Cross Party Group on Health Inequalities
Thursday 26th January 2021
Business Meeting

MSPs present: Donald Cameron MSP (Chair), Brian Whittle MSP and Emma Harper MSP

MSP apologies: Alison Johnstone MSP, Anas Sarwar MSP

Other CPG members present:
Mahmud Al-Gailani, VOX SCOTLAND
Ijeoma Azodo, University of Edinburgh
Lauren Blair, Voluntary Health Scotland
Emma Cormack, The Health Agency
ate Cunningham, Energy Action Scotland
Sarah Curtis, University of Edinburgh
Fiona Cuthill, University of Edinburgh
Sarah Doyle, QNIS
Alan Eagleson, Terrence Higgins Trust
Mairi Gordon, Samaritans Scotland
Alana Harper, Deaf Links
Mark Hazelwood, Scottish Partnership for Palliative Care
Martin Hutcheson, Terrence Higgins Trust
Colwyn Jones, British Dental Association
Alison King, Public Health Scotland
Paige Linnell , Positive Steps
Mark Macleod, Energy Saving Trust
Leigh Mair, Scottish Rural Health Partnership
Helen McCabe, Office of Alison Johnstone MSP
Gillian McNicoll, Rowan Alba
Jane Miller, The ALLIANCE
Jane Rowley, University of Glasgow
Arvind Salwan, Care Inspectorate
Jason Schroeder, Scottish Men's Sheds Association
Jonathan Ssentamu, Waverley Care
Joanna Teece, British Dietetic Association
Fiona Thackeray, Trellis
Emily Tweed, University of Glasgow
Fiona Wardell, Healthcare Improvement Scotland
Tom Wightman, Pasda
Andrea Williamson, University of Glasgow

Non-members present:
Narek Bido, ASC
Sara Bradley, University of the Highlands and Islands
Marion Butchart, Novartis
Christine Carlin, Home-Start
Suzanne Forup, Cycling UK

Lucy Albyn, Housing Society Ltd
Trish Gorely, University of the Highlands and Islands
Lucy Hetherington, NES
Alison Keir, Royal College of Occupational Therapists
Rachael Kenyon, Cyrenians
Rebecah MacGille Eathain, University of the Highlands and Islands
Caroline MacPherson, Calton Welfare Services
Fran McKay, NHS Lanarkshire
Sarah-Anne Munoz, University of the Highlands and Islands
Maureen O'Neill, Faith in Older People
Joy Rafferty, Strathcarron Hospice
Pat Scrutton, Intergenerational National Network
Katrina Smith, Edinburgh HSCP
Tamsin Smith, University of the Highlands and Islands
Dianna Stirling, DLF
Iain Templeton, Partners in Advocacy
Birgit Thaysen Goodman, Cyrenians
Ellie Wagstaff, Marie Curie
Diane Willis, Edinburgh Napier University

Welcome

Donald Cameron MSP welcomed everyone to the CPG. He started the meeting by thanking VHS in its role as secretariat for setting up the third online meeting of the CPG. He thanked everyone attending for their hard work in their individual and organisational roles during the pandemic.

1. Minutes of last meeting

The minutes of the meeting held on 12th October 2020 were duly approved without amendment, proposed by Brian Whittle MSP and seconded by Maureen O'Neill.

2. Matters Arising

There were no matters arising.

3. Proposed new members

VHS had received an application for CPG membership from Trellis, Scotland's network for therapeutic gardening, which was approved by a show of hands, bringing the total membership (over and above MSP members) to 89 external organisations.

4. Topic for discussion: deep social exclusion: dying whilst homeless in Scotland

Donald Cameron introduced the topic by saying that homelessness is often an indication of severe and multiple disadvantage and complex needs and that Scotland has double the number of homelessness deaths to the rest of the UK. He said that this was a timely discussion for the CPG to hold and that he was pleased to welcome

two presenters with specialist knowledge and experience of working in this area, Dr Joy Rafferty and Dr Andrea Williamson.

