FOLLOWING 19 DECEMBER 2012 COMMITTEE MEETING, A FURTHER RESPONSE FROM THE SCOTTISH GOVERNMENT ON HEALTH INEQUALITIES REPORT

Issue 1:
Derek Feeley: One of the issues with exhibit 10 and exhibit 11, which shows our own figures, is what is included and what is excluded. For example, exhibit 10 is largely Scottish Government spending on health improvement and the public health domain—it does not include things such as the family-nurse partnership initiative, which is very much aimed at addressing health inequalities, or the QOF payments, which are, in some respects, also aimed at addressing health inequalities. There is always an issue about what to include and what to exclude.

None of those numbers will reflect the fact that much of our health spending is made according to need and, as we heard clearly from the Auditor General, Mary Scanlon and others, need is significantly greater in deprived areas. Therefore, in the overall health budget, a significant proportion will be allocated to deprived communities.

We could carry out the comparative analysis, look at what is in these allocations and extrapolate them, but I am not sure that it would give us a strong signal about whether we would be likely to improve health inequalities.

The Convener: It might not but surely the evidence in the report shows that although some central allocations are made with an element of consideration of need it is not possible to demonstrate how that translates into distribution on the ground. If the Scottish Government is making allocations centrally with that in mind, what do you intend to do to ensure that at health board and CHP level—and perhaps more locally than that—funds follow need, which is surely the intention of central Government when it makes the allocations in the first place?

Response:
Whilst it is for individual NHS Boards to make decisions on the internal allocation of funding flows we do have a number of means by which we can track outcomes and to some extent help to influence the distribution of resources. For example the Scottish Public Health Observatory published a review¹ of equality health data needs in September 2012 in fulfilment of recommendation 74 of Equally Well. The report made a number of recommendations aimed at the NHS and Government many of which are being taken forward to improve the quality of experience of all users of the NHS by helping ensure resources are better targeted. In addition we have amended some of our HEAT targets, (e.g. smoking cessation, breastfeeding) so that they have a greater focus on deprived communities and groups which helps ensure that resources are targeted appropriately. NHS Boards are developing innovative new ways to deliver preventative services in these communities. We also publish annually long-term indicators of health inequalities which help us monitor outcomes and contribute to our understanding of the impact we are having.

Issue 2:

Mary Scanlon: I have a supplementary question on exhibit 11, which I note shows that there has been a small increase in funding for “Harms to health and well-being: alcohol, drugs, violence”, and for “Early years and young people”.

However, the exhibit shows that the budget for “Health and well-being ... diet and physical activity, health checks, smoking” has been cut; and that the budget for “Physical environments and transport”—the area that Mr Feeley just mentioned—has been cut by £6 million; and the budget for “Poverty and employment” has been cut by £5 million. So, if Sally Macintyre identified those issues in a report five years ago, why are you cutting the specific budgets for them?

Derek Feeley: I cannot speak to all those budget lines as I am not the accountable officer for all of them and I certainly do not have all the detail. However, if it would help the committee, we can do the forward comparison of what is in those particular budget lines.

Response:
Exhibit 11 is taken from a table in Equally Well which was more detailed and trying to illustrate the range of activity that the Government was undertaking to tackle health inequalities. Because many of these projects were new and still in the planning stage or in some cases demand led they did not always include the potential spend beyond 2008/09. For example in the original table in the Equally Well report £13.5m is attributed to the likely spend for Minor Ailments in 2008/09. Nothing was indicated for 2009/10 and 2010/11. We now know that an additional £13.5m and £14m was spent on Minor Ailments. There are similar examples throughout the table such as the Smarter Choices, Smarter Places project which was in its planning stage and had identified a likely spend of around £4m against 2008/09 although it noted in Equally Well that there may be future spend. We now know that £9.2m was spent on this project over the three year period. Therefore the figures quoted by Mary Scanlon were always intended to be illustrative rather than definitive and were a snapshot at a particular point in time. I will commission a piece of work that will look in more depth and detail at the overall resource devoted to tackling health inequalities. I anticipate that this may take several months and is therefore unlikely to report before the summer. I hope that is acceptable to the committee.

Issue 3
Mary Scanlon: There has been no cross-working ministerial task force for four years.
Donald Henderson (Scottish Government): Sorry, can I come in? It was before my time in my current job, but there was a reconvening in 2010, which I understand was less fundamental than the original 2008 inquiry. However, it is broadly every two years that ministers have wanted to look at this area. In fact, if it had not been for the Audit Scotland inquiry, I think that we would have kick started this work probably a bit before the summer rather than a bit after the summer, but we wanted to see where the Audit Scotland work was taking us.

