Scottish Parliament Cross Party Group on Health Inequalities

SUMMARY REPORT OF MEETINGS HELD SEPTEMBER 2015 TO FEBRUARY 2016

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Introduction

Voluntary Health Scotland (VHS) has compiled a brief overview of presentations and discussions which have taken place at the CPG on Health Inequalities since September 2015. Contributions have been diverse and informative, and have generated significant engagement from attendees. Notably, attendance has increased significantly at each meeting, reflecting a high level of interest in the chosen meeting topics and the speakers selected to present.

VHS was appointed as Secretariat to the Group on 4th June 2015 and proposes to continue this role once the Group is re-registered following the May 2016 Scottish elections.

The summary below details meetings which covered the topics of housing and health inequalities; health and social care integration and health inequalities, and a spotlight on research into health inequalities.

As a reminder, the recorded purpose of the CPG on Health Inequalities is:

- to raise awareness of the causes of health inequalities amongst parliamentarians to influence legislation.

- to raise awareness of the causes of health inequalities amongst policy makers to promote evidence based actions which reduce health inequalities.
- to avoid legislation and policies which will make health inequalities in Scotland worse.

Housing and Health Inequalities – 10th September 2015

There were two presentations:

1. Katy Hetherington of NHS Health Scotland and Neil Hamlet of NHS Fife, co-authors and presenters of the report published by the Scottish Public Health Network (SPHN): *Restoring the Public Health Response to Homelessness in Scotland.*
2. Fiona King of Shelter Scotland, on the final report of The Commission on Housing and Wellbeing: *A blueprint for Scotland's future.*

Presentation one highlights: *Restoring the Public Health Response to Homelessness in Scotland*

The issues:

- Homelessness is not a new issue for the NHS: Health and Homelessness Standards were put in place for NHS Boards and partners in 2005 but now need revised and updated.
- Homeless and insecurely-housed people have much poorer mental and physical health profiles than the general population and are at much higher risk of death from a range of causes.
- Poor health is both an effect and cause of homelessness.
- Homeless and insecurely-housed people have dramatically higher rates of attendance at Accident and Emergency ('frequent fliers') compared to the general population.
- They have higher rates of non-attendance (DNA) at new outpatient appointments (changed address, fearful to open mail, no money for bus, no confidence the appointment will do any good etc).

Early wins and developments:

- The presenters' research included speaking to many non-NHS staff about what they think can and must be done to address these poor health outcomes.
- The Health Promoting Health Service Chief Executive's letter (CEL 01 2012) is a mechanism for bringing homelessness into action reporting by health boards.

- Useful developments include: Housing Hubs Training Toolkit health module; the Commission on Housing and Wellbeing; the new Homelessness Prevention and Strategy Group; awareness raising on back of NHS Fife's data linkage work.

Key learning:

- Multiple exclusion homelessness: overlapping of mental ill-health, substance misuse, offending and prison.
- Early childhood trauma.
- Visible homelessness happens late – people present as last resort.
- High cost of this 'churn' to society – estimated at £250k to £1 million over an individual's lifetime.
- Home as either the springboard to nurture, education, life chances – or the place where opportunity is crushed out of you.
- Housing's contribution to good health and social care (housing and social care partnerships need to support housing and homelessness within remits; role of the partnerships' strategic commissioning process).

What next?

- Create a Scottish faculty of homelessness and inclusion health.
- Get the new National Health and Homelessness Group up and running.
- Event planned on remote and rural issues (December tbc).
- Exploring opportunities with Scottish Prison Service (SPS), Joint Improvement Team (JIT), The Institute for Research and Innovation in Social Services (IRISS).

