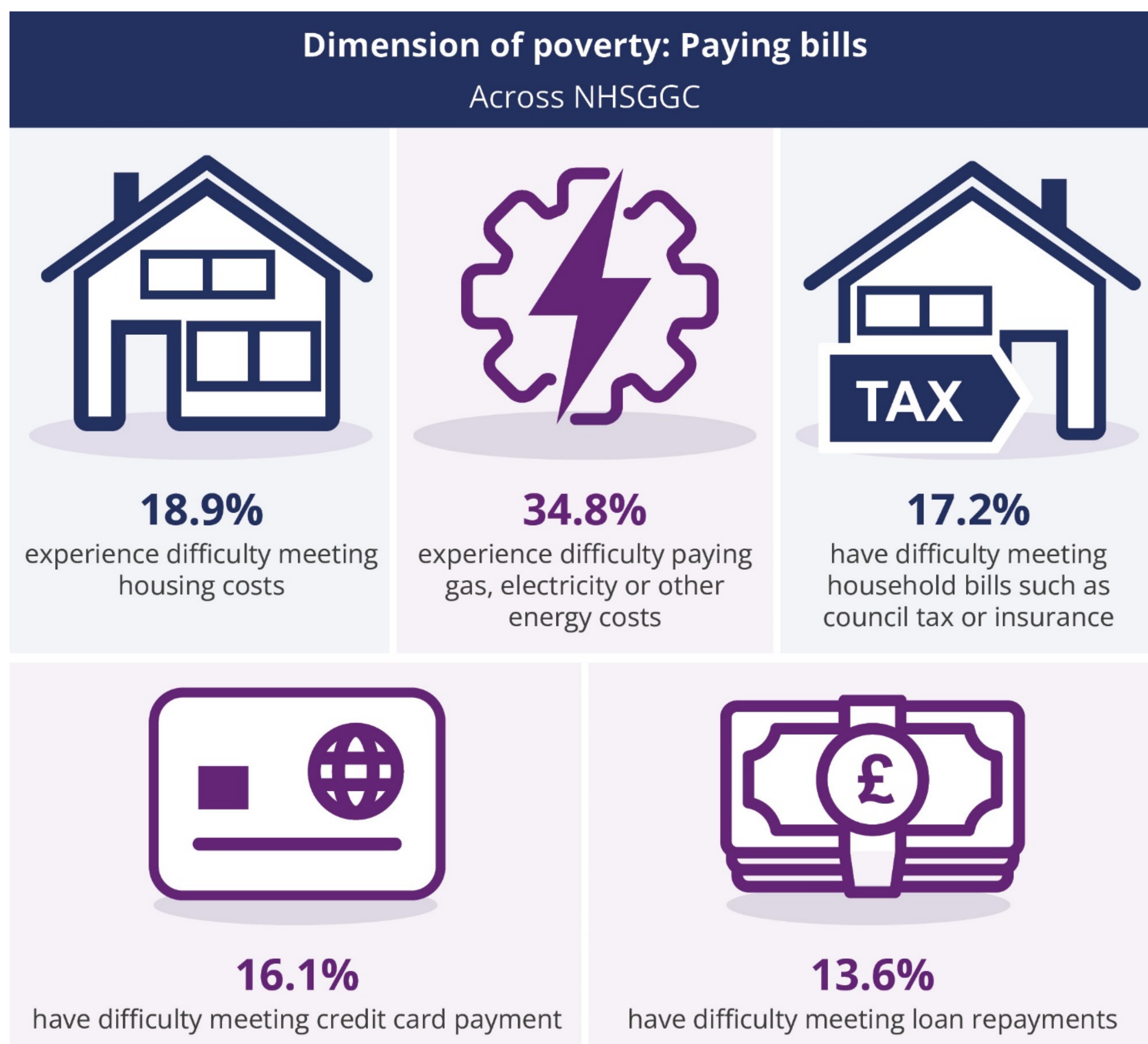
Evidence from the Joseph Rowntree Foundation highlighted that half of those in poverty have an income below 40% of the average income after housing costs[39]. 1 in 10 workers are locked in persistent low pay (of which 72% are women). More than two thirds of children in poverty live in working households.

Opportunities for families to escape the poverty trap are hampered through the existence of the ‘poverty premium’, where costs increase due to lower credit scores e.g. higher prices for home energy prepayment meters, increased interest rates when spreading payments and poorer choices for credit such as payday loans or credit cards. Within North East Glasgow, 30.2% of households experience this poverty premium, costing on average £448 per household per year, whilst in East Dunbartonshire 15.5% of households experience an additional cost of £365 a year[40].

