The national intermediary and network for voluntary health organisations in Scotland

Key Messages

Voluntary Health Scotland Annual Conference
Fair Health: Who get's it?

26 October 2022

At the first in-person Voluntary Health Scotland annual conference since 2019 we saw 200 people register and approximately 190 delegates joining us from across the third sector, NHS, Scottish Government, Scottish Parliament and beyond. Our focus was on the topic of fair health and how communities, third sector and public sector organisations can work jointly to reduce health inequalities. We heard from a range of inspirational speakers throughout the day, held two round table discussions on the National Care Service and Racialised Health Inequalities, and crowned our annual poster competition winner too.

Introductions



Justina Murray, Scottish Families Affected by Alcohol and Drugs, expertly chaired the conference, remarking on the wealth of experience among delegates and the energising feeling in the room. Claire Stevens, Voluntary Health Scotland, used Nigel Crisp's terminology to describe delegates as "health creators" and pioneers in society. She talked about our society's tendency to reach for the prescription pad which can exacerbate the Inverse Care Law. She acknowledged how difficult it is to think about prevention while we are facing a cost-of-living crisis and always firefighting. She highlighted the Health, Social Care & Sport Committee's recent inquiry into health inequalities and remarked on how moved MSPs had been by the testimonies they heard during informal evidence sessions. Claire ended by describing everyone in the room as social justice warriors and encouraged us to give people a voice and take meaningful action to create fair health.

Jason Leitch CBE, National Clinical Director, Scottish Government

Jason Leitch shared his experience working with government during the COVID-19 pandemic to communicate public health messages and create solutions to ever developing challenges. He spoke about leadership during a time of crisis and developing trust with the public. In Scotland public trust in government stayed over 80% during the whole pandemic. Jason attributed this in part to the First Minister always holding press conferences with a clinician. He also noted Scotland was the only country in the world which provided a sign reader with every press conference.

COVID-19 Vaccines
He reminded delegates the only reason we were able to live without restrictions was due to the vaccine which he encouraged everyone to take. He said the real task now was improving the global vaccine situation. Global mortality has only now stopped rising, he said we were only just entering the beginning of the end.



Leadership
Jason praised the relentless work of the volunteers involved in the vaccine rollout and said he could not imagine the pandemic without the voluntary sector.



He went on to outline the **high impact leadership behaviours** from the Institute for Healthcare Improvement and how these apply to every member of every team. These are the behaviours of the highest performing health services in the world. On frontline engagement he emphasised that you can't understand a system if you don't walk it. "Boundarilessness" was delivering care all together and breaking down boundaries because people don't care who their care comes from, they just need the care and advice.

Staff Wellbeing
Jason ended by speaking about the importance of wellbeing in the workforce, noting wellbeing wasn't a free cappuccino at work but rather a decent salary, leaving on time and having time to be with family. He emphasised we need to look after our staff and build kindness into the system.

During the Q&A:
- **Staff Wellbeing**: Claire Blair, East Renfrewshire Health & Social Care Partnership asked about how health boards could increase uptake of wellbeing initiatives and questioned whether it was just a case of freeing up staff time. Jason felt we had to encourage people to have a balanced life and managers had to work on what this looked like.
- **Access to Services:** Alistair Hudson, HIV Scotland, highlighted the culture shift we had seen in terms of access to services during the pandemic and asked if there were plans to map it. Jason agreed we learned much more about what different groups think about services during the pandemic, for example the Polish community tended to be less likely to take up the vaccine than other groups.

Chris Creegan, Strategic Adviser and Chair of the Expert Advisory Panel, Health Foundation review of health inequalities in Scotland

Chris Creegan spoke about the progress of the Health Foundation's Review of Health Inequalities in Scotland. We heard the review is due to report early 2023 but the four individual workstreams within the review would publish separate reports on their work throughout November. He explained the review was much more focused on the social determinants of health rather than the health system and access to it.

Chris shared some of the top line findings which had emerged so far:

- **Life expectancy:** The statistics show average life expectancy at birth for males is 76.6 years and 80.8 years for females. The figures continue the decrease from the previous year which was the sharpest fall from 1980-82. Deprivation continues to have a marked impact on this. Average male life expectancy was 13.7 years lower in more deprived areas. The gap is wider than previous years.
- **Stagnation:** Around a decade ago (2010-20) life expectancy stalled and started to reverse. This coincided with an unprecedented stagnation in household incomes.
- **Health inequalities:** Health consistently worsens as deprivation increases.
- **Policy and investment**: There are real frustrations from stakeholders about the lack of long-term planning and investment. Good practice exists but it isn't easily scaled up. There are questions about the maturity of our policy and delivery systems.

