The Glasgow Centre for Population Health

Building understanding, evidence and new thinking for a healthier future

Report for funding review
March 2011

PART 1

CONTENTS

List of Tables and Figures

JOINT STATEMENT

As Chairman of the Management Board of the Glasgow Centre for Population Health during the past three years, I have been very taken with the high degree of co-operation and shared aspiration of the three core partners.

The City Council, the NHS Board and the University of Glasgow all bring to the table an explicit and strongly expressed commitment to understanding more fully the influences which have a direct effect on the health of the population of Greater Glasgow and the surrounding local authority areas.

The most impressive dynamic of this engagement is the complementary perspectives that the three core partners represent.

The work of the Centre has been welcomed without qualification by the three partners and by the wider communities which they serve. There is a growing awareness of the importance of both short and long-term drivers and, increasingly, the credibility of our joint Health and Social Care programmes in areas such as Early Years is underpinned by the work of the Glasgow Centre.

All three partners are fully supportive of the continuation of this work, both for their own individual agendas but much more importantly for their shared agendas and the lessons that can be learned for application throughout the wider community in the West of Scotland and beyond.

ANDREW O. ROBERTSON, OBE, LLB
Chairman
NHS Greater Glasgow and Clyde

EXECUTIVE SUMMARY

Scotland's health profile is a matter of major national importance. It compares poorly internationally, and is improving at a slower rate than other comparable countries. Scotland's position in the European health league table deteriorated during the 20th Century, particularly from the 1950s onwards. Why this happened is not completely clear, but that it was driven primarily by the (ill-)health of the people in Glasgow and the West of Scotland is well established. These areas continue to need particular attention and sustained consideration of how their health situation can be turned around. Ongoing investment, to get to grips with the causes of their health deficit and to identify appropriate responses commensurate with the 21st century context, is essential.

The Glasgow Centre for Population Health (GCPH, the Centre) was established in April 2004 and is a partnership between NHS Greater Glasgow and Clyde, Glasgow City Council, the University of Glasgow and the Scottish Government. The Centre is a resource to generate insights and evidence, propose new ways forward, and provide leadership for action to improve health and tackle inequality. The GCPH's focus on west central Scotland has enabled the building-up of an unprecedented depth of understanding and insight into the area's health, together with development of the networks, trust and relationships that are necessary to deliver change.

Within Scotland, GCPH makes a distinct contribution through the combination of:

- having a strong analytical base, synthesising intelligence and insights from a range of disciplines and perspectives
- working firmly at the interface between research, policy and practice with a particular focus on health inequalities; ensuring that the research is relevant to – and connected with – policy and practice
- establishing an orientation towards the future; exploring different ways of doing things, and showing that change is necessary and achievable
- engaging a wide body of people, and building capacity for good decision-making and action on health inequalities.

Initially set up for a five year period (Phase 1: 2004-2009), the work of the Centre was formally evaluated in 2008 with a very positive review from its stakeholders. It was considered to have delivered well on its challenging agenda and there was strong endorsement of its achievements. In line with the recommendations of the Phase 1 review report, the partners committed to continued funding and support for the Centre for a further three years (Phase 2: 2009-2012). This report has been prepared to inform that review process.

The work of the GCPH is directed towards achieving two overarching outcomes:

- Strengthened processes for improving population health and reducing health inequalities, and
- Greater capacity for effective action to improve health and reduce inequalities.

These are being achieved through the delivery of 12 work programmes (see Table 1) underpinned by four functions: the synthesis and analysis of data; evidence-generation; creation and dissemination of new insights; and development work to influence policy and practice.

Although written just over halfway through the funding period, this report demonstrates that the Centre has made considerable progress towards achieving the

outcomes agreed for Phase 2. Letters from the three local partner organisations, included in Appendix 1 to this report, confirm their ongoing support for the Centre and highlight the many ways in which GCPH is seen to add value to their core business.

Members of the GCPH team have been instrumental in shaping health inequalities policy and its implementation nationally and locally. A range of important contributions have been made to Equally Well and to the Glasgow Health Commission, as well as to specific strategic developments such as the new Primary Care Framework for NHS Greater Glasgow and Clyde. The range of skills within the Centre enable team members to input at different stages of the policy development and implementation processes.

The Centre's large research programmes, including GoWell, pSoBid and the 'Glasgow Effect' analyses, have directly influenced policy and have achieved international recognition as well as becoming part of the regular discourse about health in Scotland. Research into interventions to address priority topic areas, such as road safety and children's nutrition, have led to specific policy developments within the city.

Innovations in making population health information accessible and usable by non-specialist audiences have been strikingly well received: Miniature Glasgow and Understanding Glasgow are prime examples. They help to address a recognised lack of capacity in data analysis within many services, and have been adopted as models by other cities.

The Centre has championed the importance of bringing a concern with health firmly into the decision-making processes of non-health services. As a result there have been seven Health Impact Assessments carried out in Glasgow since April 2009, each involving an important strategic plan for the city. The Centre's work on Healthy Urban Planning has been commended nationally and internationally.

New areas of work during Phase 2 have included a strong focus on child poverty, new analyses of breastfeeding trends, and research into alcohol and young people. Linked to this is a programme of work researching the role that social networks play in relation to young people's resilience and health-related choices. Each of these research programmes has the potential to impact over time on the associated population health outcomes.

The reach of the Centre is considerable with over 1500 people on the GCPH network. Many participate in, and are influenced by, GCPH events or work programmes. The Centre's work is published in academic papers as well as in GCPH reports and Briefing Papers, and members of the team are very active in contributing to conferences, seminars, and professional development programmes. Requests for these inputs have grown exponentially, reflecting the quality of the work and the distinct contribution it makes.

The Centre's starting point is its acknowledgement that Glasgow's health challenges have so far refused to yield to current knowledge and associated effort. Despite successes in a number of other arenas, health remains an outlier in Glasgow's – and Scotland's – performance. A key task is to learn what needs to be done for the persistent obstacles to achieving a healthier population to be overcome. If we are to make a difference, we need to do different things, and build a consciousness of a different future. Several of the GCPH programmes, including the civic conversation and work on active sustainable travel and on the resilient city, are firmly about helping to set a different agenda, focussed on the future.

The GCPH track record indicates a high level of output, leadership and influence achieved from the resources put into the Centre. Looking forward, four spheres of activity are proposed as the priority areas of focus for GCPH Phase 3. These reflect the distinctive role of the Centre and build on its successes to date. Taking them forward would make an important contribution to building understanding, evidence and effective action to improve the health and life chances of Scotland's poorest communities.

SECTION 1 – INTRODUCTION

The Glasgow Centre for Population Health (GCPH, the Centre) was established in April 2004 as part of the then Scottish Executive's programme to increase action on health improvement in Scotland, and is a partnership between NHS Greater Glasgow and Clyde, Glasgow City Council, the University of Glasgow and the Scottish Government. The Centre is a resource to generate insights and evidence, propose new ways forward, and provide leadership for action to improve health and tackle inequality. It offers an arena for academics, policy-makers, practitioners and local people to confront the problems facing population health in Glasgow and beyond. The Glasgow focus enables close working relationships and active dialogue between partners, and the development of detailed, in-depth work relevant to and reflective of local contextual factors. Nevertheless, the Centre actively contributes to wider debates and action and ensures that it brings to Glasgow and Scotland insights and evidence from other parts of the world. As a model of working it has attracted international interest.

Initially set up for a five year period (Phase 1: 2004-2009), the work of the Centre was formally evaluated in 2008 with a very positive review from its stakeholders. The Centre was considered to have delivered well on its challenging agenda and there was strong endorsement of its achievements. Particular strengths included the broad remit of GCPH's work; the flexible and responsive approach of staff; leadership of the Centre; the relevance and quality of the work at strategic and operational levels; its strong partnership working and commitment to collaboration; the development of civic engagement and ownership; the Centre's role in stimulating new thinking and new ideas; and the continual focus by the Centre on putting evidence into practice. The Centre was overall regarded as providing value for money and to have added significant value to the work of partners.

The Phase 1 review report[1] stated that GCPH needed more time to deliver its ambitious remit, and its work needed to continue to support real changes to Glasgow's health and to the work and approaches of partners. It was recommended that Scottish Government funding should continue at the same level for a further three years (Phase 2: 1 April 2009 to 31 March 2012) dependant on the local partner organisations sustaining their contributions over this period. GCPH is now entering the final year of that second phase and approaches its second review. This report has been prepared to inform that review process.

1.1 Health inequalities and the Glasgow Centre for Population Health

Scotland's position in the European health league table deteriorated during the 20th Century, particularly from the 1950s onwards, due to mortality rates falling more slowly – and life expectancy improving less rapidly – here than in other countries. Why this happened is unclear, but that it was driven primarily by the (ill-)health of people in Glasgow and the West of Scotland is well established.

Glasgow's health problems and health inequalities are deep-seated and long-standing. One of the early outputs from GCPH was the *Let Glasgow Flourish* report, providing the most comprehensive description of the city's health ever produced, and recognised as an exemplar by Sir Michael Marmot when chairing the WHO Commission on Social Determinants of Health. *Let Glasgow Flourish* emphasised a number of key issues in relation to Glasgow's health status: for example, that, on a range of dimensions, health inequalities were widening; that substantial sections of the city's population were seeing no improvement in (and in some cases were

[1] *Review of Glasgow Centre for Population Health*, JWC, March 2008

actually experiencing a worsening of) their health; the scale of emerging trends in alcohol harm, drugs-related harm and obesity; and associated concerns about the impact of these and other social and health-related factors on the wellbeing of the city's children. More recent GCPH developments (community health profiles, the *Miniature Glasgow* DVD and the *Understanding Glasgow* website) have made this sort of information, and the data behind it, widely available and accessible to a diverse range of policy-makers, service planners and providers, as well as to members of the public. These outputs are used regularly by a growing cadre of people concerned with making a difference to the city's health.

Subsequent GCPH-led analyses (reported in *The Aftershock of Deindustrialisation* report, and the three cities' work *Investigating a 'Glasgow Effect': Why do equally deprived UK cities experience different health outcomes*) have indicated that the traditionally (and often passively) accepted explanations for Glasgow's health problems – that the area's high levels of socio-economic deprivation underpinned by the effects of deindustrialisation account for the poor health status – no longer appear to suffice. Poverty and deprivation are extremely important determinants of the area's health but detailed analyses of deprivation and mortality have shown Glasgow's poor health to be quite unlike identically deprived cities such as Liverpool. Explanations other than deprivation and deindustrialisation are required – as are remedies that are not solely rooted in addressing economic circumstances.

Furthermore, a 'Glasgow Effect' is not observed in other indicators of Glasgow's performance, such as educational attainment, participation in cultural activities, or the proportion of young people Not in Education, Employment or Training. Health is an outlier in the city's performance. Continued concerted effort is needed to understand why this is, and what is to be done to turn it around for the benefit not only of the city but for Scotland as a whole. The phenomenon generates a series of research questions not only to understand better this effect as it applies to Glasgow but also to explore what the implications are for elsewhere in the UK and beyond. It is unlikely that Glasgow's experiences are exceptional. Our research can yield insights into what might happen elsewhere if the same set of circumstances played out.

The Centre's starting point is its acknowledgement that Glasgow's health challenges have so far refused to yield to current knowledge and associated effort. A key task is to learn what needs to be done for the persistent obstacles to achieving a healthier Glasgow to be overcome. This learning stance permeates all of the Centre's work. If we can think differently about the nature of the challenge, then we are likely to act differently. If we act differently, then we are likely to think differently.

GCPH is concerned with the totality of the system that creates population health, and pays attention to how the component parts of that system impact differentially on subgroups of the population. Some aspects of the system are well known – for example housing, transport, health and social services, and health related behaviour. In these cases, the Centre studies the detail of how such issues have an impact on health and wellbeing, and explores ways in which policy and service delivery structures might think and act differently. In other areas, the connection to population health is less well known and the Centre is helping to develop understanding and new conceptual frameworks, for example in the fields of psycho/social/biological interactions, and the relationship between modern culture and wellbeing. It is perhaps in these sorts of areas that the increased vulnerability of Glasgow's population is most likely to lie, and potential ways forward found.

At the core of the Centre's work is research. GCPH has strong relationships with academic institutions, without being one. It occupies a space closer to policy and delivery organisations in the city and beyond than it is usual for most academic researchers. This position makes it possible for the Centre to establish more collegiate, reflexive, relationships with policy institutions, while maintaining sufficient independence to be a credible source of research and information on key policy areas and service provision.

Through its work over the past eight years, the Centre has established itself in a strong strategic position. It is a partnership organisation that was intended by its founders to have independence and to provide valuable thinking and creative space to support change. It benefits from being part of the system and having credibility across all its partner organisations and beyond, but is not bound by some of the constraints that affect them. Its role is to support the partners and others by showing leadership in the quality and nature of its activity, in how it frames its work and evaluates its impact. A significant part of this approach involves taking a clear role in helping support arguments and thinking by describing, measuring and facilitating change when difficult decisions are to be made by partners and others.

This report presents a summary of what the GCPH team was established to achieve, how it has approached its challenging remit, and the range of outputs and impacts it has helped to deliver. Full details of the Centre's Phase 1 work were provided in the 2007 document *The Glasgow Centre for Population Health: building understanding, evidence and new thinking for a healthier future. Report for funding review*. The current report therefore focuses primarily on Phase 2 achievements.

"I just wanted to say well done to the GCPH and IFF team in having once again delivered an exceptional and genuinely 'blue sky thinking' event with Professor Max Boisot's lecture"

Edward Harkins, Networking Initiatives Manager, SURF

SECTION 2 – DEVELOPMENT AND IMPLEMENTATION PLAN 2009-2012

The Development and Implementation Plan for 2009-2012 describes the approaches and activities to be delivered by GCPH over this period (Phase 2). It was approved by Scottish Government and the local partners in June 2009. What follows is a summary of its content, as background to the report on achievements which is presented in Section 3.

