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Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 25 March 2014

Session 4

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HEALTH AND SPORT COMMITTEE

10th Meeting 2014, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Rhoda Grant (Highlands and Islands) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
*Richard Lyle (Central Scotland) (SNP)
*Aileen McLeod (South Scotland) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Gil Paterson (Clydebank and Milngavie) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Fiona Collie (Carers Scotland)
Pam Duncan (Independent Living in Scotland Project)
Dr Ima Jackson (Glasgow Refugee, Asylum and Migration Research Network)
Hanna McCulloch (Child Poverty Action Group in Scotland)
Nina Murray (Scottish Refugee Council)
Lexi Parfitt (Scottish Association for Mental Health)
Derek Young (Age Scotland)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

Committee Room 6

Scottish Parliament

Health and Sport Committee

Tuesday 25 March 2014

[The Convener *opened the meeting at 09:45*]

Decision on Taking Business in Private

The Convener (Duncan McNeil): Good morning, and welcome to the 10th meeting in 2014 of the Health and Sport Committee. As usual, I ask everyone to switch off mobile phones and BlackBerrys so that they do not disturb the meeting. It should be noted, however, that members and officials are using tablet devices instead of hard copies of our papers.

Agenda item 1 is a decision on whether to take item 3 in private. Item 3 is consideration of our approach to the Food (Scotland) Bill. Do members agree to take item 3 in private?

Members *indicated agreement.*

Health Inequalities

09:46

The Convener: Agenda item 2 is a return to our theme of health inequalities. The committee has agreed that the next inquiry on the theme will be on the early years but, before we start taking oral evidence on that next month, we have agreed to have a couple of sessions on access to services. This morning, we have a round-table session with representatives of various organisations. I welcome you all.

As usual with a round table, we will introduce ourselves. My name is Duncan McNeil, and I am the member of the Scottish Parliament for Greenock and Inverclyde and convener of the committee.

Dr Ima Jackson (Glasgow Refugee, Asylum and Migration Research Network): I am from Glasgow Caledonian University, and I am representing the Glasgow refugee, asylum and migration research network—GRAMNet—at the University of Glasgow.

Bob Doris (Glasgow) (SNP): I am an MSP for Glasgow and the deputy convener of the committee.

Nina Murray (Scottish Refugee Council): I am the women’s policy development officer at the Scottish Refugee Council.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I am an MSP for Mid Scotland and Fife.

Hanna McCulloch (Child Poverty Action Group in Scotland): I am the policy and parliamentary officer for the Child Poverty Action Group in Scotland.

Richard Lyle (Central Scotland) (SNP): I am an MSP for Central Scotland.

Fiona Collie (Carers Scotland): I am the policy and public affairs manager for Carers Scotland.

Colin Keir (Edinburgh Western) (SNP): I am the MSP for Edinburgh Western.

Gil Paterson (Clydebank and Milngavie) (SNP): I am the MSP for Clydebank and Milngavie.

Pam Duncan (Independent Living in Scotland): I am a policy officer for the independent living in Scotland project.

Aileen McLeod (South Scotland) (SNP): I am an MSP for South Scotland.

Derek Young (Age Scotland): I am a policy officer with Age Scotland.

Rhoda Grant (Highlands and Islands) (Lab): I am a Highlands and Islands MSP.

Lexi Parfitt (Scottish Association for Mental Health): I am a campaigns officer for the Scottish Association for Mental Health.

Nanette Milne (North East Scotland) (Con): I am an MSP for North East Scotland.

The Convener: Thank you. That is the formalities over. The first question is from Gil Paterson, just to get us going.

Gil Paterson: I have a fairly fundamental question. Which comes first: health inequalities or poverty? Can we solve health inequalities without solving poverty?

Hanna McCulloch: It is obvious that the relationship between poverty and health in the early years is extremely complex and in some cases it is a cyclical relationship. Part of the relationship between poverty and health is fairly direct, in that low incomes have a direct negative impact on health through things such as dietary issues. For instance, there is a fairly direct link between poverty and obesity. In other circumstances, the relationship is much more complex. Poverty causes stress in a household, which can impact on a child's mental health and cognitive development, which can reinforce poverty and ill health.