Fair Health

Chris explained the fortunes of people in th most deprived communities are not only worsening but are increasingly detached from those in the rest of the population, set adrift and storing up real trouble for the future. However, he noted 60% of Scots recognise that poverty is a driver of poor health according to the British Social Attitudes Survey. There's beginning to be more of an understanding that health isn't just about behaviours and lifestyles but social determinants.



The Implementation Gap

He discussed the role of the "implementation gap" in policy to tackle health inequalities. He felt we need to acknowledge the limitations of the powers that lie with Holyrood but equally we need to work to do better with the powers we have. There is no single policy lever that will solve health inequalities it requires a long term and sustained response. This can't be up to governments alone. Chris explained we need a whole system approach which includes the third sector. Crucially, we need to harness the public's willingness for a preventative approach.

During the Q&A:

- **Public Perception:** In response to a question about challenging the perception of health inequalities, Chris Creegan felt we needed to draw a line now. We already know a lot of the problems and the current approach isn't working. Collaboration is key to building solutions, and we need to be thinking much further into the future. Chris encouraged us to think about the country we want to be in 100 years' time not ten years' time.
- **SIMD:** Jim Hume, Support in Mind, asked whether the Scottish Index of Multiple Deprivation (SIMD) was fit for purpose. Chris acknowledged its shortfalls and said analysis of SIMD would be included in the Glasgow University strand of the review.

Panel Session: Realistic Medicine, Communities and Inequalities

- **Alison Leitch,** Community Link Worker Assistant Service Manager, EVOC
- **Sandra MacAllister**, Senior Health Improvement Specialist, NHS Highland
- **Roddy Samson,** Welfare Advice Service Facilitator, Improvement Service, iHub
- **Anna Baxendale,** Head of Health Improvement, Glasgow City Health and Social Care Partnership

The panel discussed the benefits of having multidisciplinary teams in General Practice, including Community Link Workers (CLWs) and Welfare Advice Services. They acknowledged the importance of taking a rights-based approach to healthcare and building relationships with patients, especially those often missing from services. Sandra provided an important perspective on rurality and how this can impact people's access to services. Alison spoke about the socio-economic challenges that often bring patients to general practice and Roddy spoke about how welfare advice can help support people. Anna underlined the importance of working in collaboration to improve the population's health at a local level.

Primary Care in the Highlands
Sandra provided a perspective from the CLWs in the Highlands, highlighting a car was essential for many households because their community is so remote. She noted SIMD doesn't pick up small pockets of poverty in communities, so it wasn't a very effective tool for measuring deprivation. We heard the highest rates of fuel poverty in Scotland were in the Highlands and they face significant digital connectivity issues.



Socio-economic issues
Alison explained there were CLWs in 60% of GP practices in Edinburgh, employed by third sector organisations. This allows for positive collaboration between primary care and the third sector. She felt housing was one of the greatest socio-economic factors impacting health inequalities in Edinburgh, there were 5000 people in temporary accommodation in the city. Quoting Michael Marmot, she asked why we keep sending people back to the conditions that make them sick.

Welfare Support
Roddy said welfare advice services reach particularly vulnerable groups through GP practices and often people who have never accessed an advice service before. He felt the success of the service was because there's no stigma associated with it. He said evaluation shows it frees up staff time for clinical care and GPs spend up to 50% of their time dealing with non-medical issues. Welfare advice services provide a speciality to practice teams. We heard £8500 was the usual income maximisation for individuals.

Public Health
Anna felt improving the health of the population was about aligning what we can do in partnership. She felt there was currently a very strong policy context for social prescribing, but she had concerns that "everybody's job can become nobody's job" when it comes to health inequalities. She emphasised that health literacy was vital as information was power.