2.1 Aims and objectives

Since its inception, the Centre's activities have been directed towards four aims:

1. To create and test new models for understanding the patterns, and causes of, Glasgow's enduring poor health while identifying potential solutions and actions for improvement.
2. To bring excellent and innovative population health research together with the work of policy-makers and service providers to accelerate and strengthen processes for better and more equal health.
3. To develop greater capacity for effective action to improve health through educational processes and events, provision of regular communications, and organisational and professional development.
4. To be a focus for the exchange of ideas, independent thinking, analysis and debate about population health and health inequalities, linked with similar activities elsewhere in the world.

The Phase 1 Development and Implementation Plan[2] set out eight operational objectives, representing the challenges to be met in working towards the ambitious aims of the Centre. At the start of Phase 2, these objectives were developed and amended slightly to better fit the Centre's established role and the current context, while remaining true to the original set. All the objectives are worded in a way that describes the activities (processes) to be undertaken and the purpose of these activities (the outcomes, in the short- and medium-terms, that these activities are being undertaken to achieve).

The Phase 2 objectives are:

1. To bring population health research together with policy-making and service provision to accelerate and strengthen health improvement and the reduction in health inequalities in Glasgow.

2. To establish and maintain opportunities for the exchange of ideas in order to create insights into the causes of, and potential solutions to, Glasgow's enduring poor health status.

3. To design and evaluate policies and interventions, based on an understanding of what works (locally, internationally and from new insights) to produce actions and capacity suited to Glasgow's health and social needs.

4. To create and engage in effective partnerships with organisations and communities in order to build collective action to tackle health challenges with particular attention to populations and individuals experiencing poverty, stress or disadvantage.

[2] Glasgow Centre for Population Health: *Development and Implementation Plan*, December 2003

5. To produce and disseminate first-class scientific research and analysis on the determinants of population health in order to advance understanding of health inequalities and trends in health status.

6. To increase capacity for effective action, strategy and organisational processes required to promote the health and wellbeing of Glasgow's citizens.

7. To produce communications in a variety of media in order to engage others in applying new understandings of health and health inequalities to strategies and actions for improving health.

8. To create a Centre of international standing which links with similar activities and research scientists across the world in order to contribute to and benefit from international research.

2.2 Work programmes

The Development and Implementation Plan (DIP) for Phase 2[3] responded to the 2008 funding review recommendations and to the experience and outcomes from the Centre's first five years. The original three over-riding programme principles were expanded into four, as follows:

- Strengthening understanding of health and its determinants, through **synthesis and analysis of data** of various types;
- Research and evaluation, **developing evidence** and good practice to tackle health inequalities and maximise health gain;
- Debate and fresh thinking, to **create and disseminate new insights** on population health in the context of 21st Century Scotland;
- Communication and development work, to **influence** policy and practice.

In Phase 1 the Centre's work programmes were each located within one of these four areas, but for Phase 2 a wider range of *integrated* programmes were proposed, most involving all four areas of activity. The twelve Phase 2 work programmes are outlined in Table 1, exactly as they were described in the DIP.

Table 1: GCPH Phase 2 work programmes

GCPH Phase 2 work programmes
1. ***Integrating health and spatial planning***. This programme seeks to develop the evidence base, capacity and mechanisms for health considerations to be taken into account more systematically in spatial planning processes. Core to this programme is work in delivering the *Equally Well* test site for Glasgow and in developing Health Impact Assessment processes. 2. ***GoWell: researching community regeneration***. GoWell is a long-term research and learning programme focussed on area-based regeneration processes. It involves a number of research components and considerable investment in distilling learning for local communities, the city and Scottish Government. 3. ***Understanding the psychological, social and biological determinants of disease and the effects of change of residential environment on obesity, physical activity and stress*** *(pSoBid and its follow-up studies)*. These primary research studies are helping to build understanding of the biological and psychological pathways that link deprivation and ill-health. The focus in this phase will be on intervention studies. 4. ***Resilience and social networks as resources for health***. In addition to the effects of structural determinants on health, it is clear that relational factors acting at a meso level (neither macro nor micro) can have a strong protective influence. This programme is

[3] Glasgow Centre for Population Health: *Development and Implementation Plan 2009-2012,* June 2009.

focused on building a better understanding of these factors and how they might be fostered.

5. ***Incentives for behaviour change***. Focussing initially on a trial to investigate whether financial incentives are effective in reducing smoking during pregnancy, this programme has the wider remit of exploring approaches to behaviour change more generally.
6. ***Health-related services: tackling health inequalities****.* Work completed in Phase 1 led to the development of a GCPH framework for supporting planning and action on health inequalities. This programme will support the application of this framework in a range of arenas locally and nationally, and lead to its further development. An additional focus of this programme is on models of General Practice, as a route to strengthening the primary care role in addressing health inequalities.
7. ***Strengthening the health impact of local authority services****.* This programme works both with specific council services and in a cross-cutting way to evaluate the impact of services on health inequalities and to build capacity for effective action. The work of the Glasgow Health Commission is an additional priority for this programme.
8. ***Healthy, sustainable transport****.* Approaches that reduce car use and support active travel and use of public transport have the potential to make a major contribution to individual, community and national health. There are major challenges in implementing such approaches and this programme seeks to contribute data and evidence, and to use these to influence policy change.
9. ***Partnership action on social determinants****.* This is a new programme, which will build on learning from Phase 1 and support the Centre's role in delivering change in Phase 2. It will consider partnership action on social determinants and where opportunities for embedding new learning might lie, comparing the Glasgow experience with elsewhere, and seek to build evidence of more effective ways forward in the 21st century context. This will be of interest in Glasgow and beyond, and will draw on previous and existing data and insights to inform thinking about collaborative organisational arrangements for health improvement and action on health inequalities.
10. ***Understanding Glasgow's health: local to international perspectives***. This programme draws together the work of the GCPH 'observatory function'. There is a focus on specific issues (eg poverty), building links between public health information and service planning (eg in relation to mental health and addictions services), presenting information in new ways (eg development of the Miniature Glasgow approach), and further understanding of the Glasgow effect (through comparisons with other cities and regions).
11. ***Employment, economy and health****.* Drawing together a number of different perspectives on these issues, components include the Scottish Observatory for Work and Health; analyses of the Glasgow economy and its implications for the city's health; and (subject to funding) work to develop inequalities sensitive approaches to Health at Work.
12. ***New perspectives on population health****.* As a major contribution to the Centre's responsibilities for fostering fresh thinking and a futures-orientation, this programme involves developments in relation to Civic Conversation and GCPH seminars together with a focus on 21st century culture and its implications for mental health and wellbeing.

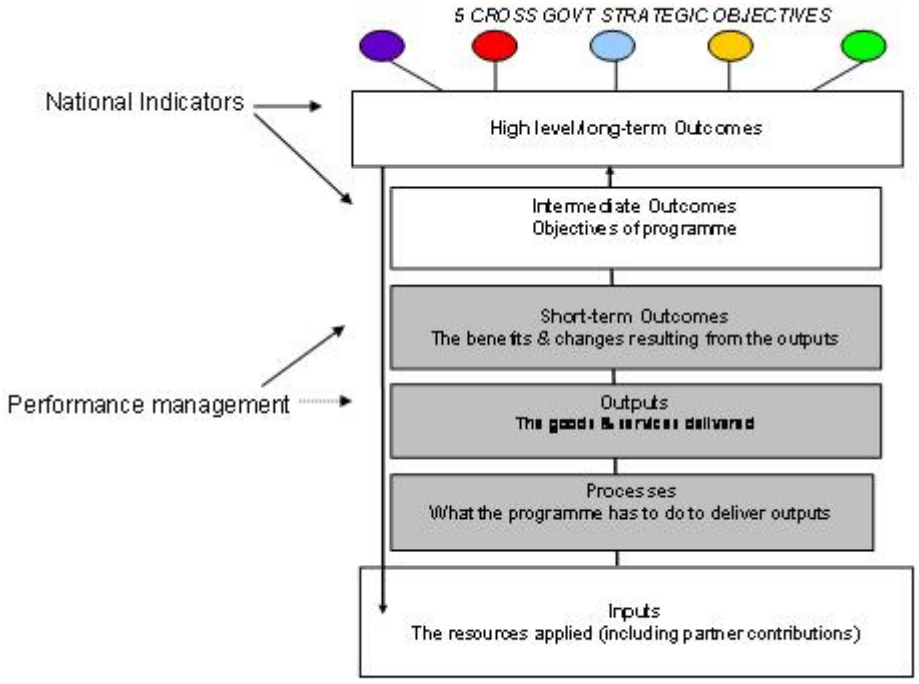
In addition to delivering these work programmes in Phase 2, the team's responsibility for responding proactively to opportunities, and demonstrating flexibility and responsiveness in taking on new work and activities, was emphasised.

2.3 Indicators of success

Two overarching outcomes were agreed for Phase 2. These were developed through a process of discussion with the Centre's staff team, Executive Management Team, External Advisors and Management Board and are in line with the Scottish Government's requirement for public sector organisations to be more 'outcome-focussed' and to relate their work to the purpose of Government.

The outcome-focussed planning approach is illustrated in Figure 1.

Figure 1: Outcome-focussed planning



This approach can be applied not only to individual work programmes but also to the work of the GCPH as a whole. It was agreed that the added value of GCPH in Phase 2 should relate to the shaded areas above – the processes (what the Centre *does* during this period), the outputs (what the Centre *delivers*), and the short-term outcomes (what *changes* result from the Centre's work).

Working through this process, the Centre's partners agreed two overarching outcomes to be delivered:

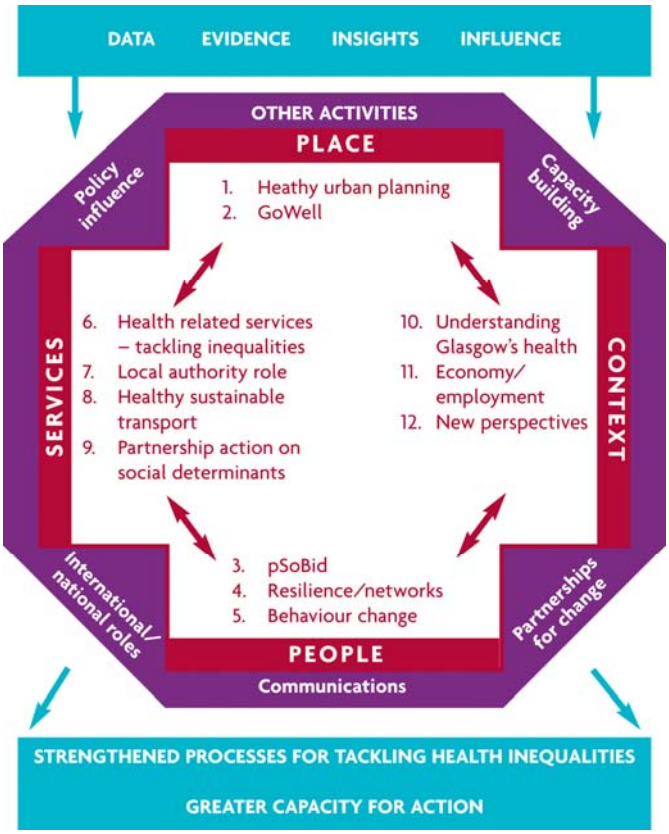
- Outcome A: Strengthened processes for improving population health and reducing health inequalities.
- Outcome B: Greater capacity for effective action to improve health and reduce inequalities

These relate directly to the Centre's aims, require the team to work effectively through their programmes and other activities, and for GCPH as a whole to operate as a learning organisation and an effective agent for change. Moreover, it was recognised that while the achievements of the Centre may be measured in terms of these two outcomes, its success in Phase 2 would depend fundamentally on the quality of its work, the credibility and expertise of the team, and the support of the Centre's partner organisations and advisors. It would also depend on the adoption of a reflective and flexible approach within the organisation. Although Figure 1 suggests a linear process from Inputs to Outcomes, in reality there are many feedback loops and a requirement to revise approaches and adopt new perspectives.

Bringing this all together, Figure 2 presents a diagrammatic representation of the Centre's work in Phase 2. The work is underpinned by the four cross-cutting GCPH functions and as a totality results in two broad outcomes: strengthened processes for

tackling health inequalities and greater capacity for action to improve health. The twelve GCPH Phase 2 programmes are shown clustered into four arenas, primarily concerned respectively with place, people, services and wider context. Interrelationships exist between them as clearly shown, and all programmes are supported by the wider activities undertaken by the Centre.

Figure 2: Phase 2 programmes of work



The next section of this report presents a summary of the Centre's achievements across this range of activities. Reports on individual work programmes are regularly presented to the Management Board, with exception reporting on progress across all programmes being provided on a six-monthly basis.

"The Commonwealth Games HIA is an example of what the Centre does really well. It was a true partnership involving Glasgow City Council, the MRC and GCPH."
Martin Higgins, Coordinator, Scottish Health Impact Assessment Network

SECTION 3 – REPORT ON ACHIEVEMENTS

This section tackles the complex business of capturing the Centre's achievements to date by:

- summarising progress made towards GCPH's eight formal objectives in Phase 1
- listing the actions taken in response to recommendations arising from the Phase 1 funding review
- describing a wide range of Phase 2 activities, outputs and outcomes - demonstrating performance against the indicators of success devised in relation to the Centre's two agreed key outcomes
- illustrating how the Centre is delivering on its 'translational' role and operating as an agent of change
- summarising how GCPH adds value to the drive to improve population health and reduce health inequalities in Glasgow and Scotland through complementing, reinforcing and informing the efforts of longer-established and more conventional parts of the public health landscape.

