Joint meeting of the Cross Party Group on Health Inequalities and Lung Health Cross Party Group

Minutes of the twelfth meeting (Parliamentary session 2016-2021)

Tuesday 18th June 2019

The Scottish Parliament

MSPs present: Emma Harper MSP, Donald Cameron MSP and Alexander Stewart MSP

Attendees:

1. Welcome, introductions and apologies

Donald Cameron MSP introduced the Health Inequalities Cross Party Group and welcomed everyone to the joint meeting. It was noted that the CPG on Health Inequalities has a broad remit, which focusses on a holistic approach to health and has included meetings on poverty, planning, the environment and prison health. There are 70 external members and 10 MSP members.

Emma Harper MSP introduced the work of the Lung Health Cross Party Group and her own work around health inequalities. She noted that she recently joined the Cross Party Group on Health Inequalities and that she is the Deputy Convener of the Health and Sport Committee. She spoke about the link between health inequalities and lung health citing that the most deprived people in Scotland have the poorest record of lung health and related mortality. The legacy of socio-economic deprivation and heavy industry has left a lasting impact such as smoking and air pollution. The perceived stigma around behaviour choices such as drinking and smoking has also meant that the most deprived and vulnerable often do not seek the support they need.

2. COPD

Dr David Anderson, Respiratory Consultant and Clinical Lead described Chronic Obstructive Pulmonary Disease (COPD) in Scotland. COPD affects 129,000 people in Scotland. Looking at data from the Glasgow SIMD index, we can see that 90% of those in the most deprived Quintile suffer from poor lung health compared to only 10% of those from the least deprived quintile. Overall, there are more females than males with COPD, this can be broken down further by age where more men aged 65 and over have COPD and more women aged 46-64 suffer from COPD.

Pulmonary Rehabilitation (PR) can have a significant impact on survival among those who attend and complete the programme, improving survival by up to 10 years. However, only a third of patients actually complete the programme with roughly a third not completing and a further third of patients not attending. Factors that affect the take up and completion rate of PR include breathlessness, poor mobility, physical health conditions, mental health issues, social isolation and deprivation.

In order to overcome these a Community Respiratory Service has been developed in NHS Greater Glasgow & Clyde that utilises multidisciplinary teams to set achievable goals with patients and supports them through their treatment and rehabilitation. The service also signposts patients to support, including financial advice within the community and helps manage people's stigma and anxiety in accessing services and support for their condition. The community service offers people a personalised service that means that they can work

towards their own goals from just being able to walk around the house, to being able to get outside to do a weekly shop and even getting back to work.

More people living in socio-economic deprivation with COPD access the Community Respiratory Service than their more affluent counterparts. The initial evaluation of the service has shown that approximately 1,000 people accessed the service in the first year, and this avoided 45 admissions per month and made a net financial saving of between £468,780 and £1,087,564.

3. Discussion

Q: What does Pulmonary Rehabilitation entail?
A: A structured programme (lasting 6 weeks in Glasgow), combining exercise with advice and support, which aims to equip people with skills to self-manage their condition and remain active. People can also be supported through activities such as choirs, mindfulness sessions and even tai chi.

Q: Have the demographics of people attending rehab changed?
A: In the Pulmonary Rehabilitation classes there are more men than women and this has remained consistent over the last 10 years. In more community settings there are more women to men attending at a 60:40 ratio.

Q: Why do people not attend or drop out of Pulmonary Rehabilitation?
A: There are a range of issues that make it difficult for people to attend or stick with rehabilitation these include disabilities, severe breathlessness, co-morbidities, poor mental health as well as a lack of understanding of rehabilitation.

Q: Do you help people with digital interventions for self-management?
A: The rehabilitation uses a range of interventions from face to face to digital apps and these are being explored further.

Q: Should Pulmonary Rehabilitation last more than six weeks and should there be screening?
A: It is important to get people to access rehabilitation earlier and to work with third sector organisations in order to reach underrepresented groups. Studies on the 6 and 8 week programme show that there are more benefits from the longer programme.

Q: Do hospital admission rates pre and post Pulmonary Rehabilitation get measured and shared with patients?
A: A drop of 15 to 20% in admission rates to hospital but the language in which this is conveyed to patients needs to change. Need to focus on changing the language to letting people know that engaging with rehabilitation will mean breathing better and living longer and healthier lives.

4. Ash Scotland, Smoking, Lung Health and socio-economic inequalities

John Watson, Deputy Chief Executive at Ash Scotland spoke about the link between smoking and the socio-economic circumstances in which people live. Around 90% of COPD is a result of smoking and seven out of ten cancers are caused by smoking. Smoking is an important part of the health inequalities debate as smoking is most likely to be determined by socio-economic circumstances rather than recreational activity. A third of people who smoke have mental health issues and 30% of most deprived people smoke compared to less than 10% of the least deprived. Across the board disadvantaged groups smoke as they have less access to alternative coping mechanisms to stop smoking.

A new report published jointly between ASH Scotland and the Poverty Alliance: 'We need to talk about poverty and smoking', shows that the way stop-smoking support is delivered needs to change and there needs to be more sensitivity towards and understanding of why people smoke. The traditional public health approach of a 'nagging finger' does not work and needs replaced with a real understanding of the circumstances people live in that lead them to smoke and the benefit people are trying to gain through smoking.

Zareen Iqbal, Development Officer at ASH Scotland spoke about partnership working with Money Advice Services (MAS) across Scotland. Stop smoking support often focuses on the health impacts on smoking which most people are already aware of, the benefit of working with MAS is that you can talk to them about the cost factors of smoking when clients are already there for financial advice. The money advice workers have built trust with people so they are in a good position to discuss sensitive topics such as smoking with them. However, training in the form of a free e-learning module as well as resources such as a cigarette packet with smoking facts have been developed by ASH Scotland to help money advice workers speak about smoking with their clients. The money advice workers can also signpost people to other forms of stop smoking support such as smoking cessation. Although still early in its development, behavioural changes are being observed with people reducing the number of cigarettes they smoke or quitting altogether.

5. Discussion

Q: How has engagement with schools regarding smoking influenced behaviours at home?
A: Anecdotally we have heard about children challenging parents smoking and taking the information they receive at school home with them to share with parents who smoke.

Q: Will there be a long-term evaluation of the joint programme with the Money Advice Service?
A: ASH have taken evaluation of the project as far as possible due to resource constraints. Moreover, there is a need for projects to be light touch as there is a reliance on frontline staff, who are already under a lot of stress, to fill out forms and carry out the extra work.

6. AOCB

John Watson asked if frontline services were interested in exploring the smoking programme further they could get in touch with him: JWatson@ashscotland.org.uk

6. Date of Next Meeting

The date of the next CPG on Health Inequalities meeting will be on 1st October 2019 and will include the AGM. The topic is still to be finalised.