At CPAG, we realise that increasing household income will not eradicate health inequalities, but it is unlikely that inequalities can be tackled meaningfully until every family has an income that is sufficient to meet their most basic needs. We would start by increasing household income. That will not solve the problem, but it is impossible to solve the problem without doing it.

Lexi Parfitt: First, I will make a specific point about mental health. We know from decades of research about the complex interaction between poverty and mental health, and we know that poverty is both a cause and a symptom of poor mental health. For example, people with mental health problems are quite vulnerable to poverty and deprivation. If a person is mentally unwell, it can be quite difficult for them to deal with bills and so on, which makes them more vulnerable. For example, bipolar is characterised by extreme highs followed by extreme lows. When people are in their high period, it is not uncommon for them to give money away and spend money left, right and centre, which leaves them quite vulnerable.

If someone is unwell with a mental health problem, they are not able to work and are in the house a lot more, so their fuel bills may be higher and they are more likely to be dependent on welfare benefits.

All the changes to the welfare system are having an extreme impact on people's mental health. SAMH has recently done a research report into how welfare reform is impacting on mental health in Scotland, and some of the findings are very concerning.

I return to the original question about inequalities and access to services. A number of people with mental health problems who are living in poverty and deprivation are dependent on the welfare system. It can be very difficult for them to access services at all if they do not have the income to pay a bus fare to get to their appointment. If they live in a remote and rural area and need to get to an appointment at a hospital that is miles away, a difficulty is that public transport does not run very regularly in the winter. All those issues can arise.

If someone cannot afford to connect into their community, they might not be able to afford to go to their support service. A number of our service users have said that, as a direct result of the welfare reforms and the reduction in their income, they can no longer afford to connect into the service that supports them. That is a big worry for us.

You asked which one—health inequalities or poverty—should be tackled first, and Hanna McCulloch rightly pointed out that we cannot do one without the other. We urgently need to make a concerted effort to tackle poverty and deprivation in Scotland, but equally we need to make efforts to ensure that our services are well resourced across geographies and across different groups that have different needs. Both poverty and ill health have to be tackled.

Fiona Collie: I agree that the answer is yes and no. Levels of debt for carers are very high. Carers are less likely to be working and are more likely to be living in deprived areas. That has a direct impact on their health. There are carers who are not in such situations and who have access to an adequate amount of money, but they face comparable difficulties in accessing support for their own health—for example being able to access general practitioner appointments and to attend hospital. That is about access to services and the availability of services, which is where we see a very big gap.

If the lack of services is tackled, more carers would perhaps be able to work, but the current level of services means that many people cannot do so. There is a group of older carers who may have access to more income but they also have significant health problems of their own and they have the same problems with accessing services.

Derek Young: A consistent theme is emerging that it is partly true that poverty is a big issue in relation to health inequalities but it is not the whole story. It is certainly true that pensioner poverty is a problem in Scotland: 160,000 pensioners live in poverty and a further 100,000 are on the edge of it. Half of pensioner households are experiencing fuel poverty, because energy bills are rising; that is a significant concern for many older people.

However, we cannot and should not ignore other challenges. One factor is public perceptions of old age, so there is an issue about whether older people feel that health professionals and allied health professionals understand their particular needs and circumstances—not only their physical health, but their social circumstances.

Another issue is the increasing use of technology in the health context, which might exclude older people who are unfamiliar with it. Lexi Parfitt mentioned rurality and physical geographical isolation. The sense of isolation and loneliness that many older people feel is not always related to poverty. Age Scotland has campaigned on that recently with the still waiting campaign, because community transport is very important where public transport options are not up to scratch.

Nina Murray: From our perspective, the issues of poverty and ill health are very much intertwined. I work with refugees and asylum seekers and the vast majority of asylum seekers live in poverty in deprived areas, predominantly in Glasgow. Accessibility of services, bus fares and travel to hospitals are key issues.

Those asylum seekers who have support live on minimal levels of Home Office support. We have recently carried out research on pregnant women and the accessibility of Glasgow maternity services. For pregnant women who have been refused asylum, who may be living on cashless support, just being able to get to maternity appointments is a huge issue. Most women did not know that they had any entitlement to support with getting to hospital appointments. We heard stories of people having to walk home after giving birth, and things like that. Poverty is a key issue for us.