Mary Scanlon: So since 2008 there has been one meeting of a ministerial task force—in 2010.

Donald Henderson: No, there was a reconvening of the process in 2010.
Mary Scanlon: Okay.

Donald Henderson: We can write to you about the details of that.

Response:
The first Ministerial Task Force met on 8 occasions during 2007/08:

3 October 2007
7 November 2007
5 December 2007
9 January 2008
6 February 2008
5 March 2008
2 April 2008
7 May 2008

The Ministerial Task Force was reconvened 2010 for the purposes of conducting a review. It met three times

12 January 2010
3 March 2010
13 April 2010

The Ministerial Task Force was reconvened for a second time for the purposes of conducting a review. So far it has met once on 29 November 2012. Further meetings of the Task Force will be necessary as part of the review process.

Issue 4:
Mary Scanlon: I do not want to go back, but certainly for 13 years, focusing on public health has not been a matter for criticism in this Parliament. I have one simple question that I asked earlier about what may not be one of the major strategies, but is important nonetheless. What can you do about getting a joined-up information technology system between a pharmacist and a GP?

In this age—in this century—with the technology that we have, why does a pharmacist have to print off information, get on his bike and take the information to a GP because there is no secure email and there is no incentive to carry out health checks? Can that be overcome?

Derek Feeley: I am sure that it can be overcome. We have made considerable progress over recent years in the electronic transmission of prescriptions, for example. Most of that now is done electronically. I do not know where that example comes from but I will investigate and I am sure that it can be fixed.
Response:
The Scottish Government promotes the sharing of appropriate information, with the patient’s consent, between organisations and as such national pharmaceutical services are all supported with the appropriate infrastructure to ensure this occurs safely and efficiently. The ePharmacy Programme provides the technology support to underpin the community pharmacy contract in Scotland. As part of the programme all community pharmacies have been connected to the N3 network and this has also provided access to NHSmail. NHSmail is an email system that allows secure exchange of clinical information, including patient identifiable information, between NHSmail users. Some pharmacy multiple groups have not taken up the NHSmail service, preferring to use their own email systems which carry their individual company disclaimers. In this particular case the issue may be that the pharmacy did not use NHSmail and therefore could not guarantee the security of the sharing of patient data electronically. It appears that this was a local service and therefore not supported by the ePharmacy Programme.

The Pharmacy and Medicines Division will consider the possibility of mandating the use of NHSmail to support health-related email communications. This would ensure a mechanism for sharing information out-with the ePharmacy Programme. In addition, they will explore the potential for securing access to resources such as the Key Information Summary (KIS) for community pharmacists.

Issue 5
The Convener: I will perhaps come back in later to follow up on that point, but I have a question for Mr Feeley. In the commentary on the distribution of GPs, the report makes the point that there are no whole-time equivalent figures broken down by deprivation. Is there any possibility of that level of information becoming available?

Derek Feeley: We can have a look at that. If we can construct even some kind of estimate for the committee, we will do that.

Response:
It has not been possible to construct an estimate of whole time equivalent (WTE) GPs across Scotland. Calculating WTE figures for GPs is not straightforward since GP practices are virtually all independent contractors and are not employed by Health Boards. However, we will be carrying out a survey of GPs this year which will indicate WTE figures for GPs and other practice-based health professionals. This will not be broken down by deprivation. Most GP practices serve populations living in a mixture of areas, some more deprived than others. In addition, the whole GP practice team is important in the delivery of health care, and as independent contractors, GPs are free to decide (within the context of the services they must provide under contract with Boards) exactly how they set up their operations in terms of employing staff to best meet patients’ needs. Health Boards have a legal duty to ensure that GP services meet the reasonable needs of their patient population.

Issue 6:
Willie Coffey: I sometimes have to remind myself that we are the Public Audit Committee, not the Health and Sport Committee. I asked the Auditor General and her team whether there was evidence to show that the investment that has been made in dental practices since 2007—in particular, the incentive scheme—had
resulted in better outcomes for public health. I ask the witnesses to indicate whether that is the case.

Derek Feeley: There are better outcomes, but they are spread throughout the deprivation deciles because a number of things that we have been doing, such as fluoride varnishing, have made a big difference, but they have made a big difference for everybody.

The best thing to do is to offer to write to the committee with whatever evidence exists about what that additional investment has bought. It has been part of a broader programme to improve dental outcomes in Scotland, so I fear that it would be difficult to identify cause and effect in relation to the investment.

Response:
I said at the time of my appearance that it is particularly problematic to attribute the effect of specific programmes of investment on outcomes and I stand by that observation. However the following areas are most likely to have been particularly responsive to additional investment in dentistry.