3.1 Phase 1: Delivery on the GCPH objectives

Progress towards the objectives in Phase 1 was summarised in the Director's report for the first funding review[4], and included the following achievements.

Objective 1:
Bringing research together with policy-making and service provision

- Developing the GoWell Programme with key agencies including GHA and Communities Scotland/Scottish Government.
- Establishing GCPH's observatory function to enhance understanding of health trends and their determinants and apply this understanding to planning and prioritisation processes at different levels.
- Evaluating established services, such as food provision in Glasgow schools and the smoking cessation service in Greater Glasgow, and supporting the application of learning from these evaluations to the development of these services.

Objective 2:
Opportunities for the exchange of ideas to create new insights

- Establishing innovative forums to expand knowledge and thinking, including Glasgow's Healthier Future Forums and GCPH's winter seminar series.
- Developing Civic Conversation and other regular discussion seminars and opportunities.
- Supporting research with exploratory and futures-orientated components.
- Supporting the Scottish Government's work programme on cultural influences on positive mental health and wellbeing with the University of Glasgow.
- Developing a programme of qualitative research in communities.

Objective 3:
Evaluation and design of approaches suited to Glasgow's needs

- Establishing and delivering the first phase of GCPH's largest research programmes – pSoBid1 and GoWell.

[4] The Glasgow Centre for Population Health: Building understanding, evidence and new thinking for a healthier future. Report for funding review 2007.

- Examining the 'Glasgow effect' by comparing Glasgow's health with that of other large UK cities, using various methods.
- Piloting and rolling-out Health Impact Assessments (HIAs).
- Supporting the development of Community Health (and Care) Partnerships' (CH/CP) policies and plans with a particular focus on health inequalities.

Objective 4:
Partnerships for collective action

- Building new, and supporting existing, networks committed to health improvement and tackling inequalities.
- Maintaining and strengthening GCPH as a living partnership
- Playing an active role in national and international developments and partnerships
- Developing (through research programmes and learning activities) partnerships with communities, researchers and a range of stakeholders.

Objective 5:
Scientific research and analysis

- Publishing and disseminating *Let Glasgow Flourish,* Community Health and Wellbeing Profiles and *The Aftershock of Deindustrialisation*
- Funding and supporting pSoBid1
- Establishing primary care observatory and 'work and health' observatory functions (both located within Glasgow University)
- Developing and implementing methods to fund and support local research
- Completing a systematic review of psychosocial determinants of health (with MRC SPHSU).

Objective 6:
Increasing capacity for effective action

- Providing training and development to professional and volunteer staff from a range of organizations and communities
- Teaching, mentoring and supervision of students and trainees
- Providing support (financial and professional) for studentships and research assistantships in public health
- Supporting capacity-building at the organisational level.

Objective 7:
Communications in a range of formats

- Developing a multi-faceted communications and media strategy including websites, publications, events etc
- Producing a series of Briefing Papers that highlight key findings and recommendations from GCPH research and activities
- Through conference and seminar presentations, discussing GCPH work and findings with a wide range of groups

Objective 8:
International standing and links

- Developing an international outlook and ongoing contacts through the Centre's seminar series, bringing perspectives and expertise from other countries to Glasgow

- Presenting learning from GCPH as a whole and from individual programmes to international audiences
- Establishing or contributing to new international collaborations (eg with post-industrial regions of Europe) and to established international networks (eg Healthy Cities)
- Collaborating with research colleagues nationally and internationally

The Phase 1 funding review reported that "*The work of GCPH during the period 2004-2007 is viewed very positively by stakeholders. The consensus is that GCPH has delivered strongly on the challenging agenda it was set.*" There was recognition that much progress had been made and that the next phase of activity needed to take this further, to impact on decision-making and practice and reach into wider arenas.

3.2 Actions in response to Phase 1 funding review recommendations

Table 2 sets out the 17 recommendations made in the Phase 1 funding review report, and the actions taken in response to these.

Table 2: Phase 1 funding review recommendations and actions in response

Recommendation	Actions taken
1. Scottish Government funding for GCPH should continue at its current level for a further three years (1st April 2009 to 31st March 2012) contingent on the commitment of the partner organisations to sustain their contributions over this period.	Local partners' contributions sustained in Phase 2, enabling Scottish Government to commit funding for the three years (at flat level of funding – £1m per annum – provided in Phase 1).
2. The broad remit of GCPH should be retained. The Centre should retain its four aims and three workstreams as set out on Page 1 of the Director's report to the review. The Centre should continue to operate at arm's length from day-to-day policy development.	Implemented. Workstreams and programmes slightly redefined in Development and Implementation Plan for 2009-12, to take account also of issues raised in other recommendations.
3. All partners should review and renew their commitment to GCPH, and should make explicit the contributions they will make during the next phase of funding. (Paragraphs 22, 37.)	Achieved. Partner commitments and contributions confirmed and clarified in Memorandum of Understanding for Phase 2.
4. Discussions should be held with senior representatives of the University of Glasgow as a matter of priority in order to smooth the transition and handover of representation on the Executive Management Team, Management Board and External Advisory Group following changes in personnel scheduled for late 2008.	Achieved. Continuity secured, with Executive Management Team (EMT) and Management Board (MB) representation from Prof Cooper and Prof McKillop. Sequential changes in University structures reflected in revised MB representation.
5. Membership of both the Management Board and the External Advisory Group should be reviewed by the groups themselves in the light of new developments within Public Health.	Implemented. Chair and Director met with all MB members to review membership and ways of working. Outcomes reported to Board in April 2010. External Advisory Group (EAG) membership reviewed and new members invited to join (Prof Kelly, Mr Elson, Dr Dobson, Prof Reid and Mrs Whittle).

6. A wider consultative mechanism should be established for GCPH.	Implemented in modified form. EAG and MB considered recommendation and decided that a single consultative mechanism would not be the best way to proceed. Instead, a range of agreed approaches to wider consultation were put in place, with consultees tailored to programmes. See Appendix 9 for summary of current consultative/steering mechanisms.
7. Additional senior support for the Director, in the form of a Deputy Director post should be put in place. The Management Board should consider whether this additional post can be funded as an 'in kind' contribution, or whether there might be other external funding which could be identified to support such a development.	Implemented. Job advertised in 2008. Dr Rosie Ilett took up post at end of March 2009. Core funding of post was identified as best option.
8. A greater degree of coherence and focus should be brought to the (14) programmes of work as set out on Page 2 of the Director's report. The focusing should be guided by stakeholder interests and may involve a 'light touch' consultation exercise.	Taken forward in Development and Implementation Plan, as illustrated in new work programmes diagram and overarching success indicators therein. These were consulted upon with partners, and approved, and are intended to enhance coherence without excessively narrowing focus, due to importance of breadth of activity, ability to be responsive to opportunities, and importance of gaining new perspectives from working across boundaries.
9. The Management Board should agree a set of 'success indicators' by which the work of GCPH can be judged at a future point.	Achieved. Indicators of success devised through presentation to/discussion with MB, built into Development and Implementation Plan, and form basis of reporting and monitoring systems.
10. The development of pSoBid (Phase 2) should be substantially resourced from external sources, with GCPH retaining a stakeholder / partnership role in any bid.	Not yet progressed. Analysis and reporting of pSoBid1 ongoing. Proposals for pSoBid2 need to be built upon robust findings, subjected to peer review.
11. The future of the research funding committee of GCPH (currently in abeyance) should be reviewed, and any future funding through the mechanism of an 'open call' for applications should be approached on a much more selective basis.	Funding committee and 'open call' process reviewed, and ceased. Arrangements put in place to support small funding requests. Larger research projects specified and commissioned by GCPH team.
12. The 'action research' / 'development' role of GCPH within the CHCP arena should be given further consideration.	Achieved. This work has extended beyond the Glasgow CHCPs and now has national significance and impact.
13. GCPH should ensure that it promotes to all partner organisations the importance of policies being introduced in ways that can allow those policies subsequently to be evaluated.	Partially achieved. This approach promoted in a number of arenas, including *Equally Well,* the Big Eat In, 20 MPH zones, and via GoWell.

14. GCPH should develop a communication plan, tailored specifically for the Scottish Government and for those stakeholders and potential stakeholders beyond the reach of its Glasgow and West of Scotland constituencies, to ensure that the work of the Centre is more fully understood and utilised.	Number of communications plans developed and implemented, with revamped GCPH website, and e-update (distributed to approximately 1500 people), playing central parts. Work and dissemination beyond Glasgow greatly increased. Individual programmes have delivered seminars/other communications specifically for Government. Recognise ongoing communications challenge.
15. The seminar series should continue. The format of the series should be kept under constant review to ensure that it remains both fresh and relevant to the core aims of GCPH.	Implemented. Evaluation carried out in 2010 and report available. Findings overall very positive, and action recommendations now being implemented. (See also template in Appendix 10.)
16. More priority should be given to academic publication of the outputs from the 'middle layer' of GCPH work (i.e. work done on behalf of NHSGGC, City Council or other organisations).	Partially achieved. More priority given to academic publications (see Appendix 6) but 'middle layer' is less amenable to this type of publication than is primary research or our larger programmes.
17. More emphasis should be given to producing summary briefing papers and to disseminating general 'high level' messages more widely.	Achieved. 38 GCPH briefing papers produced (see Appendix 6) and considerable investment made in dissemination (see also Appendices 7 & 8).

3.3 Phase 2: Delivery towards indicators of success

The Centre's *Development and Implementation Plan 2009-2012* laid out the 12 work programmes and supporting activities, to be delivered during this period. In line with the recommendation from the Phase 1 funding review, the Plan identified two overarching outcomes against which success would be judged in Phase 2:

- **strengthened processes** for improving population health and reducing health inequalities, and
- **greater capacity** for effective action to improve health and reduce inequalities.

A number of indicators of success were agreed for each of the two outcomes, with targets where appropriate. What follows is a summary of the GCPH team's achievements in delivering on these indicators to date. To avoid duplication, examples are included where they 'best fit', but it should be recognised that some achievements contribute to more than one indicator. Summary information on several of the projects described here is included in Appendix 10.

The success indicators relate to the full Phase 2 three-year period April 2009–March 2012, but this report only covers the 21 months April 2009–December 2010. Despite this, there is evidence that several of the success indicators are already being met; and given the momentum that has been built up, there is every reason to believe that by the end of the remaining 15 months, GCPH will have delivered fully on the critical impacts sought for this period of funding.

Outcome A:
Strengthened processes for improving population health and reducing health inequalities
This outcome is concerned with the work that GCPH carries out with partners and others to improve health and reduce health inequalities, through its involvement in national and local policy-making and also by providing advice and expertise. Its dimensions relate to:

- policy/strategy influence, nationally and more locally
- deploying the spectrum of GCPH core functions in exerting this influence
- evaluation studies – which in turn have a translational impact
- methodological developments and innovations.

Success indicator A.1:
Influence on policy and strategy development

- Invited inputs were made to the **Marmot review of health inequalities in England** through membership of a working group, organising a group visit to Scotland, and contributing to review reports and papers.
- There is growing **international interest in the GCPH 'model'**, seen as an exemplar of government and public sector commitment to addressing health inequalities in the context of 21st century influences on health.
- The Centre's input to the reconvened Scottish Government Ministerial Task Force on Health Inequalities, to review **Equally Well,** included membership of the Task Force, reports from the Glasgow and Govanhill test sites, development work on test site evaluation and monitoring, and developing indicators to measure progress on addressing health inequalities. The review report published in June 2010 reflected these contributions, which have impacted on government policy and thinking, and on implementation nationally and locally.
- The **GoWell** programme has contributed to policy debates and developments in several ways. Nationally, examples include the review of mixed tenure neighbourhoods, findings on anti-social behaviour, and ongoing work concerning social regeneration and community development. Glasgow Housing Association has developed an action plan in response to GoWell findings and uses the findings to inform its regeneration activities. 38 local presentations have been given, to elected members, organisations, communities and staff groups within Glasgow. There is interest in GoWell (both the approach being taken, and the findings) from the Canadian Government, European research networks, and other cities/regions. Notably, GoWell now regularly forms part of policy discussions nationally and locally, findings are often quoted, and the GoWell team is frequently approached for advice and inputs to development processes relating to area-based regeneration.
- The **pSoBid** team has worked with the Chief Medical Officer to distil strategy implications from the findings, emphasising early years and pathways between socioeconomic status, health behaviours and outcomes. This thinking has been influential not only in Scotland, but more widely. The background research, as well as the pSoBid findings themselves, has impacted across government and influenced thinking in several policy areas (including criminal justice, early years, and preventative spending) in addition to health.
- GCPH research funded by Joseph Rowntree Foundation on **alcohol and young people,** their social networks and drinking behaviours was published in December 2010, and included guidance for policy makers. Findings have also been presented to and used by the local Alcohol and Drug Partnerships.

- A framework for developing and evaluating **action on health inequalities** has been developed and applied in a number of settings, including with three of the *Equally Well* test sites in different parts of Scotland. There are proposals to use it to inform national guidance for Community Health Partnerships. This framework has helped to address the need, identified in several parts of Scotland, for support to enable practitioners/service providers to strengthen their contributions to reducing health inequalities.
- The multi-agency **Glasgow Health Commission** was established by the Council Leader in June 2008 to devise innovative recommendations to tackle Glasgow's record on health, and reported in 2009. GCPH was highly influential in this work: initially, through advocating for a Commission to be established, and then through membership of the Commission, providing information and evidence, and devising with Glasgow City Council processes for monitoring implementation of the recommendations. The Centre is now instrumental in the development of a new set of Glasgow Health and Wellbeing Indicators (*Understanding Glasgow*).
- Considerable influence has been exerted on plans and activities in relation to **children and inequalities**. GCPH led on the development of the *Healthier, Wealthier Children* project proposal which attracted over £1m from the Scottish Government. The project aims to bring financial inclusion services together with child health services across Greater Glasgow and Clyde, and was launched with input from the Cabinet Secretary in November 2010. Other examples include developing the *Children and Inequalities Strategy* in East Glasgow CHCP with colleagues from NHSGGC and Glasgow City Council, and inputting to the Scottish Government's Early Years Champion's dialogue on how best to take action to improve children's early years of life.

