Cross Party Group on Health Inequalities

Thursday 25th January 2018, The Scottish Parliament

Unofficial Minutes of the seventh meeting (Parliamentary session 2016-2021)

Official minutes of this meeting will not be posted on the Scottish Parliament website, because only one MSP was present. Scottish Parliamentary rules require two MSPs to be present at a CPG for it to be recorded as formal Parliamentary business.

MSPs present: Brian Whittle MSP (chairing)

MSP Apologies: Clare Haughey MSP, Donald Cameron MSP, Anas Sarwar MSP

Other CPG members present:

Matt	Barclay	Community Pharmacy Scotland
Salena	Begley	Family Fund
Lauren	Blair	Voluntary Health Scotland
Stuart	Callison	St Andrew's First Aid
Christine	Carlin	Salveson Mindroom Centre
Joyce	Cavaye	The Open University Scotland
Emma	Currer	The Royal College of Midwives
Paul	Gillen	Royal College of Physicians of Edinburgh
Karrie	Gillett	QNIS
Maruska	Greenwood	LGBT Health and Wellbeing
Alana	Harper	Deaflinks
Nick	Hay	NHS Health Scotland
Rik	Hodgson	HIV Scotland
Colwyn	Jones	NHS Health Scotland
Lisa	Mackenzie	Royal College of Nursing Scotland
Henry	Mathias	Care Inspectorate
Ian	McCall	Paths for All
Dorry	McLaughlin	Viewpoint
Bernadette	Monaghan	Criminal Justice Voluntary Sector Forum (CJVSF)
Susan	Mooney	Blackwood
Justina	Murray	Scottish Families Affected by Alcohol & Drugs
Rob	Murray	Changing Faces
Maureen	O'Neill	Faith in Older People
Fiona	O'Sullivan	Edinburgh Children's Hospital Charity
Arvind	Salwan	Care Inspectorate
Claire	Shanks	British Lung Foundation
Louise	Slorance	The Royal College of Paediatrics and Child Health (RCPCH)
John	Watson	ASH Scotland
Tom	Wightman	Pasda
Kiren	Zubairi	Voluntary Health Scotland

Non-members present:

Leanne	Baxter	Healthcare Improvement Scotland
Vaughan	Jones	Health and Social Care Alliance Scotland
Daniel	Lafferty	MS Society Scotland
Murdo	Macdonald	Church of Scotland
Brin	Maki	Healthcare Improvement Scotland
Rosemary	Miller	NHS Lothian
Penny	Morriss	Living Streets Scotland
Heather	Noller	Carers Trust
Christine	Perry	Soroptimists International, Crieff
Rupert	Pigot	Diabetes Scotland
Louise	Rogers	Health and Social Care Alliance Scotland
Jenny	Simpson	Trellis
Maureen	Sturrock	Soroptimists International, Crieff
Dr Fiona	Wardell	Healthcare Improvement Scotland

1. Welcome and minutes of last meeting

Brian Whittle MSP (chairing) welcomed everyone to the meeting. It was noted that the draft minutes for the last meeting held on 7th December 2017 have been circulated to all members prior to this meeting. The minutes were duly approved.

2. Matters Arising

There were no matters arising.

3. Proposed new members

Elaine Smith MSP joined the Cross Party Group, bringing MSP numbers up to 12.

The Cross Party Group also received applications from three organisations wishing to join the CPG:

- Sporta (national association of leisure & cultural trusts)
- Viewpoint (Housing Association)
- Edinburgh Children’s Hospital Charity (supports Edinburgh's Royal Hospital for Sick Children)

These were approved bringing membership up to 60 external organisations.

4. Scotland’s New Health and Social Care Standards
www.newcarestandards.scot/

Dr Fiona Wardell, Team Lead for the Standards, Healthcare Improvement Scotland and Henry Mathias, Strategic Lead for the Standards, at the Care Inspectorate presented and discussed the new Health and Social Care Standards.

The new Health and Social Care Standards set out what we should expect when using health, social care or social work services in Scotland. This is the first time that both health and social care are being regulated by the same set of standards. There has been a conscious effort to make sure that the standards are person centred and based on the wellbeing and human rights of the individual, therefore all standards start with ‘I’ or ‘My’. The older standards only recognised people’s needs when they had chosen their care and support needs whereas these standards also look at choosing care and support.

The standards are used to describe five headline outcomes as well as descriptive statements which set out the standard of care a person can expect. The descriptive statements explain what achieving the outcome looks like in practice. The headline outcomes include:

1. I experience high quality care and support that is right for me.
2. I am fully involved in all decisions about my care and support.
3. I have confidence in the people who support and care for me.
4. I have confidence in the organisation providing my care and support.
5. I experience a high quality environment if the organisation provides the premises.

The standards are underpinned by five principles: dignity and respect, compassion, be included, responsive care and support and wellbeing.

Q: Are the standards enforceable?

A: The standards are regulated by Healthcare Improvement Scotland, the Care Inspectorate and other scrutiny bodies. The old standards were much more about compliance whereas the new standards are aspirational. These new standards ae less about policing and more about changing the culture and improving quality.