### 5.1.1 Building financial security – why immediate action is needed

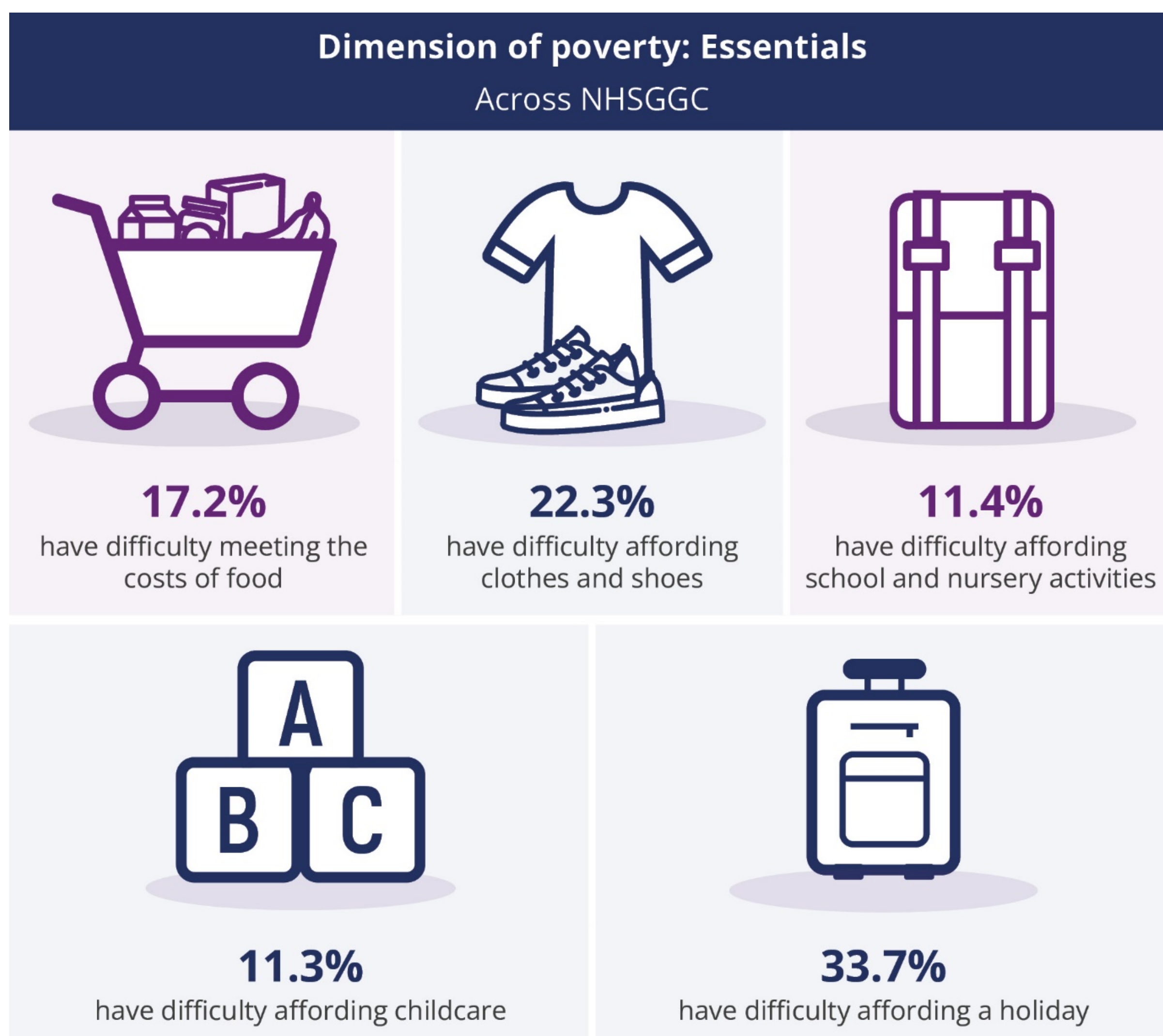
Years of austerity and other socioeconomic blows have been compounded by the wider impacts of the Covid-19 pandemic and the rising cost of living. Across society, people that may not have experienced money worries before are now cutting back due to arrears, rental increases above inflation and rising food and fuel costs41,42. The 2022/23 HWB survey starkly presents the impact of financial insecurity on ‘essentials for living’, with increases in the proportion of the population experiencing difficulty in meeting basic costs (as illustrated by Figure 14).