Success indicator A.2:
Influence drawn from across the core GCPH activities: public health information, research evidence and future orientation/fresh thinking

- The Centre has had demonstrable influence on strategic **urban planning** processes, for example through providing the health input into Glasgow and the Clyde Valley (GCV) Strategic Development Planning Authority's Futures Group, which devised future scenarios to feed into the next GCV development framework; contributing to a project to audit greenhouse gas emissions and model reductions at the GCV metropolitan scale; and organising and helping to facilitate a health stakeholder workshop to develop a main issues report for City Plan 3. This also assessed how effectively health was integrated in City Plan 2.
- GCPH influenced the development of a new **Primary Care Framework** for NHS Greater Glasgow and Clyde. *The Shape of Primary Care* report (produced by the Centre in 2008) and more recent work looking at new models of primary care provided useful background material for the strategy group. GCPH was asked to facilitate development events, and the approach taken was recognised as being of value beyond GGC resulting in the Scottish Government requesting a similar approach nationally. The 'Deep End' work, supported by GCPH has brought a particular focus on practices working in the most deprived communities, and has led to the establishment of a Deprivation Interest Group for Greater Glasgow and Clyde, to focus on these issues. It has also produced a series of themed reports (see http://www.gla.ac.uk/departments/generalpracticeprimarycare/deepend/).
- The **active travel** work programme uses a range of approaches to influence policy and plans. Presentation by GCPH of research evidence to the Glasgow Health Commission led to the inclusion of a number of recommendations on active, sustainable travel. A short synopsis of evidence and recommendations for action was subsequently submitted to the Glasgow Community Planning Partnership Executive Group and all the recommendations were approved.

Outputs from the work programme were also presented to Scottish Government policy leads in May 2010; and a seminar held in October 2010 has led to potential further collaboration with Strathclyde Partnership for Transport (SPT).

- The Centre's **culture, sustainability and economic development** project is considering the history and future for the city of Glasgow in the face of the challenges posed by these three influences. The project will highlight ways of enhancing resilience at both the individual and collective level. During 2011, this work will be fed into strategic development processes in the city such as the economic commission and city visioning exercises.
- During 2009, GCPH researched the potential **health implications of the financial crisis**, resulting in a chapter in the Director of Public Health's report, contributions to an NHSGGC corporate event on recession planning, and subsequent involvement on a Board recession planning group. The approach taken is now being mirrored in work looking at the consequences for health care of the changing demographics in Greater Glasgow and Clyde.

Success indicator A.3:
Evaluations of public health interventions and policies, with translational impact

- In the **Equally Well** Glasgow test site, GCPH leads on monitoring and evaluation of the work to integrate health into planning as a potentially important strategy to reduce health inequalities. An evaluation framework has also been developed, agreed and disseminated for the Govanhill test site, and interim reports have influenced developments there. Both test sites are seeking to develop a new model of service delivery, suited to addressing inequalities. As well as being responsible for monitoring and evaluation, GCPH staff work to bring information, evidence and public health insights to these processes, and to facilitate capacity-building and agenda-setting processes. Further, members of the GCPH team have supported this work nationally, through contributions to the national learning network and to the development of the national evaluation processes.
- GCPH has designed, managed and been directly involved in an evaluation of the **Big Eat In,** a pilot exercise in eight secondary schools in Glasgow: over one academic year, S1 pupils were encouraged to stay within the school grounds at lunchtime to encourage healthier eating habits. The evaluation results have informed next steps in relation to healthy school food policy in the city. They have demonstrated a positive impact of the Big Eat In. As a result, stay on site policies for S1 pupils are now being continued and extended by secondary schools in Glasgow, with further work proposed with primaries. GCPH has been highly influential in this area: advocating for the pilot exercise, sustaining the necessary partnerships and relationships for the work to be delivered, ensuring it was evaluated, and maintaining a focus on the learning from the pilot and implications for future developments.
- The Centre's evaluation of a **gangs pilot project** is ongoing, working with Includem and the organisational and funding partners for the project, including Strathclyde Police, Community Initiatives to Reduce Violence, Scottish Government and the Robertson Trust. The project aims to divert young people from more serious involvement in crime. GCPH is researching the outcomes for young people, and evaluating the partnership.
- Evaluation activities at earlier stages of development, but with clear translational implications, include responsibility for evaluating the **Healthier, Wealthier Children project**; participation in a large trial (with CSO funding) to evaluate the use of **incentives to support smoking cessation in pregnancy**; and, as part of a consortium based in NE England, the evaluation of **public health knowledge transfer** approaches (NIHR/SDO funded).

- GCPH staff have played a central role in promoting and applying **health impact assessments** (HIAs) in Glasgow. Seven have been carried out, including HIAs of the Alcohol Licensing Strategy, the new Housing Strategy, and the new build at South Glasgow Hospitals Campus. A major HIA process and conference for the Commonwealth Games legacy, and a seminar involving learning from the Vancouver Winter Olympics, have both contributed to the legacy plans for 2014. This is a major step forward. Prior to GCPH's leadership in this area, HIA's were scarce and not systematically carried out.

Success indicator A.4:
Methodological developments and innovative practice

- Innovative epidemiological research, instigated and carried out by GCPH using large-scale data sets obtained collaboratively from a number of European countries, is comparing health and health-related factors in the West of Scotland with those in other **post-industrial European regions**. The data set is unique; and the resulting analyses have presented various methodological challenges, particularly in achieving meaningful comparisons between data emanating from different countries' systems, and in the volume of analyses being undertaken.
- The collaborative **three cities** project with colleagues in Liverpool and Manchester aims to identify factors that highlight, and might explain, 'the Glasgow effect'. Aspects of the research (e.g. in developing a more spatially sensitive 'cross-border' deprivation index for the three cities) represent new developments in this type of analysis. The first phase has been completed and widely disseminated. Together with the European regional analyses, this work has gained recognition among the wider public health community in the UK, and is seen as being of international significance. Further phases are now being put in place.
- The **pSoBid study** employs a methodology that, unusually, combines general lifestyle behavioural and life history information, psychological and cognitive measures, and complementary biological and anthropometric measures to apply biomedical techniques to public health research. The first phase is nearing completion, and several papers have been accepted for publication.
- Using the medium of film to make population health information more accessible, **Miniature Glasgow** describes population and demographic characteristics of Glasgow as if it were a village of 100 people. In recognition of its value as a medium to present health information in a widely accessible format, the film has been added to the EU health portal. 'Miniature Glasgow' has influenced production of similar 'miniature' films by Fife, South and North Lanarkshire and Stoke. GCPH is now collaborating with colleagues in Gothenburg to develop a miniature cities comparison.
- The process of **Civic Conversation** led to the production in 2008 of *For a resilient city*, a report describing the processes involved and identifying key themes, and *Equal Exposure,* an illustrated book which received the Scottish Design Council Award for best publication of 2009. Civic Conversation activities in local communities and with organisations have continued, with emerging insights being disseminated through a regular column in *Scotregen* (SURF – Scotland's Independent Regeneration Network – newsletter). Tools, developed through the GCPH collaboration with the International Futures Forum to support different ways of thinking about the future, continue to be deployed as an integral part of GCPH programmes.
- In 2010 a project (co-funded with the Scottish Collaboration for Public Health Research and Policy) was initiated to investigate an unanticipated increase in **breastfeeding** in certain deprived neighbourhoods within Greater Glasgow and Clyde. It involves creating a new linked maternal/child dataset for Scotland and

undertaking a comprehensive range of analyses of breastfeeding trends, both locally and nationally.
- **Mental health profiles** are being developed for Greater Glasgow and Clyde, bringing together for the first time a range of data in order to provide a more up-to-date understanding of mental health and illness, their determinants, and mental health inequalities. These will be launched early in 2011.

Outcome B:
Greater capacity for effective action to improve health and reduce inequalities
This, second, outcome is concerned with the Centre's role in the areas of knowledge transfer, organisational and professional development, education, communication and dissemination. It recognises that capacity for action is built in a number of ways, and that the Centre's roles include: creating environments and delivering events that facilitate learning and different ways of thinking about health and health inequalities; direct development support for those planning and delivering services; contributions to CPD and higher education; making GCPH findings widely available and accessible; and the provision of population health expertise to others.

Its dimensions relate to:

- publications
- contributions to professional development
- collaboration, partnerships and reach.

For ease of reference, an overview is provided here. Fuller details are given in Appendices.

Success indicator B.1:
Publications (see Appendix 6 for full list)
Journal articles and book chapters
The GCPH target in the Development and Implementation Plan is to achieve publication of 12 **journal articles** annually (a minimum of 1/3 to be peer reviewed) in which a member of the GCPH team is an author. From April 2009-December 2010, 18 such articles achieved publication in peer reviewed journals including *British Medical Journal, Public Health*, *European Journal of Public Health, Journal of Urban Regeneration and Renewal* and *Journal of Public Mental Health*. There is an additional substantial body of peer-reviewed academic publication from research funded by GCPH.

Regular columns were published in *Scotregen*, which described findings from GoWell and insights from the Civic Conversation.

GCPH staff have also made valued contributions to outputs by partner organisations, including a chapter for Glasgow City Council's climate change strategy, and chapters on early years and the impact of the recession on health for NHSGGC's Director of Public Health's report: *An Unequal Struggle for Health. Report of the Director of Public Health into the Health of the Population of Greater Glasgow and Clyde and Priorities for Action 2009-2011.*

Final reports on all research projects and briefing papers
GCPH is required to deliver written outputs for policy, practitioner and academic audiences, including final reports on all research projects and briefing papers. The following have been produced since April 2009:

- **Final reports on research projects** have included those on qualitative research into active travel in Glasgow; the HIA of the 2014 Commonwealth Games; the effects of selective migration on socio-economic and health inequalities in Glasgow; the evaluation of community health profiles for Greater Glasgow and Clyde; and the evaluation of the Big Eat In secondary school pilot.
- GCPH aims to produce 12 **briefing papers** per year. Thirteen were published in 2009-2010: six GoWell briefing papers, two publications in the GCPH concepts series, and five in the GCPH findings series.
- In addition to these reports and papers, **other publications** from work supported by GCPH include the Scottish Observatory for Work and Health's Annual Report and a series of GoWell outputs including a large findings report summarising Wave 2 survey results, and a synthesis of GoWell research findings to date.

Success indicator B.2:
Contributions to professional development, collective learning and reflective practice

Learning events involving a range of organisations/personnel from different disciplines

The target here is to organise and deliver a minimum of 15 **learning events** per annum, and this has also been exceeded in the past year. A full list of GCPH events is provided in Appendix 7. These events include:

- Glasgow's Healthier Future Forums, which have a wide-ranging attendance and provide an opportunity for new material from GCPH to be considered in terms of its implications for policy and practice.
- Seminars more specifically targeted at particular groups, such as the Scottish Observatory for Work and Health discussion seminar in August 2009, the 'Active, Sustainable Travel' research seminars in October 2009 and October 2010, and the Civic Conversation World Game event in February 2010. An important development has been the capacity building workshops, delivered as part of the Glasgow City Equally Well test site, to build skills in integrating health into urban planning.
- Collaborative events, including a joint event with the Centre for Confidence and Wellbeing, on neuroplasticity and brain structure (September 2009), a seminar in collaboration with the Scottish Policy Innovation Forum on health inequalities (October 2009), and, with the Yunus Centre at Glasgow Caledonian University, a seminar on systems thinking for population health (November 2010). Working with Glasgow City Council, the GCPH team organised a seminar entitled *A Games Legacy for Glasgow – a catalyst for social change* in October 2009, bringing learning from Vancouver to Glasgow.
- In-house seminars for GCPH staff and invited participants, addressing issues ranging from rural health, to social care, to the contribution of internal migration to health inequalities in Scotland.
- Hosting visits from international visitors, reflecting international interest in the way that GCPH operates (the model is innovative, and not easily found elsewhere in the world), and in our work programmes and outputs.

Conferences and presentations

The team has presented the work of the Centre in a range of settings. A list of major **presentations** is included in Appendix 8.

Secondments and attachments

A minimum of two **professional secondments or attachments** is expected annually, with additional **student attachments** as feasible. Over this reporting period, there have been six professional attachments working with GCPH, and two

student attachments. Attachments, trainees and secondees have made significant contributions to the work of the Centre and provide positive feedback on GCPH as a learning environment. Completed outputs since April 2009 include the following:

- Analyses and an in-house report on the effects of the ageing population on need for health services (Hogg)
- Literature review on futures for primary care (O'Dowd)
- Research into licensing and food outlets proximal to schools (Riddell)
- *Accounting for Scotland's excess mortality: towards a synthesis*; GCPH report in preparation and journal article submitted (McCartney et al)

Reports are in preparation on social regeneration, health outcomes and determinants in West Central Scotland and comparable post-industrial regions, and breastfeeding in areas of deprivation. Further information on training attachments and secondments is included in Appendix 5.

Supervision of PhD and Masters projects, and provision of teaching inputs to University courses

A number of senior GCPH staff support postgraduate education through student supervision and teaching inputs.

- **PhDs**: joint supervision of two current PhD students. Two further PhDs are confirmed to start (with GCPH supervision) in early 2011. One PhD student, sponsored and jointly supervised by GCPH, successfully completed his thesis and graduated in 2009.
- **Masters of Public Health (MPH)**: Centre staff provide supervision for MPH students at Glasgow Caledonian University and the University of Glasgow.
- Team members deliver **teaching inputs** to Masters courses at the University of Glasgow (Urban Studies, General Practice and Primary Care, and Sociology, Anthropology and Applied Social Sciences) and to MPH and undergraduate students at Glasgow Caledonian University.