Our refugee integration research showed worsening self-identified health as people went through the asylum process, which indicates that there are links between people living in limbo in a marginalised situation, without the ability to work or rebuild their lives, and their reporting worsening health. There are other issues, as others have said, but poverty is one of the key issues for us.

Pam Duncan: Thank you very much for inviting us to give evidence today. I appreciate that.

We said in our evidence that disabled people experience health inequalities in two ways. First, many of them live in poverty; secondly, they are disabled and discrimination exists in access to health services across the piece. Disabled people face an intricate, multilayered problem when they encounter health inequalities in accessing health.

As we know, disabled people are hugely impacted by welfare reforms. Many of them live in poverty and fewer of them than non-disabled people are in work. The issue of poverty for disabled people is big and is getting worse. I commend you to look at some of the papers that Inclusion Scotland has produced, particularly those on the welfare reform agenda, which will give you more of a flavour of that.

The result of that problem is that many disabled people have to make very difficult choices around food, heating and, in some cases, social care. It would not be an evidence session if I did not mention social care charges. Social care charges are increasing for disabled people at a time when they do not have funding to meet those increased costs. People are choosing not to use social care services, which is not an easy choice to make and has a huge impact. We have seen in our evidence and carers organisations’ evidence the impact that lack of social care services has on people. It has a huge impact on disabled people’s health in the long term.

Many disabled people find it difficult to access mainstream transport. Buses are not always accessible and people often do not know where and when buses will turn up, so they rely on forms of transport that are often more expensive. Despite the fact that there is a concessionary travel pass, many people still have to rely on things such as taxis, which are expensive. It could be argued that mobility allowance covers that, but I would make a strong case that mobility allowance is spent several times over and often is not enough. People have difficulty in just getting to appointments.

Flexible systems such as phone appointments are often not available to disabled people, either because they are not accessible options for them or because surgeries do not use them. That is a big issue.

Poverty can lead to huge levels of isolation, which has a massive impact on health. In fact, it is almost as big a concern as some of the main things that we might ordinarily think of regarding health, for example around cancer.

Disabled people find that poverty is a huge barrier to their participation in sport and physical activity, which we know has a huge link to increases in health outcomes. That is a big deal.

This is perhaps a sidetrack, but it is important to mention that although poverty is a big issue so is funding for services. We have touched on that. Social care services operate high-level eligibility criteria, which means that prevention does not feature all that often. Peer support services are also not being funded although they have a huge impact on isolation and often help disabled people to find solutions to some of their problems.

10:00

Another example that we have heard about in the health service is communication support. For example, British Sign Language signers and palantypists for people who are hard of hearing are grossly underfunded and people cannot easily afford to fund those services themselves. It can cost hundreds of pounds to get one of those people to attend a doctor's appointment with someone. We know of an example of a woman who attended maternity appointments but, because she could not afford the communication support and that support was not provided for her, when she tried to lip read the doctor as she was being scanned she missed key phrases. The doctor would say, "That is the baby's—" whatever, and she would look at the screen and miss what was being said because she did not have the right support.

Those are crucial aspects. Yes, poverty is a big issue, but so is the funding of services.

Dr Jackson: There is also lots of evidence from Greece of increases in transmission rates, particularly of infections such as HIV, over the past two years as a direct consequence of austerity measures and increased poverty.

Gil Paterson: Every answer that we have just heard gives rise to a specific question that I could ask of each witness. However, if I did that I would be hogging the show. I will reserve my right—

The Convener: There are a number of common issues such as isolation, exclusion, geography and the resourcing of services. When we look at inequalities, we accept all the evidence of the increasing poverty and the threat of further difficulties for those groups of people who are affected. What can we do to deal with some of the access problems that exist now? That is the challenge for the committee. There is an opportunity for the people who are here to communicate how some of the issues could be mitigated. Can we use this evidence session to put on record some things that the Government and its partners could be doing to reduce the problems that people face? Is that a logical way to go about it?

Fiona Collie: Unsurprisingly, we have looked for solutions, some of which are very complicated and are related to social care funding. The Government needs to look closely at how social care is funded because it is interlinked with how people get support. A third of carers get no support whatever and become ill. Even with support carers can become ill, but without adequate support they are more likely to become ill.

