**Minutes Cross Party group on Health Inequalities March 24th 2014**

Meeting Chaired by Malcolm Chisholm MSP

Previous minutes were from joint meeting with CPG Mental Health and are available on the Parliament Website.

A Round Table Discussion followed on Health Inequalities where membership organisations discussed their current workstreams and future plans.

2 MSP's attended and 18 non MSP's



1. Aileen McLeod highlighted the Ministerial Task Group report of its review was published on the 13th March 2014 . The Health and Sport Committee is conducting an Inquiry into health inequalities in the early years.
   http://www.scotland.gov.uk/Publications/2014/03/2561

2. Andrew Docherty, cardiologist and non-exec board member from NHS Lanarkshire: expressed view that health inequalities are not prioritised by boards because there are no national criteria set for measuring impact/what is good value/what are reasonable costs. Health and social care partnerships won't have criteria to meet regarding health inequalities.

3. Kat Smith made reference to Margaret Douglas's secondment to the Scottish Government from an *Equally Well* recommendation to look at scope for developing clear criteria through development of an impact assessment tool that focused on health inequalities.

4. Pauline Craig said NHS Health Scotland has continued to implement and develop this tool for assessing health inequalities, (Health Inequalities Impact Assessment or HIIA) and is currently working on strengthening the human rights elements of it. They have applied the HIIA tool to a number of Health Scotland programmes, local NHS Board strategies and some national policies and strategies including and the health social care integration consultation document. This process flagged up some issues for consideration such as for certain care groups, migrant populations, people with sensory impairment etc and the impact assessment was published as an appendx to the

consultation document. An issue for the tool is in accessing research and planning data for small population groups,e.g. asylum seekers, travellers, migrants. She discussed issues around quantitative, qualitative, anecdotal data concerning the lived experience of health inequalities. How to plan to address health inequalities that affect minority and small populations, when overall service planning is for large/whole populations. Another challenge for HIIA is implementing changes when issues are identified through the assessment.

5. Kat said she'd looked at whether an inequalities assessment was more useful than a health inequalities assessment, but warned that it can become a tick box exercise. No evidence that the Scottish Government conducts health inequalities impact assessment as part of its policy making/proofing.

6. David White Edinburgh CHP: has successfully used the equalities impact assessment successfully to inform decision making and to /change minds and decisions that would otherwise have gone ahead.

7. Noted that the Health and Sport Committee has said it wants to look at GP funding.

8. Noted that Professor Graham Watt of Glasgow is 'vocal' on the need for investing more in less affluent areas.

9. Claire Stevens pointed out that Single Outcome Agreements are now supposed to include tackling health inequalities as a priority. Malcolm Chisholm said he wasn't aware that was an expectation. Pauline Craig said the problem with SOAs, in so far as they addressed health inequalities, is that there is a danger of 'lifestyle drift' – eg current SOAs prioritise health inequalities alongside physical activity rather than life circumstances, but she said some CPPs ARE keen to look at the issues differently.

   Link to Scottish Government Guidance on SOAs to CPPS, published December 2012:
   http://www.scotland.gov.uk/Topics/Government/local-government/CP/SOA2012/SOA2012

10. Noted that Scottish Government/centrally provided funding for Keep Well has gone/is going. Andrew Docherty pointed out that Keep Well had been successful in seeking out people in advance of a debilitating/long term condition developing. Asked what the result/impact of Keep Well has been.

11. Health and social care integration: Andrew Docherty said it has the

potential to create jobs and economic growth, ie tackle health inequalities more broadly through wealth creation. Talked about the short-sightedness of investing in youth work/youth clubs whilst not investing in/creating jobs for the same young people.

12. Pauline Craig: certain groups don't experience the same access or quality of health service as others, e.g. LGBT, ethnic, disability groups etc are still not served equally well by the health service with reports about this still being produced by advocacy groups.