**Figure 14**: Summary of proportion of people experiencing difficulty paying bills (Source: Health and Wellbeing Survey, 2022-23).




Just under two in five people said they had difficulty meeting food and/or home energy costs at least occasionally, rising to one in two in the most deprived areas with those under 25 years old, women, and people with a limiting condition most likely to have difficulties. Most significant was the rise in food insecurity (from 8.6% to 17.2%), with under 55's, women, people with limiting condition and those in the most deprived areas all more likely to have experienced issues meeting the cost of food.

**Figure 155**: Summary of proportion of people experiencing difficulty covering essential living costs (Source: Health and Wellbeing Survey, 2022-23).




The ability to meet an unexpected cost of £35 decreased overall with deprived communities experiencing the biggest deterioration. The proportion of people who had used credit to cover essential living costs significantly increased (to one in nine in 2023 compared to one in thirty three in 2017).

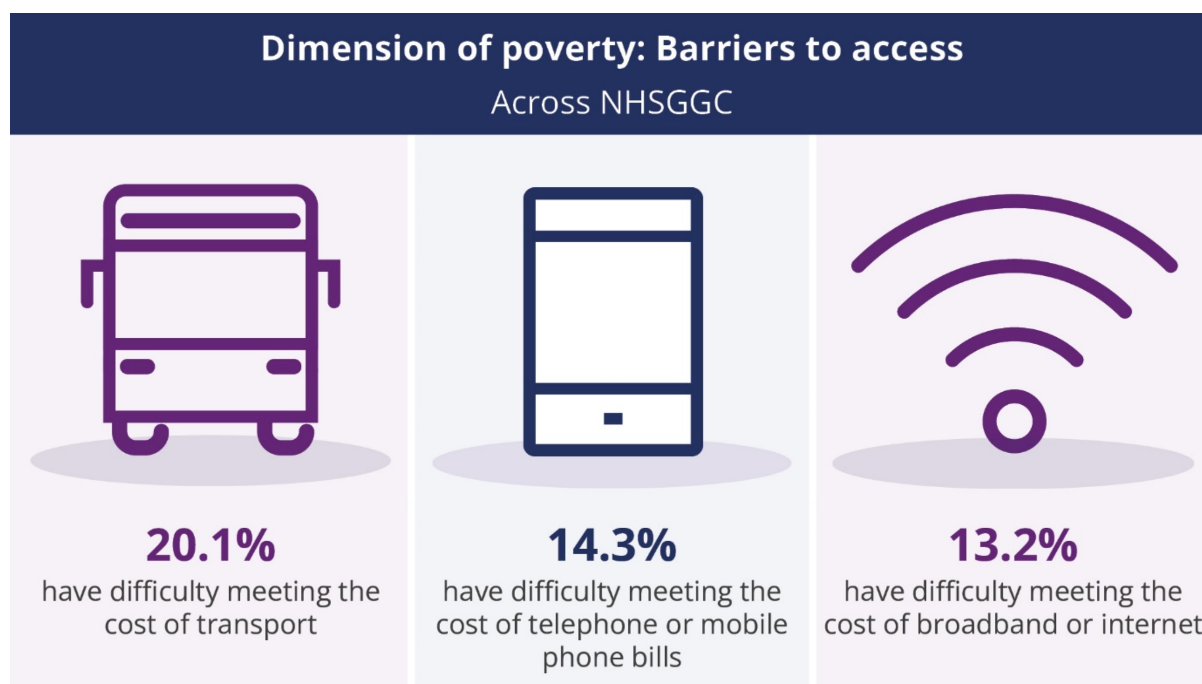
This rise in meeting the costs of essentials, as illustrated in Figure 15, is a significant concern, as lack of funds for one or more is a risk factor for destitution[43]. With a 9% rise in homelessness applications across Scotland in 2022/23, there is concern that this will further increase, resulting in more households with children living in temporary accommodation.

The economic potential of Glasgow City Region is limited by both the levels of unemployment and economic inactivity due to ill health within the population. In 2022, more than a third (34.9%) of the economically inactive working-age population was out of the labour market, primarily due to health-related reasons, equating to

100,300 residents. This is in line with the HWB Survey findings of 55% of NHSGGC residents who identified as economically active.