Patient Registrations
Between the quarter periods ending March 2007 to March 2012 the number of people registered for NHS dental services in Scotland increased by almost 60 per cent. We have also observed growth of 10.6 per cent in registrations of patients with postcode addresses from the most deprived category between the quarter periods ending March 2010 to March 20123, compared with around 9 per cent growth for the whole population over the same period. This is a welcome development showing that registration rates are improving amongst people from more deprived backgrounds. More information is available at the following link:

http://www.isdscotland.org/Health-Topics/Dental-Care/General-Dental-Service/registration-and-participation.asp

Dental Health Outcomes
In describing progress on dental health outcomes I would like to refer the committee to a recent report by the National Dental Inspection Programme (NDIP) for 2012. The programme is carried out each year, alternating between P1 and P7 schoolchildren. The exercise is sufficiently large to guarantee statistically-robust data at NHS Board level. The 2012 Report constitutes the latest in a series of reports with comparable data going back to 1988. It is an excellent resource for providing an insight into what progress has been made in improving the oral health of this important target population.

The 2012 Report covers a range of areas. I will summarise a few highlights:

2 The committee should be aware that the publication of registration data for the quarter period ending September 2012 has been delayed. ISD have identified a problem with duplicate registrations and are also investigating historical data. The intention is to publish correct figures as early as possible during February 2013.

3 Information by SIMD is only available from March 2010.
The proportion of P1 children with ‘no obvious decay experience’ was 67 per cent in 2012. This compares with 64 per cent in 2010, and 57.7 per cent in 2008. In 2003 the figure was 44.6 per cent.

All NHS Boards for the first time in 2012 met the national target that 60 per cent of P1 children should have ‘no obvious decay experience’. The target was reached at a Scotland level in 2010.

I also understand that preliminary work relating to dental general anaesthesia data for the period 2002-11 in Scotland show an overall reduction in general anaesthesia for dental extractions. This is encouraging given the continuing investment in oral health initiatives.

Health Inequalities
The NDIP programme has some good news to report on this issue. By stratifying the sample of P1 children into equal parts of 10 per cent of the population, with those with the worst tooth decay in the bottom 10 per cent and those in best oral health in the top 10 per cent, the 2012 Report was able to show that inequality, in terms of tooth decay, in the P1 age group has fallen (and quite significantly between 2008 and 2012).

Stratifying the same sample by SIMD shows that while there has been clear progress across all deprivation categories, the proportion of children with no dental decay in the most deprived category continues to lag well behind those in the least deprived (see table below). One consolation is the improvement in this particular measure between 2008 and 2012 in the most deprived category is comparable with the least deprived.
<table>
<thead>
<tr>
<th>SIMD 1 (most deprived)</th>
<th>% of Children with No Tooth Decay</th>
<th>2008</th>
<th>2010</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIMD 2</td>
<td></td>
<td>52.2</td>
<td>58.5</td>
<td>62.1</td>
</tr>
<tr>
<td>SIMD 3</td>
<td></td>
<td>58.6</td>
<td>64.5</td>
<td>68.1</td>
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<td>SIMD 4</td>
<td></td>
<td>67.7</td>
<td>73.7</td>
<td>75.5</td>
</tr>
<tr>
<td>SIMD 5 (least deprived)</td>
<td></td>
<td>73.1</td>
<td>78.7</td>
<td>81.2</td>
</tr>
</tbody>
</table>

The 2012 NDIP Report is available at the following link: [http://www.isdscotland.org/Health-Topics/Dental-Care/National-Dental-Inspection-Programme/](http://www.isdscotland.org/Health-Topics/Dental-Care/National-Dental-Inspection-Programme/)

**Childsmile Practice Programme**

The Childsmile practice programme is designed to improve the oral health of children from birth by working closely with dental practices. The programme aims to provide a continuous care service from six months of age that includes (a) oral health advice (b) annual dental check-ups and treatment and (c) twice-yearly fluoride varnish applications from two years of age.

The programme was rolled-out from October 2011 and supported by £2m of dedicated funding per annum. Dental practices will receive payments on a capitation and fee for item of service basis. Importantly, payments are heavily skewed to those patients with a postcode from SIMD 1, 2 and 3; a weighted capitation payment remunerates dental practices by 3:1 in favour of patients from the lowest three deprivation categories.

While the programme is too new to have any meaningful bearing on the NDIP 2012 Report, the expectation is that this will incentivise practices to target children from more deprived areas with consequential improvements in dental health. The preliminary data from the programme is encouraging with 84 per cent of independent contractor GDS practices delivering Childsmile interventions.