13. Alany Trusty of Deaf Links, Tayside, painted detailed picture of how this affects deaf people. People in the deaf community don't have English as their first language, so when the NHS hands them a leaflet (because no interpreter is available) it usually doesn't help, as average reading age in the deaf community is 9.
There are 13,000 users of BSL [Scottish Census 2011)
Gave illustration of the patient who sought Deaf Links help, having been diagnosed with some form of cancer but not understanding what her actual condition was, as no interpreter had been available when the NHS tried to explain her diagnosis to her. NHS then tried to postpone her scan, due to lack of interpreter availability. Role for Deaf Links as advocates: question of human rights/unacceptable that treatment of life threatening condition could be delayed in this way.
Also highlighted that the majority of people with impaired hearing are elderly, so they also face disadvantages when it comes to NHS communicating with them. The more so if also visually impaired.
Claire Stevens echoed this, saying Deaf Blind Scotland are very articulate on the health inequalities people with a dual impairment suffer due to lack of access to staff in the health service who can communicate with them adequately:

http://www.deafblindscotland.org.uk/

14. People with long-standing mental health conditions are another group whose needs are often overlooked.

15. Claire Stevens highlighted the work of Family Advice and Information Resource, which supports adults with learning disabilities to understand and access health information, including re sexual health, cervical smears, self-examination, smoking, keeping clean, diet etc.

http://www.fairadvice.org.uk/

16. Scottish Independent Advocacy Alliance said people often blame themselves/think their condition/their poor health is their own fault and don't seek help for that reason.

17. Andrew Docherty highlighted the issue being rooted in the universality of NHS services and budgeting/resource allocation on a whole population basis – assumption of equal access for all doesn't stand up, however.

18. Discussion on how we might usefully reframe how we talk about investment in health inequalities. E.g. investment in child protection is arguably investment in preventing health inequalities.

19. Claire said the role of housing in tackling health inequalities needed closer examination. Pauline Craig flagged the Go Well research that Glasgow Centre for Population Health is involved in regarding housing/inequalities. Jacquie proposed a joint meeting between the cross party group on housing and this group to discuss further. David White [Edinburgh CHP] talked about the community capacity building role of housing associations and voluntary organisations.

20. Alana[Deaf Links] talked about growing levels of social isolation that deaf people, especially older people experience, and the impact of this on their overall health. Older people typically withdraw from social contact as their hearing deteriorates, and at home any care they receive is now so time driven, carers don't have time [or skills] to spend talking to people, so older people are truly isolated.

21. AGM is 5th June.

Claire Stevens - VHS CEO extracted the section from the Scottish Government's December 2012 guidance to community planning partnerships about Single Outcome Agreements, so you can see that **health inequalities** are indeed meant to be a priority. I thought the cross-party group's reaction to that was surprising, but on re-reading the guidance I can see how it's all fairly broad brush – though I still think it would be worth asking the question of the SG as to what their analysis of SOAs has told them is being done to address health inequalities.

***POLICY PRIORITIES***

*New SOAs should continue to be developed and delivered within the context of the National Performance Framework. However, the National Group has agreed that all CPPs should have a common and sharp focus on some key priorities where the aim should be to achieve transformational, not incremental, performance improvement. These key priorities are:*

- *Economic recovery and growth;*
- *Employment;*

- *Early years;*
- *Safer and stronger communities, and reducing offending;*
- ***Health inequalities** and physical activity; and*
- *Outcomes for older people.*

*They have been chosen because they have been identified as ones where:*

- *A major contribution to achievement of the National Outcomes can be made;*
- *There is significant scope to reduce inequalities;*
- *The evidence of the need for a concerted and sustained effort to improve performance is compelling;*
- *Progress on one priority can contribute to delivery of the others, i.e. they are mutually reinforcing;*
- *Partnership working and community engagement and co-production are seen as being critical to achieving the transformational change envisaged; and*
- *Preventative and early intervention approaches have the potential to deliver significant gains over the medium to long term.*