During the Q&A:

- **Patient Rights**: Justina asked the panel how we make rights real for people. Roddy felt we needed to be able to enforce rights and advocacy was key to this. Alison added that it was about empowering patients to make decisions, tackling stigma and taking an empathetic approach. She drew on the approach to social security being taken by Social Security Scotland. Anna agreed we needed the health system to take a rights-based approach and asked how we fix the implementation gap. Sandra felt "being entitled to services" was perhaps better wording than human rights.
- **Social Prescribing:** Justina asked if social prescribing was still seen as the "fluffy" end of health care. The panel felt people understood the role of poverty in health outcomes but Anna felt some people perhaps don't know their role in tackling it. She felt knowing who the community assets were was key and Alison highlighted the importance of building relationships with patients. Alison added that CLWs need to be recognised as part of the social prescribing team. Roddy noted every GP practice was different so understanding culture was key as approaches can vary. Sandra added that GPs were now getting training in social prescribing.
- **Funding Landscape**: Rebecca Campbell, NHS Greater Glasgow & Clyde, questioned how we ensure we aren't duplicating and confusing the landscape by offering all these different types of support. Alison said funders work hard to identify gaps in provision. However, she noted the short-term nature of funding and projects was an issue and a real risk to the third sector.



- **Missing in Health:** Ese Johnson, Waverley Care, raised concerns about accountability and asked how we ensure we reach the communities missing from the table. Alison said making sure services were accessible was challenging and she felt there needed to be an overarching strategy for social prescribing in government. She noted there were Polish CLWs in Edinburgh and CLWs for asylum seekers in Glasgow. However, she noted this was left up to individual services to organise. She echoed calls from the Royal College of General Practitioners for a CLW in every practice.
- **Implementation Gap:** Amy Dalrymple, Marie Curie, asked about the implementation gap in social prescribing. Sandra felt we needed to stop evidencing social prescribing in the same way as medical interventions. Anna emphasised funding was key. She said investment felt quite crisis orientated and this leads to issues in evaluation. She explained funding needed to strengthen what's available on the ground and we shouldn't work in silos. Roddy added that we need a coherent picture of what are were trying to do and clear communication. Alison felt the third sector needed to be seen as an equal partner. We want to be proactive not reactive. Sandra urged people to be aware of the context in rural areas when developing policy and services.

Workshop - The National Care Service (Scotland) Bill

Ewan Masson from the Scottish Parliament's Participation & Communities Team and Alex Bruce, Lead Clerk, Health, Social Care & Sport Committee, provided a brief update on the progress of the National Care Service (Scotland) Bill to date and the committee's scrutiny. They explained the difference between the Scottish Parliament and the Scottish Government, noting the parliament's role is scrutiny of the legislation brought forward by the government. The committees involved would be taking evidence until Christmas followed by a Stage 1 report and parliamentary debate on the general principles of the bill.

Alex Bruce explained the National Care Service would shift powers from local authorities to a new national care body. He outlined the co-design ambitions of service and the role of ethical commissioning in establishing services.



Everyone in the room was then given the opportunity to reflect on their own hopes and concerns about creating a National Care Service and discuss this within small groups.

Feedback from delegates:

- **Fair care:** We want to create fair health and fair care for all. This ambition must include staff too through fair wages and better work conditions. Recruitment and retention of staff was highlighted as a key issue.
- **Person centred:** We must take people's values and beliefs into account as part of their care to make the service truly person centred. We should be asking people what they want from social care and taking a human rights-based approach. We want a family friendly service that's accessible and not full of jargon. Inclusion needs to be key along with reducing inequalities. Dignity, respect and fairness should be the ethos.
- **Data**: Information and data sharing needs to be improved.
- **The details**: The transition to the new service needs to be smooth. There were significant concerns that we don't have enough information about what the service will look like.
- **Third Sector**: The third sector should be involved in strategic planning and valued. Carers and the third sector must also have a meaningful seat at the table on the proposed care boards along with voting rights. We need to take a meaningful co-design and co-production approach. Partnership working should be encouraged along with collaborative working with the third sector.
- **Living experience:** We need to acknowledge there is "living experience" along with lived experience.
- **Post code lottery:** We hope the service will remove the post code lottery in care services.
- **Agility**: We need to reflect on our experience during the pandemic and learn from it. We want a service that's agile and can adapt to people's needs without unnecessary bureaucracy. Although each locality will be different there needs to be cohesion and coherence across the service.
- **Integration**: We want better integration between health and social care services.
- **Anne's Law**: Full implementation of "Anne's Law" on right to visitors for residents in care homes. There were concerns the bill in its current form does not deliver this.
- **Long-term ambitions:** We need a long-term focus, far beyond parliamentary terms. Thinking about the services we want to see in 100 years, not ten.

The views collected during this session will be fed into the Health, Social Care & Sport Committee's scrutiny of the National Care Service (Scotland) Bill.