The GP contract will include the requirement to keep a carers register, which is very welcome, but we need a bit more than that. It is all very well for GPs to keep a register, but they need to do something with it. We would like the requirement to be not just for GPs to keep a register, but for them to refer people on to support. That may not be social care support; it may be community resources, it may involve working with them to improve their mental or physical health or it may be health checks. About 12 per cent of carers are getting a health check, mostly through the keep well initiative, but there is an opportunity within the current system to enable carers to have an annual health check to ensure that they are not storing up problems for the future.

There are some good examples of local carers centres. Work is being done with hospitals and GP practices on identifying carers and putting them in contact with the local carers centre, which can start to build a package of support. That is partly about reducing isolation and speaking to other carers who are in the same situation.

There are some practicalities to consider. If a carer becomes ill and the emergency services are contacted, there is nothing that says that the person is a carer and things need to be put in place. I believe that there is an opportunity to do that through NHS 24 and patient records. We have had some discussions with the Scottish Ambulance Service about that, but it has not necessarily gone far enough to make that the practice throughout the country.

Emergency planning is critical when it comes to carers having the confidence that, when they are unwell, there will be back-up for them. If they need to go into hospital urgently, or if they need to go in for a routine operation or for routine support, they should know that there is a plan in place, and they should know what is going to happen. A carer should be able to have the operation that they desperately need.

We know of people who have turned down knee replacement operations or treatment for very serious conditions because they do not think that the support will be there. That is a fairly easy thing to solve, although it takes some time. Emergency planning is mentioned in the proposed carers legislation. If we can tighten up the provision for that, we can start to make a difference.

Nina Murray: There are a lot of interlinking, intersectional issues here. There are refugees and asylum seekers who are carers and who are living with disability or mental health issues. There are older children living in poverty. We have recommended a strategic approach to tackling those issues. An example is the new refugee integration strategy, which we mentioned in our submission. That is a positive development from the Scottish Government, which pulls together all the different areas and relates to the impact on refugee integration. That is to be commended.

We have recommended a few other practical things that could be done. For one, we could think about the impact on Scotland of the Immigration Bill that is going through Westminster. A lot of issues around poverty and the level of support that is given to asylum seekers and refugees are reserved to Westminster and the Home Office. There are policy areas that have a huge impact on refugees and asylum seekers in Scotland and which are devolved to the Scottish Parliament; they include health, education, policing and legal aid.

We recommend that the committee consider the impact of the Immigration Bill in Scotland and the potential for increased statutory charging of migrants for access to healthcare. There is a lot of confusion right across the UK around rights and entitlements to access healthcare, with people presenting to our offices who might have been turned away erroneously from registration with a GP, or who have been asked to pay for care. That does not happen that often—the legislation and guidance in Scotland is clear—but it happens, and we can provide case studies in which it has happened. There is already confusion. People move across the UK while they are in the asylum process, and we need to think about how that might have an impact in Scotland.

We raised the issue of interpreting in our submission, as did Ima Jackson and her team at GRAMNet. Interpreting is a key issue for access to healthcare for refugees, asylum seekers and other migrants whose first language is not English. That issue has been around for a very long time, and it really needs to be considered at a strategic level.

The last issue, which we have already touched on, is about people in Scotland who are living in destitution, perhaps because they have been refused asylum but for various reasons are unable to return home. That issue has been raised previously in the Scottish Parliament. There was a debate in November last year about destitution among refugees and asylum seekers. Something more needs to be done in Scotland to pick up the pieces when people are at risk of street homelessness. Although support levels are a reserved issue, more can be done in Scotland to support those people who are here while they remain here. Those are just a few things that we have recommended.

The Convener: Bob Doris, do you want to come in at this point?

Bob Doris: Yes. Nina Murray has kind of put on the record some of my concerns. I should also point out that understanding within the medical profession about what migrants are and are not entitled to is sometimes not as good as it should be. I have a constituent who was taken off an organ transplant list because their application for asylum was—wrongly—turned down. NHS Greater Glasgow and Clyde has, pretty reasonably, amended that. However, there was a misunderstanding. Whether it is GPs or health boards, although it should not be the case, there can be a grey area about migrants' rights to access services. That should be clarified.