Across the region, almost a quarter of residents (23,750) who are inactive due to ill-health want a job[44]. These financial pressures can also directly create barriers to accessing healthcare due to inability to afford transport or make it less likely to engage with digital or telephone reminders, appointments or services. Figure 16 shows the proportion of people reporting difficulty accessing such services.

**Figure 166**: Summary of proportion of people experiencing barriers to accessing transport and other services (Source: Health and Wellbeing Survey, 2022-23).




When describing the relationship between poverty and health, quality of life and life expectancy, it is important to stress that deprivation is not inevitable and health inequalities remain unacceptable. Notwithstanding the national and UK policy context and scope there are opportunities within our local political, local authority and health systems to take actions to address wider environmental influences to mitigate the experience of poverty and inequalities within our population. By working together to target services for high-risk groups such as homeless people and promoting targeted employability opportunities to support wider economic regeneration, we can respond with both the short term and longer-term actions required to break the trend in deteriorating health outcomes within the NHSGGC population.

### 5.1.2 Building financial security for better health – Calls to action

**Reduce the immediate impact of poverty on NHSGGC residents, with a particular focus on child poverty:**

- Strengthen the network of Third Sector Organisations providing social welfare, legal and debt advice, including fuel and food poverty support linked to key settings such as healthcare (primary and secondary care), schools and workplaces.
- Continue to build local social prescribing networks to address 'essentials for living' including referrals for food and fuel security support and financial, legal, housing and debt advice.
- Work in partnership to explore the potential of auto-enrolment and shared data to facilitate systematic engagement and 'passported' access to available benefits for vulnerable families to adopt a cash first approach. Prioritise actions and pathways which will reduce child poverty.
- Commit to making Glasgow City Region (GCR) a Living Wage Place.
- Drive service improvement to better respond to socio-economic deprivation and wider health inequalities through the development of a poverty proofing tool for public sector services.

**Build longer term capacity for financial security:**

- Develop a regional approach to retaining employees in fair and healthy work, including support for those with mental and/or physical health conditions.
- Work together with local employability partnerships and private sector partners to strengthen recruitment practices, including provision of apprenticeships and in-work training from more deprived communities and key target groups.
- Collaborate as public sector partners to maximise local procurement impact through the development and sharing of supply chains to promote diversification and sustainability in the local economy; making commitment to GCR as a Living Wage Place a prerequisite for NHS and public sector contracts and optimising community benefits in line with investment.
- Continue to advocate for longer term policy change with policy makers in Scotland and the UK.

## 5.2 Creating a Trauma-Informed Response

Trauma is defined as "an event, a series of events or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening". There is increasing awareness that experience of trauma is common and can affect anyone at any stage of life.

The 'Hard Edges Scotland' report[45] found that severe and multiple disadvantage experienced in adulthood, such as substance use, offending, homelessness, mental ill health and domestic abuse, often has roots in childhood trauma and adversity. The prevalence of trauma is often higher for people with multiple vulnerabilities, including those with learning disabilities, people in inpatient mental health care, drug and alcohol services and the justice system.

### 5.2.1 Creating a trauma-informed response – why immediate action is needed

People experiencing multiple forms of trauma and adversity are more likely to experience greater inequalities in health outcomes. With four or more Adverse Childhood Experiences (ACEs), there is a greater likelihood of harmful health behaviour and poorer mental health[46,47]. The 2019 Scottish Health survey identified that 71% of Scottish adults had at least one ACE and 1 in 7 adults in Scotland have four or more.

However, poorer outcomes are not inevitable. Through a trauma-informed and responsive way of working, the negative impact can be mitigated and recovery is possible. This approach includes five key principles of practice: Safety, Trustworthiness, Choice, Collaboration, Empowerment[48]. For maximum impact, this approach should be developed alongside actions to address health inequalities, poverty, and the root causes of addiction and mental health problems.

### 5.2.2 Creating a trauma-informed response – Calls to action

- Continue to work with key partners to encourage a whole system approach building on local multi-disciplinary and multi-agency working groups across GGC, aligned to the national roadmap[49].

- As employers, invest in training for line managers to develop a safe and supportive organisational culture and allowing people to remain in work (e.g. recognising the signs and symptoms of trauma and ensuring support mechanisms are in place to address this).

- As service providers, ensure the voice of staff and service user experience is embedded in re-designing and improving access to services.