Dr Joy Rafferty, a speciality doctor at Strathcarron Hospice and Master of Public Health

Dr Rafferty explained that homelessness is defined by having no suitable accommodation to live in. She elaborated that this includes those living in emergency or temporary accommodation, such as hostels, temporary flats or refuges, 'sofa surfing' and those rough sleeping. According to data from 2019/20, 36,855 households made homelessness applications to local authorities, however, the actual number of homeless people could be double this. The homeless population is transient and hidden and this makes it hard to get accurate numbers. She also said it is estimated that only half of homeless people approach local authorities for homelessness support.

Homelessness is not just about housing it is an indicator of multiple exclusion and complex need. Homeless people have worse health than the general population, with 80% having at least one physical health problem and more than 20% suffering from three or more health problems. The mortality rates for people who are homeless are around four times that of the general population, even after adjusting for health problems requiring hospitalisation and deprivation.

Palliative care is related to better quality of life, even at times longer life, and better outcomes. It focusses on living well until you die. Homeless people have complex palliative care needs and can have significantly worse symptoms at end of life than other end of life groups. However, they have poorer access to quality palliative care, worse outcomes and often die without accessing any end of life care.

Research from the UK by Dr Wendy Ann Webb shows that issues such as the need for self-determination and control are crucial for people who are homeless and nearing end of life, with the need for more involvement in decisions around health and treatment. People who are homeless often have spiritual concerns and distress, and repeated themes are around regrets, suffering, reconciliation and forgiveness. They also have a range of practical concerns, such as funeral costs. For many homeless people psychosocial care is more important, and they would like their physical care to mean they are treated with kindness and respect, not judged, and understood and accepted. They would like to have palliative care in a familiar environment, where they feel comfortable and with people they know.

Research has also highlighted the need for professionals to take the initiative. Homeless people reported they were unlikely to approach professionals if they were seriously ill and it is helpful for professionals to take the initiative and regularly visit where they are staying.

There are many barriers to homeless people receiving palliative care including the fact that many die young and it is hard to give a prognosis or understand the trajectory of their conditions. Homeless people can often live very chaotic lives and

can be a transient community which means that continuity of care is difficult. Service providers' default assumption is that people have a home.

In order to overcome these barriers greater awareness is needed and the role of community specialist palliative care nurses should be developed; the provision of trauma-informed heath and care training for all staff is needed, as well as provision of in-reach into hospitals, especially A&E where many homeless people present.

Dr Andrea Williamson, **a founder of the Deep End GPs and clinician at Glasgow's Hunter Street Homeless Service**

Dr Williamson explained that the GPs at the Deep End project was set up 7 years ago, driven by a realisation that general practice as well as wider health care delivery was not working in areas of high socio-economic deprivation. The Deep End project is a voluntary collective of both service and academic GPs who have been meeting regularly over those past 7 years.

The Deep End project is based on the SIMD index and comprises the 100 most socio-economically deprived practices in Scotland. It is important to note that 76 of those practices are based in Glasgow. The majority of people living in those areas experience socio-economic deprivation, complex co-morbidity and premature mortality. The burden of disease experienced in Scotland contains many conditions that can lead to the need for palliative care and in areas of deprivation there are fewer resources but increasing burden of disease.

The social determinants of health have been writ large during the pandemic: the impact of COVID-19 on areas of deprivation has meant an increase in issues concerning poverty, housing and employment insecurity. GPs have concerns about those who are 'missing' from care and about heightened digital exclusion. In normal times most GPs 'wait for patients to come to them' but during covid some GPs, especially those with community link workers, have started to think about the need to be more pro-active with their more vulnerable patients. Dr Williamson drew attention to the Deep End Report 36 - General Practice in the time of Covid-19

There has been a mismatch between resources and need in relation to GP practices that are in communities where there is severe and multiple deprivation like that described in Hard Edges Scotland As yet, community link workers are not universal and financial advice provision within primary care is still in its infancy. GPs with 'skyrocketing' patient/community issues are 'sunk at the bottom' in terms of resources.