GCPH materials are used in educational practice at a number of levels. For example, *Miniature Glasgow* has been utilised by the University of West of Scotland, Glasgow Caledonian University, and the University of Glasgow; and the 'Glasgow Effect' analyses have led to a number of research endeavours, both by students and more senior academics.

Other professional support

GCPH staff have supported professional development and quality practice in the following additional ways:

- Providing leadership and hands-on support for developments in **multi-disciplinary public health**. This has involved active membership of the Defined Public Health Specialist Steering Group and the Public Health Specialist Network, advocacy for more formalised training in non-medical public health, and provision of support to individuals pursuing Specialist registration.
- Academic and peer commentary as **referees** for a range of bodies and journals including: the Health Technology Assessment Clinical Evaluation and Trials programme, the National Institute for Health Research and Public Health Research Funding Board, *British Medical Journal* and *European Journal of Public Health.*
- Providing **support and expertise** to individuals (for example, as a mentor on the Mentoring Partnership Scotland programme for senior managers), groups (e.g. facilitation for the Glasgow Common Purpose Navigator programme for local leaders) and professional bodies (the Deputy Director was elected UK Vice Chair

of Managers in Partnership in 2009, alongside representing Scotland on the UK Members Committee).

GCPH staff contribute to a number of other forums and advisory groups. Further information is provided in the summaries in Appendix 5a.

Development of new perspectives on population health and inequalities through seminar series, civic conversation, other methodologies

The Centre organises a range of events each year as part of its remit to develop new perspectives on population health and inequalities. At the core is the GCPH winter seminar series – now in its seventh year, and continuing to attract a wide range of participants to hear speakers of international significance. Full details of all events are in Appendix 7. Summaries, podcasts and full transcripts are all available on the GCPH website.

The development of new perspectives on health and inequality is an approach integral to all of the GCPH work programmes, and specific examples (including pSoBid, the 'Glasgow effect' analyses, *Miniature Glasgow, Drinking to Belong,* and conceptual work on the history and future of Glasgow) have already been mentioned.

Public accessibility and credibility of GCPH learning and outputs

This indicator is concerned with ensuring that the GCPH disseminates its work in a way that is widely accessible, while maintaining the quality that assures users of the trustworthiness and credibility of the work. The websites detailed below provide an important route to public access of the Centre's work, supported by media coverage. Also relevant here are the many approaches made to the Centre requesting inputs from staff, reflecting a growing recognition of the expertise within the team.

Websites and other media

- The **GCPH e-update news bulletin** was launched in February 2010 and circulates currently to an e-list of around 1500. It includes a summary of recent work, news about events and links to internal and external publications.
- The improved **GCPH website** (www.gcph.co.uk) went live at the end of 2009, with increased functionality for greater and more efficient access to GCPH learning and outputs. Monitoring indicates three times more visits in April 2010 than in April 2009.
- The **GoWell website** (www.gowellonline.com) has continued to develop, and there has been an average 70% increase in visits to the site each month compared to the same months in the previous year.
- A third website, ***Understanding Glasgow***, will be launched in January 2011, to make information about different aspects of the city (it includes 12 domains) more widely available.
- Information and outputs about the **Equally Well test sites** are routinely made available on the Equally Well website (www.equallywell.com) and SharePoint is used to make documents available to wider test site team.
- **DVD/film outputs** have also been utilised. *Miniature Glasgow* (www.miniatureglasgow.com) is now available in 9 languages and has been viewed in 64 countries. It has also been shown as a short film on Glasgow buses. *Views of health in Glasgow* has been used by modern studies teachers, and an Active Travel 'vox pop' film has also been developed and used in seminar presentations.
- **Media coverage** since 2008 includes articles in European newspapers on the Glasgow Effect and European city comparisons work, for example '*Sueddeutsche Zeitung'* (Germany) as well as European-wide news agency 'AFP'; and ten

articles about GCPH work in UK and Scottish newspapers including *The Guardian, The Herald, The Scotsman* and the *Scottish Sun.* 'Glasgow Effect' findings have also featured on television and radio: BBC Scotland news, Newsnight Scotland, Radio 4 and BBC Radio Scotland. pSoBid was featured in a TV documentary on heart health in Glasgow. Articles relating to the GCPH appeared in *Holyrood* Magazine, as well as pieces in the ScotPHO e-newsletter.

GCPH contacted for its expertise
GCPH regularly receives requests from partners and external agencies to provide inputs on a wide range of subjects, sometimes on a one-off basis, and sometimes asking for a more regular commitment. During 2009-2010 a systematic approach was taken to document the type and number of requests. Requests came from public, private and third sector organisations, as well as from individuals and the media; most were from Scotland but a significant minority are from further away. Further information is available on request.

Success indicator B.3:
Collaborations, partnership and reach
This report contains a number of examples of collaborations that GCPH has with other agencies, and Appendix 9 describes the consultative mechanisms in place. One example of the Centre's routine collaborative practice is the *Understanding Glasgow* development. There have been over 50 contributors to this through organised events, and the website has been created by a multi-agency project group. This partnership will need to be sustained and developed for the site to deliver on its potential. The approach is also contributing to a related development – of an alternative prosperity index - being led by Oxfam Scotland.

Other illustrative examples of collaboration or partnership activity are:

- European links and pan-UK collaboration: A range of collaborative work is taking place with post-industrial areas of Europe, with the EURO-URHIS (European Urban Health Indicators System) network of participants, and with colleagues in Liverpool and Manchester. Considerable time and effort has gone in to these collaborations, which depend on establishing trust at a distance, and on the quality and value of outputs.
- NHS Greater Glasgow and Clyde: A new collaborative development in the last year has taken place with NHSGGC's Corporate Inequalities Team, facilitating legacy development and prioritisation, and identifying strategies for future action.
- Glasgow City Council: Work on healthy school food policies demonstrates sustained collaboration with City Council colleagues. Ahead of the final Big Eat-In evaluation results and through discussion and planning at steering group meetings, at least six more Glasgow secondary schools have introduced stay on site policies. The *Equally Well* test site work in Glasgow is similarly premised on successful partnership work to produce mainstream service change.
- New connections: During this phase, many new links and collaborations have been established – for example with the Centre for Translational Research in Public Health (NE England), the Mental Health Foundation Scotland, the Beatson Institute for Cancer Research, the Development Trust Association Scotland, Oxfam Scotland, BBC Scotland and with further research groups in all three of Glasgow's Universities. These are at an early stage, but they have led to joint work developments with exciting potential to help deliver of the GCPH aims.
- Reach of the seminar series: The evaluation of the seminar series, carried out in 2010, suggests over 3000 attendances to date and more than 35,000 downloads of the soundfiles from the seminars.

These collaborations contribute to the delivery of the GCPH objectives in several ways: by reducing the gap between research activity and policy and practice, by opening-up new opportunities for influence, by bringing different perspectives together to yield new insights and ways of working, and by extending the reach of our own work and outputs. What follows is a summary of how the Centre's ways of working in partnership enhance its impact.

3.4 GCPH as an agent of change

One of the particular challenges faced by the GCPH is its responsibility for operating in a 'translational way': in other words, undertaking activities that translate into changes in policy and practice, to the benefit of population health and wellbeing. It follows that it is not enough for the Centre to produce strong academic outputs or to support the delivery of established programmes or policies. At the core of the GCPH model is the need for the team to demonstrate agency in changing processes, mindsets and the framing of problems.

The ***process* of 'translation'** in the area of population health is not self-evident, linear, or simply a case of generating and applying the best available evidence to determine ways forward. A linear model of impact works best when health problems have relatively straightforward individual-centred interventions as solutions. Strategies to reduce health inequalities and to improve the health of a city like Glasgow sit at the opposite extreme. Intelligence and evidence of different sorts need to be generated and synthesised, environments supportive of change need to be fostered, and understandings of alternative futures generated.

From the summaries presented earlier, it can be observed that the GCPH is having an impact in both a 'direct' and a more 'diffuse' manner. **Direct impacts** have followed a linear model of influence: an output from the Centre (such as new information or a research report) being translated into a set of actions by others. One example is the community profiles for Greater Glasgow and Clyde (which also acted as a precursor to the profiles produced by ISD for the rest of Scotland). Feedback from those to whom the profiles were distributed was brought together in an evaluation report[5] that concluded:

"The profiles have been widely influential in planning and policy across the Greater Glasgow and Clyde area: informing debates and planning priorities, assisting in targeting resources, influencing service redesign, supporting funding and project applications, raising awareness, informing communities, aiding research and in work with a specific focus e.g. alcohol, inequalities, smoking cessation. The importance of having local data for neighbourhoods or similar small areas, to highlight inequalities, for comparison and to quantify need, was repeatedly emphasised."

Similar 'direct' impacts can be identified across the GCPH work programmes. This form of evidencing only works, however, where there is a defined output (whether a research report, finding, conceptual idea, or methodology) and clear lines of demarcation around what comprises the Centre's work and what belongs to others. Much of the core work of GCPH involves approaching problems as co-learners with others (such as in GoWell, Equally Well, and work with local authorities, the NHS and partnerships). The two overarching GCPH outcomes for Phase 2 ('strengthening process' and 'creating greater capacity for effective action') can only be fully achieved through approaches involving reciprocal learning, due to the limits of singular perspectives on complex problems and the requirement for inter-sectoral

[5] Glasgow Centre for Population Health. *Evaluation report for Community Health Profiles* (p16). GCPH, 2009.

responses in an environment of wider culture change. This is where the Centre's impact becomes more diffuse.

At **the most diffuse end of the impact spectrum** sits the seminar series, Civic Conversation and other learning events and communications where the Centre introduces people and organisations to stimulus material with no preconceived idea of how those participants will react to it or use it. The approach is not based on a systematically identified 'need' for support on a particular issue, or the building of a defined set of skills or capacities. Rather, the Centre provides a space, stimulation and set of high quality inputs to enable others to learn and build capacity. The 2010 evaluation of the seminar series demonstrated the value that participants placed on this approach. Direct evidence of the application of learning from these events to day-to-day practice was less strong, but the feedback clearly shows that the series fills a professional development niche that is not being addressed by others.

"The Seminar Series appears to occupy a clear niche...It appeals to people who can see some connection with the health sphere and have an appetite for learning."
"Its main strengths are in the quality of presentations. This is in terms of their thought provoking content, the status of those delivering, the currency of the issues being discussed, the format (lecture style, but presented in an accessible manner) and, to a lesser degree, the frequency and timing of the events."[6]

An understanding of **the GCPH translational role** requires recognition of the continuum from 'direct/linear' to 'diffuse/relational' – but a second continuum is also evident, reflecting proximity to, or distance from, those enacting the desired change. A couple of examples again help to illustrate this. The phase 1 review of GCPH recommended further attention to academic publications and to dissemination beyond Glasgow. These outputs potentially enable the Centre to impact (either directly or in a more diffuse manner) upon those further away from our day-to-day activities. Research papers published from the pSoBid study have made an impact on colleagues researching similar issues in other places. The BMJ paper on plaque counts resulted in the Royal College of Pathologists awarding a Gold Medal to Kevin Deans (the first author) for this work. The pSoBid paper on early life influences prompted interest from CDC Atlanta. Communication in the GCPH e-bulletin about the Centre's literature review on partnership working led to follow-up requests from a range of places. Presentations of GCPH work by other members of the team to international audiences have prompted follow-up requests for further information and advice to inform developments (eg by WHO, European networks, individual cities, and research groups).

However, the GCPH translational role is strongest when working closely with the partners (near to the Centre) who will take actions forward. Proximity enables trust to be developed, allowing challenging findings to be taken on board and facilitating the two-way learning that enhances the relevance of future research. This is a particular strength of the GCPH model, focussing on a city region for a sustained period of time, thereby enabling a depth and duration of working in this way with partners.

From the work of the Centre to date it has become evident that the achievement of changes in policies and practice often requires not only the dissemination of evidence or ideas, but also the **establishment of mutual relationships** that allow learning to be acted upon. Feedback from the Equally Well test site team in Govanhill illustrates the value of this sort of approach.

[6] FMR Research. *GCPH Seminar Series Evaluation* (p25). FMR, 2010.

"The Glasgow Centre's (GCPH) involvement in partnership working in Govanhill through Equally Well has made a difference on several levels from the strategic to the operational; there has definitely been an impact on our ways of working. (Person involved) has quickly adapted to the circumstances within Govanhill and to the partnership dynamics within the area. I have been particularly struck by the way in which he has developed strong working relationships with all partners in the area in a very short time."

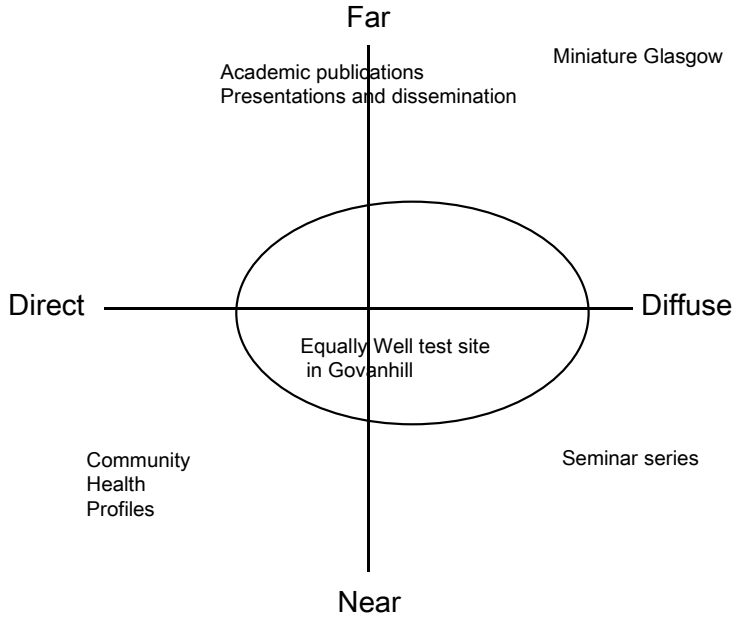
"The GCPH 3-month review of the Govanhill Hub is an output that sticks in the mind – it was critical yet supportive and encouraging. It gave us a steer on some difficult operational issues yet I know partners and staff within the Hub felt positive about the findings." (Personal communication from the chair of the Govanhill Operational Hub.)