## 5.3 Broadening Access to Digital Health

Despite the acceleration of digital approaches to work, education and public services across Scotland since the Covid-19 pandemic (particularly as a result of lockdown) digital access remains unequal across society[50,51].

The HWB survey identified that within NHSGGC, 1 in 11 people do not use the internet (9%). This and other national surveys show that there are a number of groups most likely to be digitally excluded including older people; people in lower income groups and those without a job; people in social housing; people with disabilities; those whose first language is not English; and people with fewer educational qualifications or those that left school at 16.

The HWB Survey showed that digital exclusion was experienced in a number of different ways:

- **Internet access**: 1 in every 11 people (9%) do not use the internet. This rises to 1 in 8 people who live in our most deprived areas, 1 in 6 of those with a limiting condition and 2 out of 3 people over the age of 65 years.
- **Maintaining access**: 13% are finding it difficult to meet broadband/internet data costs and 16% are having difficulties meeting telephone/mobile costs.
- **Digital skills and confidence**: 69% of those using the internet had used it for health related use; 33% to access local council information.
- **Digital skills for health**: 61% had used the internet to access health information, 22% to make an appointment and 20% had accessed for other health service instead of having to go to doctor/hospital.
- **Motivation for uptake** of digital support - of those that do not use the internet, 88% said that nothing would encourage them to do so however 8% said they would if devices or broadband was cheaper.

The rapid growth in digital transformation risks widening inequalities between households further, particularly as those who could benefit most are the least likely to be online[52]. As more public services including healthcare offer digital contact as the primary route this risks further isolating the digitally excluded and will increase health inequalities. Just 1 in 11 people in NHSGGC are using the internet to access social security payments despite 3 in 10 relying on benefits for at least some of their income.

### 5.3.1 Broadening access to digital health – why immediate action is needed

As new digital innovations continually evolve, digital inclusion is not a static issue, with learning of new technologies required for all. This means the benchmark for digital inclusion will continually shift.

Those that can access and engage with the digital world benefit in a variety of ways such as instant access to information and online services, more convenient

appointments and shopping experiences, saving money through access to banking and price comparison, improved digital skills for education and the workplace and increased social connection[53].

Digital Poverty is described by the Digital Poverty Alliance (DPA) as: "the inability to interact with the online world fully, when, where, and how an individual needs" and has recently been defined as experiencing a lack of appropriate device or internet connection, a lack of digital skills or being unable to get online more than once per week (with severe digital poverty being a combination of two or more of these)[53].

Whilst there are variations in geographical internet connection speeds and coverage across NHSGGC, access to devices or internet connection is largely driven by financial barriers, with 1 in 3 people reporting difficulties in keeping up with costs and 1 in 9 people having cancelled a broadband or mobile contract in the past month. Housing status such as social renting, and temporary accommodation or homelessness can also impact on people's ability to commit to mobile data or broadband contracts and relying on public Wi-Fi can have security and/or privacy issues[54,55,56].

Knowing where to get safe, quality and reliable health information and advice is important for self-care and self-management of health conditions. Connecting Scotland reported improved ability to find advice and guidance on important issues for those engaged in their digital access and skills programme during the pandemic, however health information sources such as NHS Inform compete with a huge volume of unverified health information sources[57].

### 5.3.2 Broadening access to digital health - Calls to action:

- Work in partnership to ensure online public services are clear for all whilst maintaining and improving existing offline services to prevent digital exclusion alongside the move to digitally-led service delivery models.
- Collaborate with key partners both within and outwith health services to develop social marketing campaigns to help influence motivation to get online for the 'essentials of daily living'.
- Improve search engine optimisation for digital public services so that people are easily navigated to quality assured online health information.
- Collaborate to strengthen asset based community hubs in building digital capacity and explore opportunities to co-locate digital support alongside core community services utilised by most at risk groups such as money advice services.

# 5.4 Connecting people and health: affordable, accessible and sustainable transport

A good transport system provides a means of travelling safely, reliably, affordably, and accessibly from home to a range of everyday activities. There are well known health benefits if at least one part of a travel journey is active and the use of public transport is a sustainable travel option which can help reduce air pollution[58] - a major impactor on health.

Current transport policy prioritises sustainable transport[59], promoting active travel (walking, cycling and wheeling), followed by public transport and then private car travel as a last resort. Evidence suggests approaches such as 20-minute neighbourhoods, where residents can meet their day-to-day needs within a 20-minute walk of their home, have potential to decrease health inequalities, improve quality of life, improve the local economy and deliver climate action[60].