Do you think that that is an issue for not just asylum seekers and refugees but black and minority ethnic communities more generally? If a white person turns up at a GP surgery, it will almost certainly not be assumed that they are an asylum seeker or refugee, so there is a series of questions that that patient will not be asked. The same applies to hospitals. The same applies in relation to the Immigration Bill and how that impacts private landlords in Scotland. Some of the most vulnerable people in Scotland need to go to private landlords for accommodation. Many of those people may be from black and minority ethnic communities and some of them may have been through the asylum system. Are Scottish landlords informed enough to know that the Immigration Bill's consequences will not—I hope—apply in Scotland? There could be unintended consequences there. I would like to hear the panel's comments on that.

Finally, I want to mop up wider issues of the black and minority ethnic community, asylum seekers and refugees in relation to mental health, poverty and employability. Many asylum seekers and refugees come with a significant skill set, which goes downhill when they arrive here because they are not putting that skill set into action, which makes them less employable once they eventually get refugee status and leave to remain. Worklessness may have an impact on their mental health, which may eventually put additional pressure on the Scottish national health service. They eventually access those services but their needs are much more complex. My questions are rather wide-ranging but it is important that we get some of that on the record.

The Convener: That was rather wide-ranging, Bob, and it is not the complete focus here, although there is obviously relevance.

Dr Jackson: I agree with many of Bob Doris's points. You mentioned the UK Immigration Bill. We need clear guidance about what Scotland will decide about who is allowed access to services. As I said in my submission, the creep is happening. Migration on the level that we have had is new to Scotland, but we do not have to go through all the processes and systems: we can learn from other jurisdictions about migration issues and decide to have clear guidance about who is allowed access to services. From my perspective, everyone should have access. The evidence for what is being done in the Immigration Bill around issues such as access to health is very limited. There are ideas about benefit tourists and health tourists and so on, but there is very limited evidence for that. The policies are being introduced in England, but Scotland has an opportunity to make its own decision on the issue.

10:15

Bob Doris talked about asylum seekers and refugees, but most of the migrants who come here are working and paying their taxes—and paying them at a higher rate so that they can access services. You talked about black and minority ethnic groups, but many migrants are white. There are complex issues, such as language ability, which cannot be dealt with at the front desk, or when someone is in crisis and is trying to access a service or A and E. It makes no sense for that to be the moment when a person starts discussing immigration status and access to health services.

We have an opportunity in Scotland to think about all that and to learn from the evidence that we have. Migration is relatively new in our system, but we do not have to experience the problems that other countries are experiencing with delays and so on.

The Convener: What evidence is there that people are being refused access to health services? I do not know about other members, but Bob Doris has obviously come across a big case that related to the transplant list. In 15 years as an MSP, I have never encountered a situation in which someone was refused A and E treatment because of their background. What is the extent of the problem?

We have to be careful that we are not suggesting that what is happening in England will be replicated here. We have a devolved health service and most people here believe in its ethos. Should we be particularly concerned about the problem? On the wider issue about access to health, we have heard about problems that people face because of their age, disability or class. Is there evidence that people are being turned away from A and E or hospital services?

Dr Jackson: I do not have evidence of people being turned away from A and E; I have evidence that going to A and E is problematic and that there can be delays when people engage with such services or try to access GPs. Such delays impact on people's care. It can be harder to engage with services, which can be to do with misunderstandings front of house, language issues or a person's anxiety about not understanding the service.

As I said in my submission, people do not understand the signposting about where to go to get the correct service. That also creates delay. Our system was set up for people who understand it; because migration is relatively new in Scotland, is happening to an unprecedented level and will continue, we need to look at the system from the point of view of someone who does not understand it.

The Convener: That is a problem of the present and the recent past. People have talked about the Immigration Bill, but we are in control of the health service, and if there is a problem that is causing concern for our witnesses and the people whom they represent, we need to ensure that there is guidance so that we can put things right and provide the services that people need.

Nina Murray: We welcome the approach of the current Scottish Government and successive Scottish Governments to universal access and a human-rights-based approach to healthcare. You are right: the legislation in Scotland is clear, as is the guidance about who should and should not be charged for access to healthcare in Scotland. However, across the UK there is an issue to do with the rhetoric around the Immigration Bill and public opinion on immigration.