And again

"(Person involved*) has developed very positive relationships with a range of individuals and organisations locally and actively contributes to the planning and delivery of the Govanhill Neighbourhood Management Initiative. A particular example of where (person involved) has brought added value to this initiative has been in leading on an evaluation of the Operational Hub – this has really impacted on the way the hub plans and delivers services." " (Person involved) brings a huge amount of added value to the initiative strategically by contributing to planning sessions, facilitating workshops and advising on key trends and data."* (Personal communication from Area Manager, Community Planning South East Team)

The translational activity emanating from GCPH, as summarised above, is illustrated in Figure 3.

Figure 3: Landscape for GCPH translational activity



GCPH outputs have translated into actions across this full landscape, but it is arguably the central area represented by the oval that requires emphasis. It allows

for working not only with discrete and codifiable outputs but with complex ideas the application of which may not be immediately apparent; it goes beyond broadcast approaches to ones that are tailored to particular circumstances; and it allows for co-production and shared learning.

The example of the Centre's work with the Govanhill Equally Well test site has been used to illustrate this. The experience there characterises a set of approaches adopted across the GCPH team, and evident in many other programmes and projects including the following:

- The impacts of the GoWell programme depend on the relationships established with local partners and national government, on the GoWell team responding to feedback and requests from these partners, and on a shared stake in programme delivery. Research outputs could be produced without these, but the ongoing translation of findings into policy impact and action plans could not.
- The programme of practice development and support for CHP actions to address health inequalities has had influence nationally as well as within GGC. Significantly, the GCPH programme manager who led this work reflects that her learning was around what was possible within existing practices, the barriers to change that can hinder implementation, and an understanding of the priorities that motivate colleagues to change. The Centre's independent identity, while being highly conversant with service imperatives, reportedly gave partners a feeling of space to be creative outside the logistics of service delivery and to think about what could be done if they were setting up the service differently.
- The Big Eat In (a secondary school pilot project testing out a lunchtime stay on site school policy) similarly sits within the arena of sustained mutual learning and development involving both direct translation of findings into policy and more diffuse influence. The Big Eat In Pilot itself resulted from earlier research initiated by GCPH looking at primary schools, the recommendations from which were followed-up with key contacts in Glasgow City Council. The GCPH programme manager was asked to reflect on her learning. "*The good relationships were important but also just being able to take time and be sensitive to the reality of practice also helped in taking the process forward.*" "*GCPH was able to demonstrate good practice through the earlier research, particularly around highlighting the issues as a public health priority, and also bring in a dimension that wasn't just about schools but was about the interaction between schools and the environment, bringing in issues such as urban planning, licensing policy, commercial interests etc*." The latter quote again illustrates the added value of not being reliant on direct, linear approaches to influence.

3.5 Summary

This substantial section has summarised the considerable progress already made towards achieving the outcomes agreed for GCPH Phase 2. In this phase, the importance and benefits of the networks and partnerships that have taken time and care to establish – and indeed the Centre's credibility more generally – have become all the more evident.

GCPH is now a well-recognised and established part of the public health landscape in Scotland. It is increasingly looked-to by other organisations to bring a different skill-set, or specific knowledge or expertise, to challenges that they are facing.

The Centre has also fulfilled an agenda-setting role. It has initiated and led a number of developments resulting in changes to the way that things are done. Important policy-relevant research has been carried out, with GCPH providing the necessary mechanisms and environments to bring people together from different sectors and

disciplines, and emphasising the translational aspects of these research programmes.
Direct ('linear') influence has been achieved on important national and local policies and programmes, and this has been important in complementing and enabling the more diffuse influence of the Centre's conceptual and exploratory work.

The reach of the Centre is considerable with over 1500 people on the GCPH network, receiving information about our outputs; many participate in, and are influenced by, GCPH events or work programmes. The Centre reaches into its partner organisations through a variety of routes and at different levels; into academia through its research, publications and conference presentations; into professional training and development through teaching inputs and research supervision; into public discourse through contributions to public events, mass media, and web-based outputs; and into strategic public health developments through membership of/evidence-giving to strategy groups of various types. In doing all of this it draws on, and brings together, learning from its scientific research, its practice development role and its future orientation to make a distinct and unique contribution to the drive to improve population health and reduce health inequalities in Scotland.

In relation to the work for the Scottish Government on children's early years –

"Can I also take the opportunity to thank you profusely for your immense contribution to this work – it's been invaluable!"

Susan Deacon, Honorary Professor, School of Social and Political Science at the University of Edinburgh

SECTION 4 – RESOURCES: HUMAN AND FINANCIAL

This section describes the resources available to the Centre and how these are deployed. Annual budget plans are prepared for the Management Board, with the most recent month-end accounts presented to each Board meeting. The financial governance procedures are those of NHS Greater Glasgow and Clyde, and the Centre's accounts are managed by the Finance Department of the NHS Board.

4.1 Core resources from Scottish Government and local partners

The core resources for GCPH are provided by Scottish Government and the three local partner organisations: NHS Greater Glasgow and Clyde, Glasgow City Council and the University of Glasgow. All four organisations have remained firmly committed in their support for the Centre since its establishment and have sustained their contributions since GCPH was established in 2004. In agreeing to the Partnership Memorandum of Understanding (see Appendix 1) for the current phase of GCPH work, the local partners recognised the difficulty of quantifying the true value of their in-kind contributions but committed to "*contribute on an approximately equal basis over this period, and should any disparities emerge, these will be considered by the Management Board*". These contributions are as follows:

Table 3: Core GCPH resources

Organisation	Description of contribution
Scottish Government	£1,000,000 per annum
NHS Greater Glasgow and Clyde	Funding for the Director's post Financial management and governance HR and recruitment services and support Communications and media support
Glasgow City Council	Office accommodation and property maintenance A regular attachment from Council Services to carry out research IT support Design support for materials
Glasgow University	Participation of academic staff in GCPH research programmes Provision of venues for GCPH events Assistance with external grant funding bids

While the Scottish Government's annual allocation has been a fixed amount from GCPH's inception, the Centre's operational costs have increased year-on-year, mainly due to pay increments and awards. The impact of the fixed allocation has been mitigated by the fact that underspends arising in the earlier years of the Centre's life, while the work programmes were building up, have been available to cover increased costs in more recent years (and indeed the core award for 2010/11 was reduced by £240,000 in light of unallocated early underspend). However, no residual underspend is expected beyond 31 March 2012 should the Centre continue, making reconsideration of the size of the core grant highly desirable in the interests of maintaining an appropriately high level of activity. By way of illustration, it has been calculated that GCPH's allocation for the 2011/12 financial year would be £1,332,121 instead of £1m had the Centre experienced the same percentage increases to its funding as NHSGGC.

Central to the Centre's success is the quality and commitment of the staff team, who comprise a highly valued resource not only for the GCPH partnership but also for

population health more widely in Scotland. Details of the team, and of those who have elected to come to GCPH for training or other experience, are contained in Appendix 5. It is notable that despite the greater degree of contractual security provided in other public health organisations and academic departments, the specific role of GCPH – working at the interface of research, policy and practice, and focusing on the intractable health issues of the Glasgow city region – has attracted and sustained this skilled staff group.

4.2 Additional income generated for specific programmes

The amount of income secured in addition to the core funding has been considerably higher in recent years than it was in Phase 1 (see Table 4). Income generated by the Centre has grown year-on-year, and comprises funding for substantial long-term programmes (most notably GoWell, and the Culture and Wellbeing programme) as well as for smaller-scale programmes (such as those on alcohol and breastfeeding).

Almost all of this additional income for specific initiatives comes from government or the NHS in Scotland. Members of the GCPH have also been successful in securing some funding from research bodies (JRF, shown above; the CSO (£224,000), and the NIHR/SDO programme (£299,566) – the last two in conjunction with academic colleagues whose institutions hold these grants, and on which grant applications GCPH staff were co-applicants). Three other substantial grant applications (one to ESRC and the others to the NIHR Public Health Research Programme) in which GCPH staff played a central role were unsuccessful. However these will be revised and resubmitted should partners continue to regard them as a priority. Other research grant applications are currently in development/under consideration.

Table 4: Income generation

2004/05:	**Total £15,000**
2005/06:	**Total £141,750**
▪ GoWell funding NHS Health Scotland, Communities Scotland and NHSGGC	£127,250
▪ Other	£14,500
2006/07:	**Total £236,390**
▪ GoWell funding NHS Health Scotland, Communities Scotland and NHSGGC	£153,200
▪ Positive mental health programme funding from Scottish Executive	£70,000
▪ Others	£13,190
2007/08:	**Total £382,538**
▪ GoWell funding NHS Health Scotland, Communities Scotland and NHSGGC	£153,200
▪ Smoking study funding from NHS Health Scotland and NHSGGC	£47,000
▪ Culture and wellbeing programme funding from Scottish Government	£70,000
▪ Others	£112,383
2008/09:	**Total £449,611**
▪ GoWell funding NHS Health Scotland, Scottish Government and NHSGGC	£143,812
▪ Smoking study funding from NHS Health Scotland and NHSGGC	£34,000
▪ Culture and wellbeing programme funding from Scottish Government	£105,204
▪ Alcohol study funding from JRF	£35,613
▪ Scottish Observatory for Work and Health funding NHS Lanarkshire, NHSGGC, Scottish Government and Scottish Centre for Healthy Working Lives	£55,000
▪ Others	£75,982

2009/10	**Total £612,986**
▪ GoWell funding NHS Health Scotland, Scottish Government and NHSGGC	£261,676
▪ Culture and wellbeing programme funding from Scottish Government	£110,229
▪ Alcohol study funding from JRF	£36,370
▪ Equally Well test site funding from Scottish Government	£89,293
▪ Scottish Observatory for Work and Health funding NHS Lanarkshire, NHSGGC, Scottish Government and Scottish Centre for Healthy Working Lives	£60,000
▪ Others	£55,418
2010/11*	**Total £590,754**
▪ GoWell funding NHS Health Scotland, Scottish Government and NHSGGC	£261,676
▪ Culture and wellbeing programme funding from Scottish Government	£110,245
▪ Healthier Wealthier Children evaluation funding from Scottish Government	£45,700
▪ Equally Well test site funding from Scottish Government	£69,883
▪ Scottish Observatory for Work and Health funding NHS Lanarkshire, NHSGGC, Scottish Government and Scottish Centre for Healthy Working Lives	£60,000
▪ Breastfeeding research, funding from SCPHRP	£36,800
▪ Others	£6,500

4.3 Summarised annual expenditure

GCPH expenditure falls into four categories: research, communications, Centre management and running costs, and core staffing. The breakdown across these categories over the past three financial years is shown in Table 5. The figures for 2010/11 are those from the financial plan for the year; for the other two years they reflect actual expenditure.

Table 5: Summary expenditure

	2008/09	**2009/10**	**2010/11**
Research	£871,144	£839,515	£1,413,286
Communications	£93,061	£30,726	£50,000
Running costs	£129,767	£79,547	£120,000
Core staffing	£407,681	£586,664	£658,423
Total	£1,501,653	£1,536,451	£2,241,709

Several points are evident from this Table.

First, the research expenditure is highly variable. This reflects expenditure associated with income generated for specific programmes, a shifting balance between research carried out 'in-house' and that commissioned externally, and the costs associated with different phases of research programmes (most costs being associated with data collection and analysis, rather than the developmental and dissemination phases). For example, the jump in predicted research expenditure in 2010/11 is significantly driven by research commissioned to further explore the 'Glasgow effect', involving data collection in Manchester and Liverpool as well as Glasgow.

* Final total not yet confirmed in end of year accounts

Second, core staffing costs are increasing steadily year-on-year. This is partly explained by an increase in staff numbers – reflecting the recommendation from the last funding review to reconsider the GCPH 'research funding' role, with a view to focussing research on core GCPH programme areas, and to managing more of the research in-house. As a result, since the first funding review, a number of time-limited Public Health Research Specialist posts have been established, managed by the Centre's public health programme managers and fulfilling direct research and development roles within these programmes. The only additional senior post created in the Centre has been the Deputy Director post (again a recommendation from the last funding review). The increase in core staffing costs is also, of course, a reflection of individuals' moving up their incremental scales and of pay awards.

Lastly, communications costs and running costs are being contained. Annual variations reflect particular circumstances (eg the publication of the community health profiles for NHSGGC, and the move to new office accommodation in 2008/09). The move to fewer paper-based publications, and the associated development of the Centre's e-communications, is enabling savings to be made on both of these lines and the aim is to contain total costs in these two categories to £150,000 per annum for the foreseeable future.

4.4 Summary

Prior to considering future direction, a few points can be drawn out in summary.