## 5.4.1 Affordable, accessible and sustainable transport – why immediate action is needed

Issues of affordability, reliability, access and safety mean that many people face barriers to travel and/or sustainable transport options.

Positive perceptions of public transport have dropped significantly in recent surveys (from 74% of respondents in 2017/18 to 61% in 2022/23). Those in older age groups, women and people with a limiting condition had less positive views. However, those living in most deprived communities, where car ownership is lowest, were significantly more positive (64%) about public transport.

Despite free travel for those under 22 in Scotland, the cost of public transport is a concern for more than 20% of young people (16–34-year-olds), as well as for people living in the most deprived areas and people with a limiting condition. Women, who often take on the main burden of caring and household tasks, are more dependent on public transport and often undertake complicated multi-modal multi-purpose journeys. The Scottish Women's Budget Group (SWBG) Women's Survey 2023[61] highlighted that 28% of respondents said they were struggling to manage transport costs, rising to 41% for disabled women and 54% for single parents.

Perceptions of safety on public transport were relatively high (88%) although women (85%) and people with limiting conditions (82%) felt slightly less safe.

Public transport that connects people to amenities is also crucial. A recent report on improving public transport in the Glasgow City Region[62] noted that a third of Glasgow residents stated access to healthcare was an in issue (linked to lack of direct public transport, frequency and cost)[63].

Whilst health services have adapted to provide more home-based support, virtual face to face appointing, telephone and email interventions reducing the need for

travel, this is not yet the norm and may pose in itself further barriers for those facing digital exclusion.

### 5.4.2 Affordable, accessible and sustainable transport – Calls to action

- Collaborate with partners to locate public sector services and interventions with proximity to well-connected public transport links.
- Take an active role in developing options to improve public transport services and better connections for communities in the SPT region.
- Work with employers to review and promote support available to increase active travel and use public transport to work.
- Collaborate with partners to identify opportunities to reduce impact of affordability on access to healthcare and where possible reduce the need for patient travel as part of planned service transformation workstreams.

## 5.5 Strengthening Communities and Places

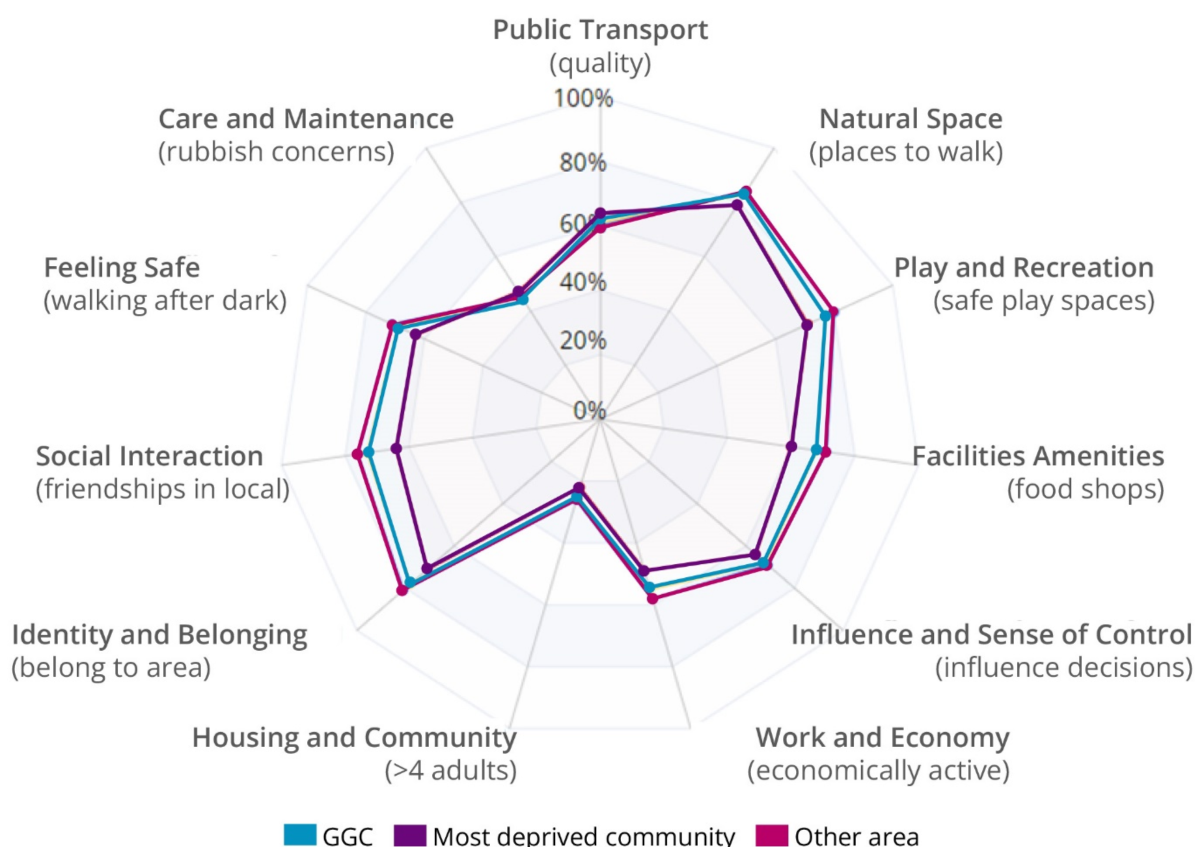
Assets within communities, such as the skills and knowledge, social networks and community organisations are the building blocks of good health. Community life, social connections and having a voice in local decisions are all factors that make a vital contribution to our health and wellbeing.