Those who are homeless often at the sharp end of exclusion, disadvantage and multi-morbidities. This has implications for end of life care. It is important that health and care staff work with the informal care givers around a person, which at times are only family members. The duty is on the service for the delivery of care and not on the individual and this means sticky and permeable care: professionals should be accessible and need to 'stick' with a person and ensure they are not passed on. It is essential that trauma informed practice is at the core of all health and care delivery and that professionals are sensitive to the stigma experienced by their patients.

Questions and discussion

Donald Cameron invited questions and discussion. Contributors to this session (whether verbally or via the Chat function in Zoom).

Q: How far are we from meeting these aspirations?
Andrea: Individual practices and the third sector are using collaborative person-centred approaches and delivering trauma informed services. There needs to be more services that are designed with the people who will use them.
Joy: There is increased awareness and some great examples of good practice, however, this needs to be resourced in order to mainstream.

Q: What is the geography of homeless service provision in Scotland?

Andrea: Service response to homelessness is driven by what is happening in London and Glasgow but now there are more localised responses being developed in different urban and rural locations to meet local needs. There is a need for robust needs assessment and multiagency working to develop local service provision.

Brian Whittle MSP: prevention is needed but there is a lack of opportunities and resources in our communities to engage with health and education services. How do we act before people become homeless and before people become addicted [to alcohol/drugs]? We must get better at allocating resources, but what else can we do?

Q: How to you allocate resources effectively to prevent homelessness - is this about tackling Adverse Childhood Experiences?

Joy: Million dollar question; however, interesting research around upstream investment in pre-natal and childhood experiences and support for children and parents.

Andrea: Providing people with money to live a dignified life and not in poverty will mean that parents can nurture their children. This is not an overnight fix but can really tackle fundamental issues. Andrea highlighted a study which examined the effect of missed primary healthcare appointments on all-cause mortality in those with long-term mental and physical health conditions. The findings of this study showed that missed appointments represent a significant risk marker for all-cause mortality, particularly in patients with mental health conditions. The existing primary healthcare appointment systems are ineffective in supporting patients with mental health conditions to engage with medical interventions or services. The study found that more needed to be done in order to engage and support those with mental health conditions and multiple long-term conditions.

Comment: The Queens Nursing Institute of Scotland (QNIS) is building a community or practice for community nurses in areas of multiple and severe deprivation, to emulate the Deep End project, and will also be looking at areas such as palliative care.

Q: There is a lot of bureaucracy around accessing support, for example, homeless people needing an address in order to register for a GP so that they can access support for addictions. How can this be overcome?

Andrea: There is a mixed picture across the country, with Glasgow having access to specialist services. It is important to raise awareness of the bureaucratic issues so that we can work round them or tackle them.

Comment: GP Cards launched by the Scottish Government in 2019 spelling out everyone's right to register with a GP, even if they haven't got an address.

Q: We need to look at how people access care: for example, gypsy travellers are being supported to be able to access GP services across the country – can this model be used for other groups?

Andrea: Many people are falling through the gaps of service provision and initiatives like the GP card are really useful. However, it is good to be mindful of the fact that GPs in areas of deprivation are already overburdened and lack resources so can't fully support those with additional needs. There needs to be proper resourcing so that those with additional needs such as support to get to appointments, literacy or health literacy issues, poverty and other needs can be supported.

Comment: Autistic people can be particularly vulnerable and some may become homeless inadvertently and may have no-one to turn to. They may also have no understanding of what a virus is or how to avoid it. Some may have no executive skills, can't form a plan of action and can't follow one created by someone else. Some may have no jobs or opportunity for earning money, or just don't know how. They may have obsessions, follow rules inappropriately, lack flexibility of thought and may have things that they have to do compulsively. They may do things that other people would find unacceptable or criminal. They may be afraid of authority and what they might do to them, and this can incur a fight or flight response - or even state of complete inability to do anything. On top of it they can experience constant and debilitating anxiety.

5. Any other business

It was noted that this is the last meeting of the CPG prior to the Scottish Parliamentary elections due to take place on 6th May and that thereafter VHS will seek support from MSPs to re-establish the group for a further Parliamentary term.

Donald Cameron thanked VHS and the members of the CPG for four and a half years of illuminating discussion and interesting contributions.