- All partners have maintained a strong commitment to the Centre, and have sustained their contributions (whether in cash or in kind) throughout the past eight years. This has enabled GCPH to grow its activities, recruit and develop a strong and valued team of staff, and deliver on the substantial – and in many ways ground-breaking – body of work described in this report.
- Over the period, the Centre has steadily generated increasing amounts of income over and above its core allocation. This is tied to particular initiatives, and does not contribute to the general running costs or infrastructure of GCPH.
- Annual expenditure associated with the current level and type of activity is now over £1.5m, with core salary costs (excluding the Director and those funded from grants additional to the core allocation) projected as £679,446 for the 2011/12 financial year. Longer-term projections are problematic given current uncertainties about public sector pay awards, but on the basis of an average annual increment of 2% to cover pay inflation and any scale increments, the salary costs associated with current core staffing levels are projected to rise to £750,161 by 2016/17.
- Moving forward, the aim is to contain the costs of running the Centre and its communication activities to £150,000 pa. Nevertheless, if core funding remains at current levels, the core staffing complement (ie those not funded from short-term, programme-linked grants) will need to be reduced in order for there to be sufficient funds available to enable the GCPH team to carry out the research and other activities required for them to fulfil their roles.
- The next section presents some possibilities for the future, the implications of which can be considered as part of this funding review process.

In relation to Miniature Glasgow –
"I think this is a first class tool in explaining the mix of Glasgow's population in an easily understood manner to a disparate audience."
Robert Booth, Executive Director, Glasgow City Council

SECTION 5 – LOOKING AHEAD

Scotland's health profile is a matter of major national importance. It compares poorly internationally, and is improving at a slower rate than other comparable countries. High mortality within the West of Scotland has a substantial impact on these national mortality rates. Within Scotland, all but eight local authority areas have premature death rates (men, aged 0-64, 2001 data) that are better than the Scottish rate as a whole[7]. Scotland's health problems are concentrated in those other eight council areas: Glasgow City is the most extreme (having a rate 64% greater than Scotland) followed by Inverclyde and West Dunbartonshire. These areas continue to need particular attention and sustained consideration of how their health situation can be turned around. Ongoing investment, to get to grips with the causes of their health deficit and to identify appropriate responses commensurate with the 21st century context, is essential. The GCPH's focus on west central Scotland has enabled the building-up of an unprecedented depth of understanding and insight into the area's health, together with development of the networks, trust and relationships that are necessary to deliver change.

5.1 Building on the Centre's distinctive contribution

Within Scotland, GCPH makes a distinct contribution through the combination of:

- having a strong analytical base, synthesising intelligence and insights from a range of disciplines and perspectives
- working firmly at the interface between research, policy and practice with a particular focus on health inequalities; ensuring that the research is relevant to – and connected with – policy and practice
- establishing an orientation towards the future; exploring different ways of doing things, and showing that change is necessary and achievable
- engaging a wide body of people in public health, and building capacity for good decision-making and action on health inequalities.

The following three factors are fundamental to the Centre achieving its contribution. First, the co-location and combination of the three original GCPH functions (public health information, evidence-building and future-oriented fresh thinking) has been essential.
Second, the Centre's focus on knowledge utilisation has led to a premium being placed on attending to translational approaches and the usability of the research as an integral part of the research process.
Thirdly, the Centre's partnership structure has fostered shared ownership of and commitment to the work.

The Centre remains a highly relevant and critically important resource for continued efforts to improve health and reduce health inequalities in Scotland. Its achievements to date have taken time and sustained effort, as well as intelligence of various forms. The Centre's distinctive characteristics and its focus on the least healthy parts of the country should be preserved. Making a difference in Glasgow will make a difference nationally; and through understanding the drivers of this area's poor health we have the potential to prevent similar circumstances developing elsewhere.

5.2 What might Phase 3 look like?

Several issues core to the current review process (eg resources, timeframes, partner priorities, and understanding of how GCPH best 'adds value') need to be clarified before it is possible to develop plans for the next phase of GCPH activity. What

[7] Leyland AH, Dundas R, McLoone P, Boddy FA (2007). *Inequalities in Mortality in Scotland 1981-2001* MRC Social and Public Health Sciences Unit Occasional Paper no.16

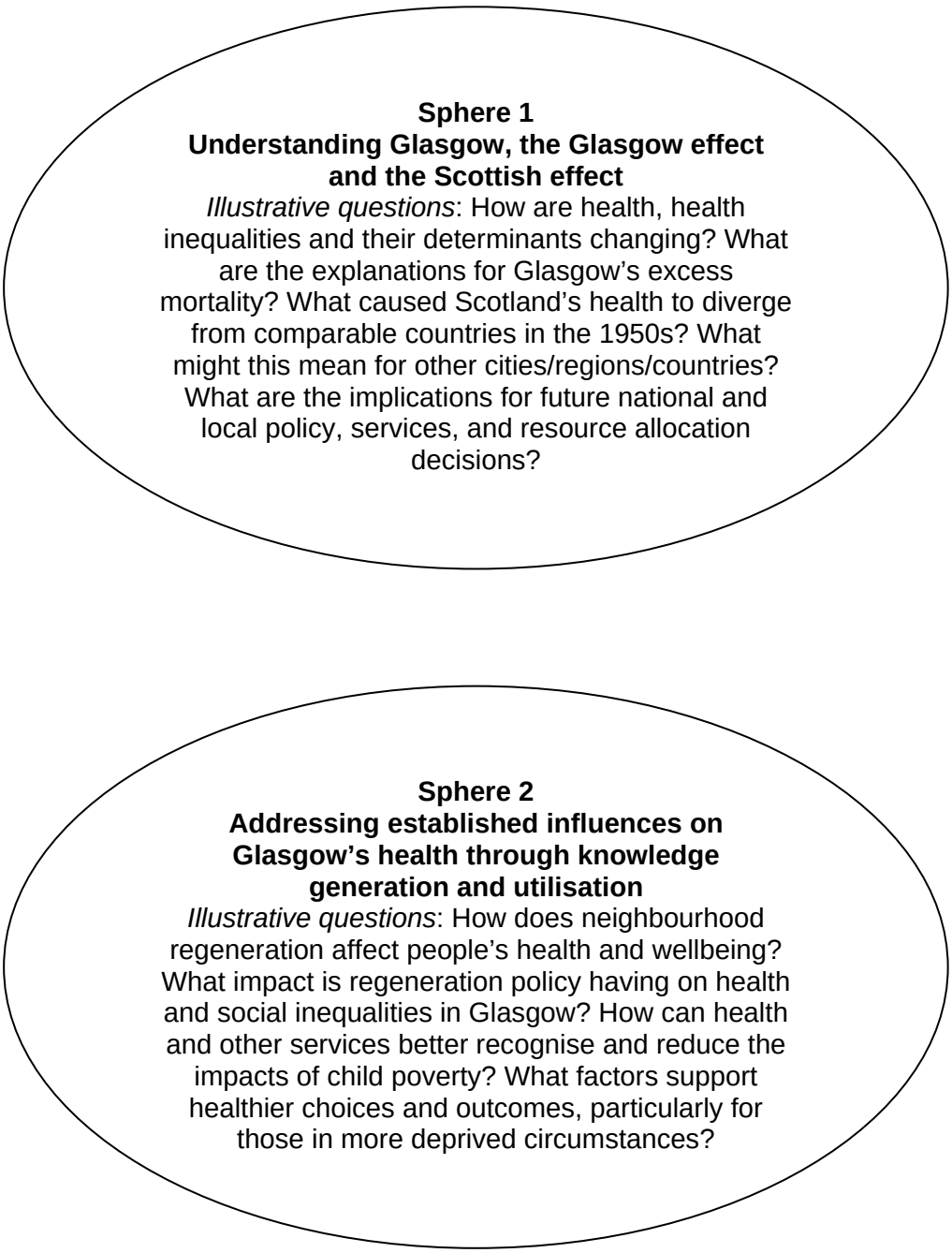
follows is therefore not a plan. Instead, a number of spheres of activity are proposed, on which the GCPH expertise might best be focussed as we move forward. These build upon established momentum and collectively seek to maximise the Centre's impact on the systems within Glasgow, nationally and beyond that could create the conditions for a different health profile in the future.

Fundamental to the approach taken is a recognition that the current financial climate necessitates, even more than before, a need to work efficiently and maximise the value realised from the resources that are available. The following approaches are among those that will be taken to achieve this.

- Containing the annual running costs of the Centre, including expenditure on communications, to £150,000 (a 12% reduction on 2010/11 plans).
- Maximising the synergies and collective expertise within the GCPH core team, by moving from the 12 separate programmes of delivery listed in Table 1 of this report to a smaller number of 'clusters'/spheres of activity. This should yield benefits and efficiencies associated with team working.
- Continuing to pursue the generation of income additional to the Centre's core funding and in-kind support. Research partnerships will be important for this, and the establishment of the new Institute for Health and Wellbeing at the University of Glasgow (to which GCPH will be affiliated) provides an opportunity for these to be further developed.
- Investing in retaining and building the Centre's staff expertise, which is our most valuable resource; and also investing in building capacity among the Centre's core partners, who collectively represent a large and influential force with the potential to impact directly on the population's health.
- Making the most of the Centre's established networks, and the evidence and insights generated during Phase 1 and Phase 2. Added emphasis will be placed on ensuring that learning from work to date is maximised, and that existing findings/materials are used to support changes in policy and practice.

Four spheres of activity are proposed as the priority areas of focus as we look ahead, building on what has been achieved to date. These are represented in Figure 4. The text that follows seeks to illustrate what could be achieved in five years' time, if these spheres of activity were to be adequately resourced and taken forward with the full support of partner organisations. In the longer term, work in each area has the potential to lead to better use of national and local resources, as a result of the evidence generated and the approaches developed.

Figure 4 Proposed spheres of activity for Phase 3



Sphere 3
Support for service redesign
Illustrative questions: What are the characteristics of services/projects that build personal capabilities and assets? What are the differential impacts of these approaches on different population groups? What further guidance/information is needed to develop the role of CHPs and other services in addressing health inequalities? How can health impact more routinely be considered in decision-making? What new service models are needed to reflect the operating conditions of the 21st Century?

Sphere 4
Leadership orientated towards a different future
Illustrative questions: What are the characteristics of a governance system that supports action on health inequalities? What skills and approaches will be needed to provide leadership on health in the future? Can the necessary combination of practical developments, service change, leadership, governance mechanisms and public participation be put in place to provide tangible case studies of how different approaches might be implemented?

5.3 Sphere 1: Understanding Glasgow, the Glasgow effect and the Scottish effect

Activities within this sphere will focus on getting a better understanding of the factors that have caused health in the Glasgow area, and in Scotland more generally, to diverge from comparable cities/regions/countries. The work carried out in this arena in Phase 2 has been of international significance and is highly valued by policy-makers and practitioners in Greater Glasgow and beyond. A good understanding of what's happening to the city's health and its determinants is needed to inform policies and interventions and to monitor change over time. It also forms an essential underpinning for all of the Centre's work. In addition to the epidemiological analyses at the core of this sphere of activity, in Phase 3 the work will bring qualitative research insights alongside the quantitative and continue to develop ways to make population health information accessible and useful to non-specialist audiences.

What will success look like in five years' time?

- The Glasgow Indicators project – and the associated child health indicators – will be fully developed, including within-Glasgow comparisons and city comparisons. The indicators will be regularly used by policy makers and planners in the city to inform priorities and to support integrated planning with a focus on improving the city's health. The indicator set will allow monitoring of progress across sectors.
- The multi-faceted programme of research into the Glasgow effect and Scottish effect will have led to a reframing of our understanding of the system that creates health in Glasgow and Scotland. Different disciplines and perspectives will have been brought to bear, yielding new insights on the issues. The resultant understanding will be widely shared and accepted.
- Findings from the culture and wellbeing programme will have been distilled for Glasgow and integrated into the processes above, so that the role of wider global and cultural influences is reflected in our understanding of the more local health situation.
- Implications for policy, resource allocation decisions, and practice will be identified.
- Findings and methodological developments will be disseminated widely.

5.4 Sphere 2: Addressing established influences on Glasgow's health and health inequalities through knowledge generation and utilisation

GCPH has been central to the establishment of a range of research and evaluation programmes which focus on factors known to impact on population health and health inequalities. These factors include life circumstances (like poverty and housing) as well as health-related behaviours (like breastfeeding and alcohol consumption). The studies are firmly rooted in the objectives of better understanding the impact of (established or new) interventions and recommending ways in which that impact might be increased. They have national policy significance as well as local relevance. The studies vary in scale: some have been quite small and short-term, others built up into a more comprehensive programme. The largest is GoWell which comprises a longitudinal, multi-method, research and learning programme currently scheduled to run to 2015. Areas of focus reflect priority issues for partners (breastfeeding, for example) and new service developments (such as Healthier, Wealthier Children). A depth of insight is gained from sustained research endeavours over a period of time and it is therefore proposed that, while there are many additional areas about which knowledge is needed, the priority is to sustain the programmes that will run beyond the end of March 2012 (GoWell, food in schools, child poverty) and if resources permit to build upon others with the potential to make a distinct contribution to national and local policy (young people and alcohol, breastfeeding, incentives for

behaviour change). New areas of focus (eg mental wellbeing) might also be developed. During Phase 2, GCPH supported the building of academic capacity in the economics of public health. This will enable economic analyses to be incorporated into some of these programmes in the future, thereby further strengthening their potential to assess the cost-effectiveness/value for money of interventions.

What will success look like in five years' time?