There are differences in the charging regimes across the UK, which can be confusing for people. Often, if people are marginalised and vulnerable and their immigration status is insecure, they are afraid of accessing services. We have examples of people who accessed maternity care later on in their pregnancy because they were afraid of making contact with the authorities because of the perception that they would be refused access or that, somehow, they would come into contact with the authorities—predominantly, the Home Office—as a result.

We have case studies of people who have been turned away from GP registration in Glasgow. There are not many. The vast majority of refugees and asylum seekers are able to access healthcare, and they all should be able to, but there are instances in which health professionals on the front line—particularly gatekeeping staff right on the front line who make the decisions about who can and cannot access care—are not aware of that.

I am aware that we are hogging the topic, so I do not want to go on, but we need to examine the matter.

The Convener: We will move on to gatekeepers, because I think that we will have different experiences. I recently had a discussion with my disabled group, who sometimes find it very difficult to get past the receptionist and get an appointment with the GP. Sometimes, they feel that the GP does not have enough time for them because they have communication problems. Does anybody want to talk about the gatekeepers—those people whom we phone up looking for an appointment and who say that we cannot have one?

Derek Young: I alluded to the issue earlier. I will give a few examples. Many GP surgeries now have computerised booking systems for appointments. If a patient is not able to have a face-to-face conversation with a member of reception staff, it may make it more difficult for them to articulate what their problems are and, if they are not familiar with technology, they may not want to feel incompetent when they are presented with a computer terminal when they arrive at a doctor’s surgery.

That is a low-level but practical example. A more serious example is whether older people who turn up at open surgeries or A and E during busy periods when they are not able to be seen quickly have the information that advises them how long it will take so that they can factor that into their decision about how they will travel to the health centre. The national concessionary fares scheme encourages older people to use public transport, and they do. If they arrive by public transport, it is a busy evening and they are not seen and discharged until the early hours of the morning, how will they get home when no bus services are running?

If front-of-house staff considered more proactively what the needs of people waiting might be, based on their circumstances, that would be a real example of the preventative approach that the Scottish Parliament and the Scottish Government have endorsed based on the Christie commission.

The Convener: Do we have any information about whether front-of-house staff are trained to take account of that, or whether they are aware of what to do when they are presented with somebody with a language problem or communication difficulty? I know, because I see regular notices in my local newspaper, that they have training days. Just like the bank, they shut for a couple of days. Do you have some good examples of people being trained to deal with the different types of patients that might arrive?

Derek Young: That is a pertinent question to ask NHS Education for Scotland and I recommend that you do that.

The Convener: Yes, Derek. [*Laughter*.]

Derek Young: We are aware, however, that the standards of care for older people in acute settings in hospitals are functional at the moment. Healthcare Improvement Scotland is reviewing them and we are keen that they include measures such as patient experience, respect for dignity and communication standards because those strongly impact on a patient’s overall experience. They are harder to inspect than functional aspects such as how quickly somebody was seen or discharged but, if we put them in the standards, they will be inspected and reported against. That would be an important way in which everyone could see how well particular health boards were doing at meeting the challenge.

Pam Duncan: There are various issues around gatekeeping for disabled people. Our colleague mentioned the accessibility of drop-ins and staff being aware of what might be an issue. For example, family planning and sexual health clinics are drop-in clinics. That can be quite difficult for some disabled people to manage because of transport issues and because, if someone needed a personal assistant with them, they would not be sure how long they would be so it might be difficult to get that assistance.

Another point follows from Derek Young’s comments about accessibility. Quite a lot of work has been done on accessible and inclusive communication that takes into consideration visual and hearing impairment, as well as other communication impairments. A toolkit has been co-produced with people who have communication impairments and the Improvement Service. If that was standardised and people throughout the health service were encouraged to use it, that would take us a great distance towards addressing some of the access issues.

There are other issues around gatekeeping and turning up at surgeries. Rooms in hospitals and doctors’ surgeries are often not easily accessible to wheelchair users. In my experience, I have gone to several different appointments and have not been able to be seen on the assessment bed—if that is the right word—because it cannot be moved up and down and I cannot get on it. Issues like that are particularly pertinent. Obviously there would be a cost to replacing such things, but I think that it should be done.

I spoke earlier about BSL, and it is important to make sure that front-line staff are trained. To pick up on the training issue, in our submission, we have said that front-line NHS staff and management should all be required to undertake disability equality training that is provided by disabled people. We think that such training is distinct from disability awareness training, which is more about awareness of particular impairments. That is also important, but disability equality training should be considered.