Healthy and sustainable places support good mental and physical health. This requires access to safe green spaces, clean air, opportunities for active travel, good quality housing and a range of amenities and community resources.

The evidence is growing for approaches that focus on communities, enable strong participation from members of the community, and build on their existing strengths (asset-based)[64,65,66,67,68]. The Kings Fund[69] describes work to develop social capital and local assets as one of the most promising ways of working to reduce health inequalities. Places can create and nurture health but can also be harmful to health. The right to feel safe, without discrimination or experience of crime is fundamental. The quality of the local environment and access to services all provide a sense of place and wellbeing for an individual.

The Place Standard[70] sets out indicators used to determine the quality of place. NHSGGC HWB survey indicators aligned to these are illustrated in Figure 17 below:

**Figure 177**: Assessment of quality of place using HWB survey indicators (Source: Health and Wellbeing Survey, 2022-23).




## 5.5.2 Strengthening Communities and Places – why immediate action is needed

Across NHSGGC, significant changes have been seen in relation to our social capital (i.e. our ability to work together to achieve a common purpose through shared values and/or resources). Indicators such as the levels of reciprocity and trust within local areas are viewed less positively than in 2017; the proportion of those who valued local friendships or who had a positive view of social support has also decreased. These changes vary with age, with older age groups more positive in relation to social connectedness and support. Women are more likely than men to be positive in relation to social capital. People living in the most deprived communities were more likely to be positive in relation trust, local friendships and support, but less likely to feel they belonged to their community or were able to influence decisions.

There has been an increase in the proportion of people feeling isolated from family and friends. Whilst almost two thirds of our population felt socially engaged and empowered, there has been a significant decrease in the number of people who felt they belonged to their local area, felt valued as members of their community and felt that local people could influence local decisions.

There have also been increasing concerns in relation to the four care and maintenance issues in the local environment of rubbish, dog dirt, safe play and pleasant places to walk, with more negative views in more deprived communities.

The overall changes in our population relating to social capital and social engagement/empowerment measures are worrying. After demonstrating improvement until 2014, the steep decline from 2017 suggests our communities are less equipped to be resilient in this post Covid era. Importantly, the decrease in positive perception of social capital and place related indicators across NHSGGC is attributable to areas out-with the most deprived communities. With less change in deprived communities this has resulted in a more equal perception across communities. However, this narrowing of the ‘gap’ between most deprived communities and other areas reflects a ‘levelling down’ rather than an improvement for the most deprived communities.

As the evidence base for strengthening communities grows, and in the context of limited public resources, there is a compelling case to adopt an explicit approach of targeting communities with the greatest need or highest levels of vulnerability, whereby the provision of universal services (such as health, education, employability support) are on a scale and intensity that is proportionate to the level of need (proportionate universal response) to ensure limited resources have the greatest impact.

### 5.5.3 Strengthening Communities and Places – Calls to action

Minimise the impact of reduced public funds on our most vulnerable communities by working together.

