Cross Party Group on Health Inequalities

Minutes of the Meeting held Thursday 25th February 2016, Committee Room 4, The Scottish Parliament

MSPs in attendance for whole or part of meeting: Malcolm Chisholm MSP (chairing); Anne McTaggart MSP.

See Appendix for list of other attendees.

1. **Welcome, introductions and apologies**

   Malcolm Chisholm MSP welcomed those present. A formal note of attendees and apologies was taken.

2. **Minutes of the meeting held on 26th November 2015**

   These were approved as a correct record.

3. **Matters arising**
   None.

4. **Proposed new members**
   All new member applications were approved. New members are: Changeworks; Changing Faces; Energy Action Scotland; Shelter Scotland; Fife Society for the Blind; the Centre for Health Policy, University of Strathclyde; The Open University, Scottish Families Affected by Alcohol and Drugs; Genetic Alliance UK and LGBT Health and Wellbeing.

5. **Research Matters: What can NHS Scotland do to Prevent and Rescue Health Inequalities?** Presentations from:
   - Stewart Mercer, Professor of Primary Care Research, University of Glasgow and Director of the Scottish School of Primary Care
   - Graham Watt, Professor of General Practice, University of Glasgow and Co-ordinator of General Practitioners at the Deep End.

Stewart Mercer gave a presentation which talked about the role of the NHS, especially primary care, as a social determinant of health. Points highlighted:

a. 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/)
b. 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.

c. 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.
d. Care Plus then piloted measures based on the above feedback, including longer consultation times.
e. 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.

Please see attached slides for more information.

Graham Watt presented on the Deep End Initiative, which works to help GPs better serve the needs of those in deprived areas suffering from multi-morbidities. Points highlighted:

a. Over 2 million Scots are getting £10 less health spend per head than the 60%+ more affluent of the population.
b. Scotland spends the least on health care in Europe, bar one other.
c. 15% of patients account for half of the work of GPs.
d. 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.
e. Gatekeeping – unless the right approach is taken at primary care, people will continue to flood into emergency and out of hours care.
f. The Deep End Initiative is about changing the approach of GP surgeries in deprived areas experiencing the effects of inverse case law.
g. GPs at the Deep End work in 100 general practices serving the most socio-economically deprived populations in Scotland.
h. 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.
i. More investment in primary care/GPs is required as an upstream solution to tackling Scotland's health inequalities and reducing pressure on acute services.
j. 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.
k. 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 attached slides and www.gla.ac.uk/deepend for more information.

6. Questions and discussion

a. Gillian Smith – Director, Royal College of Midwives – questioned whether going down the research route is not seen as an attractive prospect by GPs.

Graham said that lack of funding for such opportunities is the reason there are so few GPs in primary care research roles.

b. Malcolm Chisholm MSP – group convener – asked how you can explain higher (per head?) spend in more affluent areas.

Graham explained that 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.

c. Linda Morrow – Chest, Heart and Stroke Scotland – asked Graham and Stewart whether they had looked at the principle of self-management in the third sector.

   Stewart Mercer said that they had looked at how best to deliver this in deprived areas. One example of self-management is the work that has been down with the Alliance in putting in place Community Link Workers, which has expanded care horizontally in the community. He agreed that more research would be very helpful to help inform self-management. The results of the link worker project will be published in early 2017. He emphasised that self-management in deprived areas needs to improve and link workers are one way of doing this.

d. Anne McTaggart MSP asked both speakers - what would the magic pill be?

   Graham emphasised that 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.

e. Rob Murray – Changing Faces – noted that the Scottish Government's new mental health strategy is not out yet. He also highlighted that mental health waiting times for CAMHs were not being met and asked for the speakers' thoughts on this.

   Stewart explained that 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. He suggested that mental health workers perhaps need to be part of the primary care team.

   Graham said that mental health services are not well enough integrated at primary care level. He explained that the Deep End wish is for mental health workers to be attached to general practice.

f. Eric Carlin – SHAAP – asked the speakers about the effects of stigma on illness, how can professionals change that feeling of stigma that some patients get?

Graham talked of a pilot scheme in Glasgow which has looked at how labelling of services such as 'alcohol support' can be avoided and better placed under the GP label i.e. although the service is there, it is not dominantly labelled as such when a patient walks in and so they will feel less self-conscious using it.

g. Gordon Neil – Audit Scotland – asked the speakers how optimistic they are that health and social care integration will help this required shift from acute to primary care.