Q: If aspirations are not achieved what can be done to regulate or enforce the standards?

A. Some standards can result in immediate action others require a more nuanced response. This requires both internal quality assurance and external audits. Not all standards apply to everyone for example some apply to children and young people and people with complex needs. The standards are referred to as a passport, not what does happen but what should happen. One of the five overarching principles is compassion and it sits alongside more objective principles.

Q. How are you going to inspect the standards are being used? Will service users be at the heart of inspections?

A. We are phasing inspections so not all standards will be inspected. We are testing what and how to inspect. We will conduct face-to-face observations, go out to speak to people and gather service user experiences so it will not be a traditional office-based inspection.

Q. The aspirational aspect of the standards is commendable but how many people know what their human rights are? Also how do you marry a human rights based approach with what can actually be provided in relation to staffing levels and budgetary constraints?

A. People may not be familiar with what their human rights are so, for example, standard, 1.5 “If I am supported and cared for in the community, this is done discreetly and with respect”, is an example of a human right to make it more

accessible and tangible. We are also conducting community outreach and roadshows. The standards pertaining to human rights are also active and not passive as seen in standard 4.1 for example, “My human rights are central to the organisations that support and care for me”.

We are looking at what indicators we may use to assess these but it is positive that for the first rime the standards contain an equalities and human rights focus.

Comment: I really appreciate the human rights approach and I have seen it working through my own personal experiences in Edinburgh. I would like to see dignity and respect being adopted more widely and see people being able to take ownership of their care and having their human rights upheld.

Q: Why is there not a focus on access to Independent Advocacy? People, often the most vulnerable, do not know what advocacy is and it is underfunded.

A. The onus is on staff and organisations to make sure people are aware of independent advocacy. In the standards, advocacy is seen as an important right see standard 2.4 and 2.12.

Q. BSL users find it hard to negotiate this document are their BSL friendly and easy read versions available?

A. Yes the standards are available in Easy Read and BSL friendly formats as well a number of other languages.

Q. Families can struggle to get involved in an individual's health and care. Can families use these standards to hold services to account? There does not seem to be anything specific for families and carers. Also is there anything relating to a family's right to involvement in terms of as a supporter and not a carer?

A. In the Glossary section, the interpretation of Advocate is broad and includes family members. Standard 5.8 relates to services being located near family, and also statements such as 5.15 about visitors are new to the standards. There can be tensions between family and service user's wishes. There is already legislation and policy pertaining to carer's rights and the standards are focused on the "I" and "My". Standard 2.8 looks at what matters to me – so the service user can decide who to involve. We are, however, taking note of the issues and points raised today so we can tease out issues and explain them in supporting documents and video/interactive resources we are producing.

Q. Sometimes family and carers' need advocacy themselves, this is not included in the standards.

A. The standards are focused on the individual. However, standard 4.26 looks at carers needs.

Q. Standard 4.24 talks about appropriate and safe recruitment. Are there more plans for guidelines to support safe recruitment?

A. This is a top level issue, the organisations should have codes of practice looking at recruitment, disclosure, training needs and staff development.

Q. Are there regulations for private and small organisations that can at times have unsafe recruitment practices?

A. All care providers are subject to assessments and inspections. We need to share good practice and maybe have service users on the interview panels. We will look at how to evaluate this.

Q. I agree with the aspirational direction that the standards have. How do you make sure standards 1.25 "I can choose to have an active life and participate in a range of recreational,

social, creative, physical and learning activities every day, both indoors and outdoors", is actually being delivered?

A. There is a push by all scrutiny bodies to improve activity levels in care homes at all age levels. We are producing guidelines, resources and conducting outreach work to help care homes improve levels of activity. This issue is also about training and upskilling staff but also about empowering staff to enable them to make risk assessments. It is also about working together and sharing information about a person's needs to enable things to happen for an individual in a safe and effective way.

Comment: Brian Whittle MSP: I still do some coaching and I am coaching a young person with special needs. It is important to believe in an individual's potential to do things.

Q. Is it a living breathing document and can changes be made through evaluation and assessment of its effectiveness? Can people participate by providing information, best practice to affect positive change?

A. Yes

Q. In Standard 1.1 gender identity is omitted; also there is reference to mental health but not a person's physical health status, for example, the stigma attached to having a HIV diagnosis.

A. We will take this away and evaluate the omissions and try to address this. We are happy to come and discuss this or any other issues with organisations.

Comment: Brian Whittle MSP: This Cross Party Group always raises issues and areas of work that are my own passion and there are always very important and valuable issues being discussed.

5. Any other business

Brain Whittle MSP informed the group that the Cross Party Group on Improving Scotland's Health has approached the Health Inequalities Cross Party Group with the proposal that the two CPGs hold a joint meeting on a topic of mutual interest. He commented that Health Inequalities is a cross-cutting topic and that a joint meeting would be quite powerful. It was unanimously agreed that a joint meeting with the Improving Scotland's Health CPG should go ahead.

6. **Date of next meeting**

The next meeting is scheduled for Thursday 3rd May 2018 at 1pm.