- GoWell: The fourth survey wave will have been carried out, with analysis thereafter. The programme's evidence about the processes and impacts of area-based approaches to regeneration will have been widely disseminated, contributing to Scotland being recognised internationally for its research in this field. Implications for service redesign, community empowerment and better use of regeneration budgets will have been highlighted and used to influence national and local policy, as well as action plans of partner organisations.
- Action to reduce child poverty will have been given priority in a sustained way by the Community Planning Partnership and national government. Building on the Healthier Wealthier Children evaluation, GCPH will have become known as a source of expertise on the role of mainstream services in recognising and reducing the health impacts of child poverty. This expertise will be being applied not only in the NHS in GGC but more widely.
- Further development will have taken place of the Centre's Phase 2 research into new approaches with the potential to impact upon some of the intractable health-related behaviours that are predominant in poorer communities. Possibilities include: follow-up research and development work on the issues of breastfeeding (in Phase 2 we examined the reasons why some deprived communities have seen increases that are not typical of comparable communities); alcohol and young people (in Phase 2, qualitative research examined young people's drinking at different life stages and by gender); the use of financial incentives to support smoking cessation in pregnancy; and approaches (in-school and in the wider environment) to support healthier lunchtime consumption among secondary school pupils.
- GCPH will routinely provide evidence and information to advocate for and support public health action by local authorities and others, building on experience in Phase 2 on issues like 20mph zones.

5.5 Sphere 3: Support for service redesign

The focus here will be on supporting service development and implementation to impact on health inequalities. There are three axes in this sphere. The first involves new primary research focussing on understanding the characteristics and health impacts of asset-based projects and services. It also builds on the important work carried out in the Centre to understand the role of social networks. The second takes further a number of approaches (like HIA, the integration of health considerations into planning, and support for CHPs) that the Centre has been involved in developing or evaluating, and seeks to embed them more firmly and widely. The third recognises that, in the new economic and environmental climates, current models of service provision are unsustainable. New approaches, which more accurately reflect the operating conditions of the 21st Century, are needed.

What will success look like in five years' time?

- New service models will seek to build on clients' assets and involve interventions that increase personal capacities. There will be a shift towards more community-led and person-centred services. The GCPH contribution to these developments will have involved a new programme of intervention research that builds on both the pSoBid study and a theoretical framework developed from case studies examined at the end of Phase 2. pSoBid elucidated differences between deprivation groups in cognitive health, personality profiles and a range of biomarkers. In phase 3, GCPH will evaluate asset-based interventions to assess their impact on a similar range of markers, and to develop evidence as to how these interventions can take account of and help to address some of the psychological and social factors underpinning health inequalities. Attention will be paid to issues of resilience and social networks. Although focussed on Glasgow this research will have national implications.
- GCPH will have worked with community planning partners and other organisations in Glasgow to strengthen the city's approaches to community empowerment. As a result, there will be increased community influence on decisions and asset management.
- Health impact assessment will be a more regular part of policy development, with a wide awareness and acceptance of the tools and approaches.
- Health considerations will be routinely taken into account in area-based planning processes in the city. The range of Healthy Urban Planning developments supported by the Centre, the city's lead role in the WHO Healthy Urban Environment networks, and the experience from the Equally Well test site will collectively have provided a strong and convincing basis from which to mainstream these approaches. The successes of the Equally Well test site in Govanhill will also have been taken further, with neighbourhood management models being introduced to other localities.
- Nationally, CHPs and other services will have further guidance on their roles in addressing health inequalities, informed by the inequalities framework developed during Phase 2. GCPH will have continued to support that national development, and in parallel will have developed a linked framework/approach to support services in addressing mental health inequalities.
- In light of the economic constraints of the recession, the unsustainable nature of established models of service, demographic trends and the poor population health outcomes being achieved, there will be wide recognition that new models of service delivery are needed and GCPH will play a role in defining the characteristics of such service models.

5.6 Sphere 4: Leadership orientated towards a different future

The effects of services and interventions are partly determined by the contexts in which they operate. GCPH activities within this sphere will seek to support the development of cultures and organisational contexts that will enhance the effectiveness of interventions to address inequalities. Without commensurate attention to these wider contextual issues, programmatic interventions will not achieve the necessary impact.

What will success look like in five years' time?

- The wisdom and materials generated through the GCPH seminar series (8 series will have been held by the end of Phase 2), Healthier Future Forums (14 will have been held), civic conversation, scientific meetings and research outputs will have been further disseminated, synthesised and distilled to facilitate change in the approaches adopted by partner organisations and others. Members of the GCPH

team will place a greater emphasis on contributing to processes of leadership development, event facilitation, CPD and organisational development.
- There will be new models of governance that support action on health inequalities. These might include different types of accountability. GCPH will have been involved in national and local discussions about such developments.
- Supporting the presence of leadership orientated towards a different future will have required some specific 'case studies' to work through the implications of different types of leadership, how existing approaches to service delivery might be changed, how public support might be mobilised and so on. Potential 'case studies' are: (i) The Child-friendly City, taking forward the Glasgow Health Commission's recommendation in this regard; (ii) The Resilient City, taking forward the implications of the GCPH review of past and future influences on Glasgow's health; and (iii) The Sustainable, Active City, committed to supporting active travel and physical activity more generally, and the development of an infrastructure that places a priority on reducing the city's ecological footprint. Working with partners, the GCPH will have had an important leadership role in taking developments such as these forward, providing evidence, demonstrating the feasibility of alternatives to the established ways of doing things, supporting change and monitoring progress. This will help to strengthen Glasgow's resilience in a global context of rapid change and uncertainty. Again, these local developments will have national relevance.

5.6 Resource requirements

What is set out above represents a portfolio of work more ambitious and far-reaching than that delivered by the Centre in either of its previous phases. Within each of the four spheres of activity, the scale will be determined by the amount of resource available. Once the future priorities for the Centre have been agreed, the relevant proposals will be developed into costed plans for more detailed consideration. It is not feasible to provide detailed costing at this stage. However, to guide discussions about future options, an indicative and very provisional outline of the resource requirements follows.

Staffing

- Current staff funded from GCPH core funding comprise the Deputy Director, 6 public health programme managers, 4 public health research specialists, the communications manager and officer, the office manager, two programme administrators and the team administrator.
- The collaboration with the International Futures Forum, which has been central to establishing the seminar series and building a future consciousness into all GCPH programmes, adds an additional 60% FTE to that core staff resource.
- Current core staffing levels would indicatively enable two senior staff and one research specialist to be deployed on each of the four spheres of activity described above. This would allow demonstrable progress to be made in each of the spheres.
- Associated costs for these posts are £720,000 for 2011/12 and are projected to rise to £790,000 by 2016/17.
- The Director's post is contributed as part of the NHSGGC contribution to the Centre. All other posts are funded from additional income generated or from research/programme budgets.

Communications and running costs

- In line with the assumptions set out above, it is planned that these be contained to £150,000 per annum, representing a 12% reduction on 2010/11.

Research and development activities

- It is in this area of expenditure that costs are most difficult to predict.
- There is potential for research in spheres 1-3 to be funded (at least in part) from additional income generated. This approach will fit well with some of the research proposed but not with the more exploratory research and practice-based evaluations. Nor does it fit with the completion of existing programmes. Additionally, time delays in securing funding mean that research linked to policy developments in the shorter-term is more appropriately funded from the Centre's programme budgets if at all feasible.
- Sphere 1: This area of activity is now well-placed to seek external research funding for further studies relevant to understanding the Glasgow effect/Scottish effect phenomena. However, costs associated with the development of Understanding Glasgow and the associated childrens' indicators, with local surveys, and with approaches to support the use of population health information to inform planning and practice should be met from the Centre's core funding. Based on experience to date, a minimum of £30,000 pa is required for these developments. Additional core funding would enable further issue-based research to be progressed more quickly. Priorities previously identified include analyses looking at the contribution of drugs and alcohol to the Glasgow effect/Scottish effect. This is an example of important thematic work which could be undertaken immediately from 2012/13 if funding were made available for an additional public health research specialist.
- Sphere 2: As a minimum, continuation of the established research programmes on GoWell, child poverty and food in schools is proposed. The full benefits of investments to date will not be realised if such programmes do not continue. The annual GCPH programme costs associated with these programmes (containing them at 2010/11 levels) would be: GoWell (£100,000), child poverty (currently all externally funded), food in schools (£30,000). As with Sphere 1, external research funding would be sought for further studies but if continuity would be beneficial (eg in relation to action on child poverty) or there are particular time-pressures or policy timescales to be met, the Centre team could deliver other policy- and practice- relevant research if it was funded to do so.
- Sphere 3 is premised on a significant new research programme, building on pSoBid findings and generating new evidence about asset-based approaches to tackling health inequalities. This would require funding. As a ball-park, the nearest comparison is the pSoBid study which cost £100,000 per annum for 2 years in addition to major contributions of staff time from Glasgow University. It would be highly desirable to retain enough capacity to evaluate the longer-term effects of the Equally Well test sites in Glasgow, beyond the current period of Scottish Government funding for Equally Well (which runs to April 2012). This capacity is not currently included within the GCPH core allocation, and a strong case could be made for providing funding for one public health research specialist to do this work (£50,000 pa). The other core programme cost in this sphere concerns the funding of HIA and healthy urban planning activities. Commensurate with Sphere 1, an annual budget of £30,000 is proposed. In Phases 1 and 2, contributions to the Greenspace Partnership, and to meet some of the costs associated with Glasgow's participation in the Healthy Cities network, have been met by GCPH. It would be desirable to continue to meet these costs (ave total £50,000), but they are not included as prerequisites here.
- Sphere 4: Delivery in this sphere of activity depends less on the availability of a programme budget than on the capacity within the core team and the commitment of local partner organisations. It will require additional inputs from external experts in leadership development, organisational development and

group facilitation. It will also require the capacity to bring to Glasgow experts and exemplars from elsewhere, and to undertake small-scale research into organisational and community cultures. Recognising that the scale and scope of these inputs will need to be defined in detail, an indicative sum of £40,000 is proposed.

Table 6: Indicative resource requirements

	Minimum annual costs	Additional priorities
Core staffing	(2016/17 costs) £790,000	
Communications and running costs	£150,000	
Sphere 1 R&D	£30,000	£50,000
Sphere 2 R&D	£130,000	£50,000 per additional topic[8]
Sphere 3 R&D	£180,000	
Sphere 4 R&D	£40,000	
TOTAL	£1,320,000	

From this Table it is evident that the GCPH could deliver on the portfolio of work described above if a one-off re-levelling of core funding was applied. (As noted in section 4.1, it has been calculated that GCPH's allocation for the 2011/12 financial year would be £1,332,121 instead of £1m had the Centre experienced the same percentage increase to its funding as NHSGGC.) If additional programmes within Sphere 1 or Sphere 2 are seen as priorities, there is an indicative cost of £50,000 per topic. Note too that Table 6 is calculated on the basis of projected salary costs at the *end* of a five year period. At the start of the period core salary costs (including the IFF collaboration) are approx £720,000 (£70,000 less), so if flat funding was provided at this level, additional research in Sphere 1 and/or Sphere 2 could be carried out at the start of Phase 3 without additional resources being required.

Should funding be provided at the original level of £1m per annum then it will not be possible to retain the Centre's complement of core staff or to deliver the full spectrum of proposed activity.

5.6 Summary

Over the past decade, Scottish governments of all hues have stated their commitment to placing health and social inequalities at the heart of policy-making and service delivery. Progress has been made but major challenges remain. The issues addressed by policy frameworks such as *Equally Well*; *the NHS Scotland Quality Strategy* and *Achieving our Potential: a framework to tackle poverty and income inequality in Scotland* are long term and complex. In addition, a Discussion Paper on Community Regeneration is being developed and there is cross-government involvement in the development of asset-based approaches. Progress is needed over a range of timescales and through a coherent set of approaches, informed by a depth of insight into the causes and consequences of poor population health and an orientation towards a different future.

The four areas of focus proposed above would:

- help to explain why Scotland's health and Glasgow's health diverged from comparable places over the latter half of the 20th Century

[8] NOTE: ballpark figures based on a having an in-house researcher and a small level of data collection /transcription/analysis costs.

- contribute to a stronger evidence-base on how to address established determinants of health inequality (such as area deprivation, child poverty, and health-related behaviours)
- attend to the processes of knowledge transfer and utilisation required to impact on policy and practice
- champion new city-level developments, designed to position Glasgow more strongly for a healthier and sustainable future, and
- support and evaluate a range of approaches to service reform, in the context of financial pressures and the need to prioritise environmental sustainability.

Each of these is a major agenda, and depending on the resources available and feedback from this funding review process, some may need to be dropped, or different priorities identified. The GCPH track record indicates a high level of output, leadership and influence achieved from the resources put in to the Centre. The GCPH team looks forward to further discussions about the way ahead, and to building on the Centre's achievements to date.

In relation to Understanding Glasgow -

"Congratulations. A major achievement to have brought all this together and more to the point, to have brought all the people together around this shared enterprise."
Prof Bill Sharpe, Visiting Professor, University of the West of England

ACKNOWLEDGEMENTS

This report has been produced for consideration as part of the GCPH funding review being carried out in Spring 2011. The funding review will comprise an assessment both of the extent to which the Centre has delivered on its aims, and of the role it could/should play in the future. The review will obtain in-depth feedback through interviews with some key stakeholders, and anyone is welcome to contribute views through the GCPH website or in writing. I hope that many people will take the opportunity to let us know what they think about what we do and how we might develop in future.

The progress in this report has been made possible through the support, hard work and contributions of many people. Many thanks are due to them all: our funders and partners; the principal investigators and researchers on GCPH projects; those who learn and work with us in a range of ways; members of our steering and advisory structures who give so generously of their time and expertise; and at the heart of it all, the core GCPH team. Sir John Arbuthnott was the driver behind the Centre's establishment and the initial chair of our Management Board. This baton was picked up by Andrew Robertson OBE in 2008 and he has given his support and leadership to the Centre's work in a wide range of ways, enthusiastically championing the importance of a focus on communities and inequality. Sir David Carter has expertly chaired the External Advisory Group, with a perfect mix of intellectual rigour, humanity and good humour. The members of the Executive Management Team have been a regular source of advice and guidance, and have personified the GCPH partnership structure at its best. Particular thanks are also due to a number of other individuals, but it is not possible to mention them all here. I am truly grateful for their wisdom and support.

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