Stewart said that he was hopeful, but that the various uncertainties such as finance, make it hard to say.

Graham cited work by Dr Helen Irvine which has shown that investment in community health services has done nothing to reduce health inequalities over the last few years. He explained integrated care as a cultural challenge that takes time. He noted that the main challenge is sharing of power, resources and funding from national to local level.

h. Christine Carlin – Mindroom – asked what was happening with a pilot in Inverclyde GP practices

   Stewart explained that this project had just got underway and there wasn't enough information yet to report on it. Its format will be about practices working together in clusters.

   Graham highlighted a similar project – Govan SHIP – which has implemented longer appointment times, attached social workers and multi-disciplinary teams. These address many of the asks of Deep End GPs.

i. Malcolm Chisholm MSP asked both speakers to outline what their priorities are.

   Graham said that his would be addressing disinvestment in general practice – 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.

   Stewart explained that 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. He emphasised that resources need to be shifted from acute to primary/community care.

7. Update on research into health inequalities in the sight loss sector

Gozie Joe Adigwe – Senior Eye Health and Equalities Officer, RNIB Scotland – presented briefly on RNIB's work on health inequalities.

Gozie highlighted various interventions that had been put in place to reduce avoidable sight issues. These were targeted at communities and specific groups e.g. South East Asian Community, West African Men, who were 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.

Gozie talked of the various barriers people face 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.

Various interventions were put 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:

- 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

Please see attached slides for more information.

8. Questions and discussion

a. David Ross – Fife Society for the Blind – asked whether staff experiencing what sight loss is like is the most appreciated part of training.

Gozie agreed that it's very important that staff know what sight loss is like, but that it's also important that they have knowledge on how to prevent sight loss and other eye health issues.

9. Any other business

Claire Stevens – Voluntary Health Scotland (VHS) - expressed thanks on behalf of the group to co-convener Malcolm Chisholm MSP, who will be standing down as an MSP on 23rd March 2016.

Research knowledge exchange event – Claire also informed the group that, due to the high level of interest from people wishing to present research at this CPG, VHS will be organising an event to give some of these a platform to showcase their work.

10. Next meeting: Date TBC

Appendix1:

Attendees on the 25th February 2016.

Gozie Joe	Adigwe	RNIB Scotland
Mahmud	Al-Gailani	VOX-Voices of eXperience
Dr John	Anderson	NHS Health Scotland
Jackie	Baker	The Open University
Liam	Beattie	HIV Scotland
Kate	Bovill	The Breastfeeding Network
Claire	Burnett	RCPCH
Susanne	Cameron-Nielsen	Royal Pharmaceutical Society Scotland
Eric	Carlin	SHAAP
Christine	Carlin	Mindroom
Joyce	Cavaye	The Open University
Malcolm	Chisholm	MSP
Sara	Collier	RCPE
Alison	Crofts	Voluntary Health Scotland
Jennifer	Fingland	SHAAP
Jacquie	Forde	The Wellbeing Alliance Ltd
Anne-Marie	Fox	MRC/CSO SPHSU
Natalie	Frankish	Genetic Alliance UK
Alice	Gentle	Royal College of Nursing Scotland
Lisa	Glass	Shelter Scotland
Ben	Glencross	Falkirk Football Community Foundation
Derek	Goldman	The Open University
Maruska	Greenwood	LGBT Health and Wellbeing
Nick	Hay	NHS Health Scotland
John	Holleran	SFAAD
Colwyn	Jones	NHS Health Scotland
Eleana	Kazakeou	Office of Jim Hume MSP
Andrew	Lindsay	Big Lottery Fund
Dr Nashwa	Matta	RCPCH
Anne	McTaggart	MSP
Helen	Melone	Energy Action Scotland
Stewart	Mercer	University of Glasgow
Linda	Morrow	Chest Heart & Stroke Scotland
Rob	Murray	Changing Faces
Gordon	Neill	Audit Scotland
Laura	Plumb	EVOC
Gillian	Rae	RCPCH
Dr. Tony	Robertson	University of Stirling
Catherine	Ronald	Voluntary Health Scotland
Elizabeth	Reilly	British Psychological Society
David	Ross	Fife Society for the Blind
Claire	Stevens	Voluntary Health Scotland
Gavin	Thomson	Diabetes Scotland
Mona	Vaghefian	Cancer Research
Graham	Watt	University of Glasgow GP's Deep End