Presentation two highlights: *A blueprint for Scotland's future, The Commission on Housing and Wellbeing*

- Established by national charity Shelter Scotland, the purpose of the independent Commission was to examine the relationship between housing and wellbeing; to test the established views of the housing sector against other perspectives, and to build understanding and links across from housing into other sectors. All but one of the Commissioners were non-housing people.
- The Commission selected eight types of wellbeing relevant to assessing the benefits of good housing. One of these was health.
- Its final report was published on 10th June 2015. *A blueprint for Scotland* contains 47 recommendations for action. Shelter Scotland is focused on raising awareness of the report, stimulating discussion and getting the recommendations onto the public agenda.
- Scale and cost of some key issues:
    - 30% of prisoners leave prison with no address to go;

    - re-offending increases dramatically where people have nowhere to stay;
    - it costs £26k to see a homeless person through the homelessness process;
    - 39% of Scottish households experience fuel poverty;
    - homeless children miss 55 days of school pa on average.
- Housing which is secure, adequately heated and free of serious condensation and dampness and which provides adequate space and supports independent living is important for good physical and psychological health and positive educational outcomes.
- Housing should be a full and equal partner in health and social care partnerships.

Questions and discussion following presentations:

- What scope there was for those present to get involved with the National Health and Homelessness Group.
- The importance of involving 'experts by experience' when looking for solutions, including people with experience of prison. The valuable role of the organisations Positive Prisons and VOX. Scottish Prison Service has now employed a policy specialist on housing, with whom the Scottish Public Health Network plan to engage.
- Whether NHS Fife's experience of 'A&E frequent fliers' was likely to be replicated elsewhere. Also, the extent to which integrated teams designed to support people with multiple problems, such as the long-established Edinburgh Access Practice (NHS Lothian/Keep Well) had been replicated elsewhere in Scotland.
- Edinburgh Access Practice means that some homeless people are supported into more sustainable solutions eventually, but some are so damaged and/or fearful of mainstream services (e.g. can't cope with tenancy rules) that this is not realistic. Edinburgh's experience is that austerity measures/benefit sanctions are driving up homelessness and insecure housing. Edinburgh has created a network of advocates who can talk to DWP officials when necessary.
- The abolition of the need for homeless people to demonstrate they are in 'priority need' has had a very positive impact but has had little impact on those groups who have been disproportionately represented in the homelessness statistics for 20 years or more.
- There are well established specialist health services for homeless people but the real challenge is addressing the inadequate response of mainstream health services (including some GPs) to homeless and insecurely housed people. Rural areas are of concern.
- Various views expressed on the Health and Housing Standards. They have been useful in those areas of Scotland where agencies have been keen to do

the work, but not in areas where there has been little enthusiasm. The standards do not reflect the current environment or Government agenda and are not to the front and centre of people's thinking.

- Health and social care integration must be seized as an opportunity to build engagement and embed housing into the partnerships.
- Integration partnership strategic plans are the place to push for the wider preventative agenda of helping people to live in a healthy environment.
- Giving children the best start in life and following a GIRFEC approach is challenging for midwives when homeless/insecurely housed families forced to move from place to place, an issue compounded by silo thinking/structures.
- What other ways forward are there? Investment in socially and private rented housing and in supporting owner occupation - requires a 20 and 30 year investment programme to be effective; make a better case for 'spend to save' and get criminal justice and health sectors (etc) to champion the importance of housing.
- Does the NHS Fife data support the case for more targeted universal services rather than a whole population approach? More analysis to be done to see whether the onset of Housing Options did influence the trends/patterns.
- Discussion on the opportunities and challenges for NHS front line staff (GPs, health visitors, midwives etc) when they become aware a patient lives in a cold/damp/badly maintained house.
- The case for greater NHS staff awareness of and confidence to raise these issues was made, but also the value of multi-agency, cross-sectoral partnerships designed to draw in expertise and resources from the most appropriate source.
- The MARCH initiative in Midlothian is a formal partnership that is addressing fuel and other poverty factors that affect people's health outcomes.
- Care and Repair services and housing associations are well placed to intervene effectively and support anticipatory planning – e.g. interventions in relation to fuel/cold, falls, minor repairs etc.