When disabled people who use personal assistants or social care go into hospital, if they are in for a certain period of time, such as four weeks, their self-directed support can stop, although that can depend on the local authority's contractual arrangements. A disabled person like me, who has had a personal assistant for a number of years, cannot just say to their assistant, "Right, we're not paying you now because I am in hospital. Come back in three weeks when I am out." People need their salary. That is a really important issue for terms and conditions.

I also think that we could be quite innovative. When disabled people are in hospital, either for an acute condition or for something to do with their long-term condition, they might still need that personal assistant's support to do stuff that nurses would not ordinarily do for someone who is in hospital, and things that a person would need to be done whether they were ill or not. Personal assistants could do such things if they were allowed to support the person who was in hospital. That could resolve both the issues that I have mentioned.

There are also broader issues to be addressed, and you asked for solutions to some of the problems. Solutions lie in housing and people's ability to get into and out of their own houses. On the really basic level, those solutions could address isolation and delayed discharge, because if someone's house is not accessible, they can get stuck in hospital. Health and social care integration is a really positive move, but housing is not ordinarily or by default going to be considered under that, and it is a huge issue.

We note that a lot of targeted approaches to improving health outcomes and addressing inequalities are geographically based, but disabled people can experience issues that are not necessarily geographical, although there are geographical issues. For example, I consider myself to have quite a lot in common with disabled people in Edinburgh, perhaps more so than I do with non-disabled people in Glasgow, where I live. Sometimes broader, space-based approaches do not pick up on some of those deep-seated inequalities.

The apprenticeship scheme is one of those. It has been really successful in getting young people back into work, but it has not been quite as successful at getting disabled people into work. Targeted approaches for equality groups within broader interventions will be important in the future, and we suggest that good, robust data collection, and understanding who people are within those areas or interventions will also be really important, as will data sharing.

I do not know how often I have gone to appointments and found that people have not shared information about me. To build on Fiona Collie's point, we need a system for flagging up issues so that people just know that someone needs certain supports. For example, I might arrive somewhere and be told that the consulting room is upstairs. That sort of thing can be really important. Co-production and working with disabled people can help us to do that, because we can help people to guess what the issues might be before they arise.

10:30

The Convener: Well done, Pam, for getting the full policy in there.

Lexi Parfitt: I will make a couple of points about gatekeepers and potential solutions, but first I want to talk about an issue that is one step before accessing services and GPs, which is about awareness levels of the services that are available. The issue about people knowing which healthcare professional can help, what support they are entitled to and how they can get to that source of support was alluded to earlier. The issue of understanding who can help and how to get to that person cuts across all communities and the general public, but it applies particularly in deprived areas and among people from black and ethnic minority communities.

There is also a broader issue about better understanding of mental health and the people who can provide support, and of where to get information about that. In certain communities, people often come into contact with mental health support services only at a very late stage. That might be at a crisis point or through another route, such as criminal justice. Access to services is a huge priority for us, and we have been campaigning on it since early 2012. The issue is how we ensure that people have a better understanding of mental health, how we support the promotion of good mental health and behaviours and how we get people to know about the healthcare that is out there and that they can access.

On the issue of GPs as gatekeepers, we have just done a big piece of research with the Royal College of General Practitioners Scotland. That research has not quite been launched yet, but it is referred to in our submission. We already know that about 30 per cent of GP appointments have a mental health component. The GPs at the deep end group, who are GPs with surgeries in the 100 most deprived areas in Scotland, were asked about their current concerns, particularly in the austerity context. They said that their number 1 concern is worsening mental health. However, when we asked about how able they feel to deal with the increasing influx of mental health issues in their surgeries, about 49 per cent said that they have not had any form of accredited training in mental health in more than a year. That is quite a large number. When we unpicked that a little and asked what kind of referrals GPs can make, many said that they had not referred in the last three months because waiting times are too long, there is no such service in the area, or the referral criteria are unclear.

So there are pressures on GPs, and we could help to alleviate those pressures, support GPs better and ensure that they can link with other services that might be able to support individuals. To try to take a bit of the pressure off, SAMH has been working with the Health and Social Care Alliance Scotland on bringing link workers into GP surgeries to provide the linkage between GPs and the services that might be able to support individuals. The aim is also to be a bit more innovative in the way in which we support people with mental health problems more broadly, in particular through things such as social prescribing.