- Undertake engagement with local communities and community organisations in response to HWB Survey data to shape further action to improve health and reduce health inequalities.
- Ensure planning, decision making and system change is informed through local intelligence including lived experience with a particular focus on groups often marginalised.
- Design our communities, including streets and public spaces, to be more child friendly to facilitate play and exploration which will support children's rights under UNCRC, be beneficial to children's development, wellbeing and health, and benefits all people by aligning to commitments to liveable neighbourhoods and sustainability.
- Create a shared focus on community resourcing to build capacity, increase participation and mobilise community assets, prioritising those that will reduce social isolation, through cross-organisational working and community commissioning.
- Deliver community wealth building outcomes which benefit our local population through individual and collective effort as Anchor Organisations, working as part of Glasgow City Region Anchor Network (a group of public,

private and third sector place based organisations working together to provide leadership to build community wealth).

- Further develop place-based partnerships in order to promote pathways to participation for those who face the biggest barriers and have greatest vulnerability ensuring greater access to services and support.

# 6. Conclusions

This report provides an update on the health and wellbeing of the population of Greater Glasgow and Clyde against the background of the Covid-19 pandemic and the current cost of living crisis. It sets out a stark reality of worsening health, with a particularly steep decline in mental health and wellbeing. Any narrowing of inequalities in health and wellbeing were due to a ‘levelling down effect’, i.e. those formerly doing better seeing a steeper rate of decline in health, but those most disadvantaged still being pushed into further deterioration. Experience in relation to other pandemics or catastrophic events would suggest this is not unusual[71], however in the context of long-term austerity and high levels of prevailing poverty within NHSGGC it suggests that we are now more likely to see an excessive negative impact with a stalling or reversing of our population’s wellbeing and prosperity.

The ongoing severe financial pressures across public services and for individuals and families pose a significant risk to population health. This is demonstrated by strong evidence linking the impacts of austerity to increases in premature deaths and decreases in life expectancy which will be most extreme for those already worst off.

However, this economic pressure also poses an opportunity and obligation to radically reinvent how we support our population in order to achieve more with less. We need to work with our communities to build on their assets and strengths, recognise the importance of person centred support for the most vulnerable, tailor our services to support those with the greatest need and fundamentally strengthen our partnership working to do things differently together.

This will require strong and coordinated collective action. We need to seize all available opportunities to improve health and action needs to be rooted in a human rights based approach, with a focus on equality of health and wellbeing. Strongly aligned to the Marmot Review, the application of proportionate universalism, providing the strongest support to those with the greatest needs, will improve equality in outcomes.

Health inequalities remain unacceptable and this report is a call to action for all partners across NHSGGC. In summary, we call for:

## Giving every child the best start in life

- The foundations for our physical and mental health, relationships, abilities and habits including diet and activity are laid in childhood. Our commitment to prevention and reduction in inequalities needs to have children’s outcomes at its core.

## Enabling all people to maximise their capabilities and have control over their lives and strengthening the role and impact of ill health prevention.

- Strengthen the factors that boost positive mental wellbeing, address root causes of poor mental health and ensure swift mental health support for those in distress,

- Enable all people to eat healthily, be physically activity in their daily lives and maintain a healthy weight.

- Tackle the conditions that can give rise to or exacerbate drug use and drug harms, such as stigma, trauma, deprivation and homelessness and reduce the health impact of drug use through prevention, harm reduction, treatment and recovery services.

## Ensuring a healthy standard of living for all, creating fair employment and good work for all, creating and developing healthy and sustainable places and communities

- Enable all people to access the financial support they need, ensure that all services contribute to mitigating the impacts of poverty, create fair employment and good work opportunities for all and ensure that all organisations and services contribute positively to their local communities.

- Tackle the conditions that can give rise to or exacerbate trauma, including gender based violence, stigma, deprivation and homelessness and ensure that all people who have experienced trauma are supported through trauma sensitive practice to access all services they need.

- Enable all people to gain the benefit of digital access and optimise digital opportunities for better health, whilst ensuring those who cannot or chose not to have digital access receive equally good services and support.

- Enable all people to use affordable, accessible and sustainable transport in a way that maximises health, environmental and economic benefits for individuals and communities.

- Bolster our communities and the places in which we live (with opportunities for children and young people at their heart), build on the strengths and assets of communities and organisations by working together to design support around the needs of those who are most vulnerable and ensure that all organisations and services contribute positively to their local communities, including through fair employment and work.

# 7. Acknowledgements

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