Round Table Discussion - Racialised Health Inequalities

Andrea Lenssen and Rahima Kashim, Racialised Health Inequalities & Health Equity, Scottish Government, provided some insight into the extent of the health inequalities faced by different ethnic minority groups and then facilitated table discussions about how we can create fair health for everyone.

Race, racism and racialisation
Rahima emphasised that black and ethnic minority people were not a homogenous group, a point which was echoed during the wider discussion. She highlighted that black women were four times more likely to die in child birth than white women. She explained the difference between race, racism and racialisation. Noting racialisation was the systematic factors that created health inequalities. She explained the cumulative effect microaggressions and structural racism can have on people. This can lead to chronic stress which is a risk factor for hypertension, mental disorders, diabetes, breast cancer and obesity. Rahima highlighted the shocking BMA finding that 95% of doctors who died from COVID were from minority ethnic communities in the UK.

The Race Equality Framework for Scotland
Andrea said racialised health inequalities were a systemic issue that required a systemic response. She outlined the government's vision for 2030 which was co-produced with minority ethnic groups and the third sector. The government is trying to involve people with lived experience in a meaningful and sustainable way. She said their approach was "do something, do more, do better" quoting Michael Marmot. The Expert Reference Group on COVID and ethnicity was working on a race equality immediate priorities plan. The key themes were:

- Accountability and leadership
- Data and experience
- Workforce and capability



Data
Andrea noted progress had been made on collecting ethnicity data as this was now being collected as part of the COVID-19 vaccine programme to help create an inclusive approach. She praised the work of the Vaccine Inclusive Steering Group in this.

Participants were then invited to reflect on steps they had taken or could take to identify inequalities faced by minority ethnic people they serve/support. Some key feedback included:

- **Communication**: CLWs noted translation services in general practice had not all returned since the pandemic. Often practitioners were relying on a telephone translation service which had significant limitations. This creates substantial barriers to accessing health care. The importance of translating materials into understandable language was highlighted.
- **Inclusion Service:** The NHS Minority Ethnic Inclusion Service was cited as a positive example of working with communities and third sector to engage with people.
- **Representation**: Having representative staff in the NHS is key, we need a more diverse workforce in health and the third sector.
- **Awareness:** We need better education and awareness on racialisation. We have to have more conversations about racialisation and health inequalities, keep this on the agenda and gain more knowledge about people's experience.
- **Actioning Contributions:** People are fed up giving up their free time to contribute to policy and service developments without seeing any change. This becomes tiresome, tokenistic and disempowering.
- **Building Trust:** Waverley Care shared that they operate an open-door policy to build trust in services. Margaret Lance underlined the importance of taking services to people. We need to actively reach people not just sit and wait for them to access services. If people aren't in the usual places go to the unusual places.

Poster Competition



The day finished with two-minute pitches from each of our poster finalists. Congratulations to the ALLIANCE entry 'Fair Health – Community Links At Work' which won the competition.

Finalists included:

- **Action for ME**: Learn about ME
- **ASH Scotland**: Engaging communities towards being smoke-free: reducing poverty and health inequalities
- **Chest Heart and Stroke Scotland**: A year of Community Health Defence
- **COPE Scotland**: Challenges on the sea of life and what can sustain us
- **Families Outside**: Hidden Sentences
- **Kidney Research UK**: Diversity in organ donation within Scotland
- **See Me**: With Fairness in Mind
- **Sleep Scotland**: Healthy sleep- who gets it?
- **The Health and Social care Alliance Scotland (The ALLIANCE)**: Fair Health – Community Links At Work
- **The Health and Social Care Alliance Scotland (the ALLIANCE)**: Protecting human rights in an evolving digital landscape

You can view all the posters and blogs by each of the finalists on the VHS website. Thank you to everyone who entered.



Thank you from the Voluntary Health Scotland team to all our speakers, delegates, facilitators, exhibitors, poster entrants and helping hands who made our conference possible.

Photographed right to left:
Claire Stevens,
Kimberley Somerside,
Lauren Blair,
Roisin Hurst,
Alison Crofts,
Findlay Smith.

For more information please contact Kimberley, Policy & Engagement Lead: kimberley.somerside@vhscotland.org.uk

vhs voluntary health scotland
18 York Place, Edinburgh, EH1 3EP
0131 474 6189 mail@vhscotland.org.uk www.vhscotland.org.uk @VHSComms

Registered Scottish Charity SC035482. A company limited by guarantee SC267315