The three speakers' top priorities for the Scottish Parliament:

- Tackle poverty and get more upstream to prevent problems arising in the first place.
- Use the opportunities provided by the Fairer Scotland and Healthier Scotland conversations to take the debate forward.
- Focus on the 32 health and social care partnerships – put them under pressure to ensure housing is fully and effectively involved.
- Stop expecting damaged people to be able to slot into public service models.
- Support middle managers in the public sector to have the courage to do the right thing.

- Ask health and social care partnerships to consider setting up localities of interest (not just geographic localities): 'the most excluded' are not easily identified by geography.
- Build 10,000 new socially rented houses a year over the next 5+ years.
- Revisit Housing Options: works well for those who simply don't know their options, but doesn't work at all for those people who are not even engaged.

Health and Social Care Integration and Health Inequalities – 26th November 2015

There were three presentations:

1. Gillian McCamley, Community Connectors Programme Manager Glasgow.
2. Cath Denholm, Director of Strategy, NHS Health Scotland, the special health board focused on promoting the evidence base on the causes of health inequalities.
3. Robby Steel, Consultant Liaison Psychiatrist at Edinburgh's Royal Infirmary.

Presentation one highlights: *Community Connectors*

- Community Connectors is a new partnership between Glasgow Council for Voluntary Services and three Glasgow-based housing associations, funded through the Integrated Care Fund as part of Glasgow's accommodation work stream within health and social care integration.
- A person centred, assets based approach that has had 153 referrals in its first 11 weeks, and engaged 300 organisations across Glasgow. Connects vulnerable older people (e.g. bereaved, not eating well, socially isolated through poor health/discharge from hospital etc) to services and resources, and provides volunteer buddies, themselves older people.
- Born from the experience of Reshaping Care for Older People (RCOP) which demonstrated how the third sector can add value, increase older people's social connectivity and independence, and take pressure off public sector services.
- Designed in response to asking older people: "What keeps you well?" and to responses like: "Please work better together!" and "We are fed up of being described as a burden on society when it is we who are the biggest providers of unpaid care" and: "We would rather serve lunch than take it" and: "Bureaucracy has made volunteering too so complicated".

Discussion following presentation one:

- Asset mapping – using data built up during RCOP as starting point.

- Evaluation – squaring the circle between measuring hard data and assessing the impact of the person-centred approach.
- Barriers to volunteering faced by people with poor mental health.
- Upstream potential – the programme's intelligence/data gathered should inform and make for better decision making by the integration authority.
- Barriers to accessing community assets/resources if there are long waiting lists and/or transport difficulties for people getting to them.
- Gaps that no-one takes responsibility for filling: e.g the blind man unable to attend hospital appointments because there was no-one to help him get there.
- Other useful models: House of Care; Link Workers (The Alliance) with Deep End GPs.
- Information-sharing issues across agencies even within the same partnership is challenging but must be addressed.
- Integration agenda is slowly opening up opportunities for third sector and housing associations to gain recognition, be seen as partners with NHS/local authority, and provide vital evidence of what works - BUT sweeping funding cuts are undermining and removing voluntary/community assets.
- Smaller, neighbourhood based services provided by third sector are very poorly understood/appreciated by NHS – health prefers services to be city wide and commissions on that basis.
- More work needed to strengthen engagement and understanding between NHS and third/housing sectors, e.g. through programmes like VHS's Learning to Lead in Health.

Presentation two highlights: *A NHS Health Scotland perspective*

- Fundamental causes lie in global, political and societal decisions and concern human rights.
- Interventions focused on information campaigns to ask people to change their behaviours are least effective.
- For change to happen, we need: appropriate fiscal policies and structural changes; consciously advocating and planning for health equity; targeting and intensive interventions for those whose needs are greatest.
- By taking a human rights approach, health and social care integration could help assure people's right to safety, dignity, participation, information and empowerment.

Discussion following presentation two:

- The 'stigmatising public discourse on strivers versus skivers'.
- The extent to which addressing the fundamental causes of inequalities is in the remit/power of health and social care integration.

- The usefulness of the Fairer Scotland and Healthier Scotland debates in raising awareness.

Presentation three highlights: *Locality of interest: integration, homelessness and exclusion*.

- NHS Lothian set out to reduce pressure on hospitals and provide a more person centred response to people who present repeatedly whilst in crisis and mental distress, pro-actively supporting them to self-manage more effectively.
- Lothian High Demand service identified the 2,000 people who put most demand on its hospitals and set out to understand who they were and what their needs were.
- Characterised as the 'Penrose population": predominantly homeless people, often with overlapping issues concerning addictions, low level crime and police involvement. This marginalised population is the embodiment of health inequalities, having 'spectacularly poor health outcomes by any measure: mental, physical, dental and sexual'. They are high users of all services (NHS, social care, housing, prison, third sector) so the issue is not a lack of resources, because services expend high levels of resource on them. The problem is expecting them to fit into pre-determined services.
- The Patient Anticipatory Care Team (PACT) is designed to address these issues. What works:
  - Being pro-active about going to see these people - don't expect them to make or keep appointments.
  - Changing NHS culture, behaviours and responses to be more person-centred is not possible whilst rigid targets are in place.
  - Recognising that inequalities are sustained by people's lack of a voice/power.
  - Recognising that homeless people embody health inequalities and should be at the core not the margins of what health and social care integration needs to delivery - so make homeless people a locality of interest.
  - Making room for other agencies, including third sector and police, to be engaged/involved in helping.

Spotlight on Research into Health Inequalities – 25th February 2016

There were three presentations:

1. Stewart Mercer, Professor of Primary Care Research, University of Glasgow and Director of the Scottish School of Primary Care
2. Graham Watt, Professor of General Practice, University of Glasgow and Co-ordinator of General Practitioners at the Deep End
3. Gozie Joe Adigwe, Senior Eye Health and Equalities Officer, RNIB Scotland

Presentation one highlights: the role of the NHS, especially primary care, as a social determinant of health

- Inverse case law means that primary care services in the most deprived areas are unable to cope with the needs of patients with complex needs, including multi-morbidity. Research has shown that the increased burden of ill health and multimorbidity in poor communities results in high demands on clinical encounters in primary care. Poorer access, less time, higher GP stress, and lower patient enablement are some of the ways that the inverse care law continues to operate within the NHS and confounds attempts to narrow health inequalities (extract taken from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2094031/).
- Multimorbidity is a big issue in Scotland, with the majority of over 65s having 2 or more conditions. Overall, more people have 2 or more conditions than only one.
- The Care Plus study looked at how to address the issues of Inverse case law – it asked what would help general practice meet the needs of deprived areas? Patients said a focus on the whole person was needed, as well as longer consultation times and a GP who knows them (i.e. continuity of relationship with the same GP). Staff said that they needed support in order to deliver this.
- Care Plus then piloted measures based on the above feedback, including longer consultation times.
- Results – patients receiving longer consultation times were more satisfied with the service they received; although their health may not have necessarily improved, patients in the target group didn't see their health deteriorate, compared to those in the control group.

Presentation two highlights: the Deep End Initiative - better serving the needs of those in deprived areas suffering from multi-morbidities

- Over 2 million Scots are getting £10 less health spend per head than the 60%+ more affluent of the population.
- Scotland spends the least on health care in Europe, bar one other.
- 15% of patients account for half of the work of GPs.
- When questioning the fairness of NHS services, it was suggested that only emergency service is truly fair, whilst standard of access to/experience of hospitals and primary care, is determined by social background.
- Gatekeeping – unless the right approach is taken at primary care, people will continue to flood into emergency and out of hours care.
- The Deep End Initiative is about changing the approach of GP surgeries in deprived areas experiencing the effects of inverse case law.

- GPs at the Deep End work in 100 general practices serving the most socio-economically deprived populations in Scotland.
- Experience from the Deep End initiative shows that patients need referrals that are local, quick and familiar and appointments that are extended and provide continuity of care to address multiple needs. There's a 'your problem is our problem' approach, rather than one that requires a patient to fit in with what's available.
- More investment in primary care/GPs is required as an upstream solution to tackling Scotland's health inequalities and reducing pressure on acute services.
- Whilst there is a lot of research on precision medicine, there is a lack of research on 'what works' at primary care level, especially in deprived communities – general practice needs to change in order to effectively address multiple morbidities and health inequalities and research is required to support this. This is reflected in the lack of opportunities for GPs themselves to move into research roles.
- A huge proportion of the Government's health spend continues to go to hospitals – transformation of primary care will not happen successfully unless more investment is directed from hospitals to primary care.
- Please see www.gla.ac.uk/deepend for more information.

Discussion following presentations one and two:

- The greater resource need per patients in deprived areas means that the same amount as allocated to a more affluence area practice, has to stretch further. The allocation formula of the GP contract means that funding is per head and pays no regard to complexity of need or unmet need i.e. if a practice can take no more patients – there is currently no way of recording unmet need.
- Self-management in deprived areas needs to improve and link workers are one way of doing this.
- Relationships are the golden ticket – people are going to need community-based links to a small pool of professionals. He said it's a cultural challenge that requires a mind-set shift from acute to primary and community care.
- Mental and physical co-morbidity is 3 times higher in deprived communities compared to affluent communities and that the link between mental and physical health is not acknowledged enough. It was suggested that mental health workers perhaps need to be part of the primary care team.
- The Deep End initiative wish is for mental health workers to be attached to general practice.
- Work by Dr Helene Irvine has shown that investment in community health services has done little to reduce health inequalities over the past few years.

Integrated care is more of a cultural challenge that takes time and requires sharing of power, resources and funding from national to local level.

The priorities of the first two speakers:

- Disinvestment in general practice needs addressed – the quality of care in the community is what keeps people out of hospitals and general practice needs greater investment to fulfil this gatekeeper role.
- There is a need to act on prevention to reduce multi-morbidity. A strong generalist workforce in general practice is required and needs to be supported. Resources need to be shifted from acute to primary/community care.

Presentation 3 highlights: Update on research into health inequalities in the sight loss sector

- Various interventions have been put in place to reduce avoidable sight issues.
- These have been targeted at communities and specific groups e.g. South East Asian Community, West African Men, who are considered particularly at risk of certain sight-related illnesses (diabetes and glaucoma respectively). Notably, people with a learning disability are 10 times more likely to get a sight condition.
- The Glasgow Community Engagement Project (CEP) focused on prevention of avoidable sight loss and was one of five projects across the UK that targeted at risk groups – it aimed to develop evidence of interventions that improve eye health.
- People face various barriers in addressing eye health e.g. often there are no symptoms, there is a perception that eye care/glasses are expensive, language and communication barriers can be significant. Often people don't think to look after their eye health until they actually have symptoms or loss of vision.
- CEP put various interventions in place, including a community-based eye strategy which included a programme of promotion in the community, as well as recruitment and training of eye health volunteers.

Results of CEP:

- The initiative saw a small increase in the proportion of survey respondents to have seen, read or heard information on eye health.
- There was a small increase in the proportion of respondents who were aware of their eligibility for an eye exam.
- In general, relationships at primary care level improved and more attention was given to eye health in the community.

Next Steps:

- Development of an eye health and diversity training pilot.
- Collaboration with Glasgow Caledonian University.
- Eye health needs to be considered more of a public health priority.

View the Group's minutes and annual reports on the Scottish Parliament website.

Express interest in joining the Group or attending future meetings by emailing lauren.blair@vhscotland.org.uk.

Compiled by Voluntary Health Scotland on 19th May 2016.