So a number of things are happening on that, but although such solutions are effective and should absolutely be resourced, funded and brought forward, there are broader structural issues to do with how we support people to have better mental health and to know about their entitlement and which types of healthcare professionals are out there that they can access. That is also about how we support healthcare professionals to plug individuals into the wider support, wherever they are and whether they come from a deprived community, a BME community or live in a rural area or whatever.

The Convener: There are some common themes there.

I think that Hanna McCulloch had her hand up—it must be getting painful.

Hanna McCulloch: I just want to discuss the barriers to accessing healthcare services that exist for deprived families but not for other families, some of which are very practical. For instance, the committee will be aware that an increasing number of conditions are being placed on jobseekers allowance, which is placing constraints on people’s time, because of the number of interviews that they need to attend and the amount of jobseeking-related things that they need to do.

That increased conditionality and the threat of sanctions can really restrict the amount of resource and time a person can commit to their own health. Our advice line took the case of a father who was sanctioned three times in the space of two weeks because he kept missing interviews. He missed the interviews because he had to look after his child, who was unwell.

The same point about the barriers to accessing healthcare is true of people in low-paid employment who may have to work extremely long hours to care for their families. People in low-paid jobs are also less likely to have the kind of flexibility and autonomy within the role that would allow them to get away to go to health appointments and so on.

There is a need for flexibility, for services to be reactive to those pressures and to consult people in such situations to ask, “How can we best tailor our services to make them accessible to you?” There is also a need for health professionals to work closely with families and to be more reactive to what their needs are.

The Convener: Thanks. It is important to mention the wider aspects to do with employers and everything else.

Dr Simpson: I want to switch slightly to issues that have been alluded to already—to the field of mental health. People with mental health problems—particularly if they are severe and enduring mental illness problems—have poor physical health. It is part of the inequalities issue—life expectancy is one of the most glaring outcome examples. People with severe conditions or with learning disabilities also have poor physical health and they die younger.

Given that the primary care system is becoming more proactive and less reactive—that shift is occurring, although it is not there yet—are we identifying those people and providing a combined care service that includes mental health, physical health and social care or do we still have those issues all split up into bits? How much is that responsible for some of the existing inequalities?

Lexi Parfitt: I completely agree with what you say about mental health. We know from the deep-end GPs and from the work that we have been doing speaking to GPs that, as you rightly say, GP appointments in the most deprived areas of Scotland are characterised by multiple, interconnected mental, physical and social issues. That is a priority area to be investigated.

We also know that people in the most deprived areas develop multimorbidity—co-occurring, complex, long-term illnesses—about 10 years before the rest of the population, so you are absolutely right to raise the point about complexity and about not putting mental health, physical health and social issues into individual boxes.

It comes back to the purpose of the meeting and to the original point about whether we can seriously tackle inequality of access to health services without also looking at the broader structural issues of poverty, inequality, deprivation and so on. Part of the thinking behind the link worker programme that SAMH is involved in with the alliance is about addressing those issues by having somebody based in a surgery so that, when an individual first comes into contact with their GP, they can very early on be put into contact with somebody who has the knowledge of the local area, what is available and what types of service and support would be useful to that person.

For example, if somebody has come in with a mental health problem but the link worker is aware that there are also financial or debt difficulties or that there is perhaps a physical issue—perhaps the individual is overweight and there is an exercise club that they could be referred to—having that more holistic understanding across the different issues is one step towards addressing the points that you raise.

Dr Simpson: Are any outcomes from that programme available yet?

Lexi Parfitt: I believe that it is still very new and it is available in only a limited number of GP surgeries. However, we will certainly be monitoring it because we believe that, once we have monitored the outcomes, we could definitely push for it to be rolled out more widely.

The Convener: Pam Duncan will be followed by Fiona Collie and Derek Young. We need to be conscious of time.

Pam Duncan: I will be really quick this time.

I think that social care, physical health and mental health are still more split than they should be—even though we are moving towards a more integrated service, which is something that we welcome and which we hope will improve the situation. We have always advocated joined-up policy making and joined-up service delivery, because they are sensible and are needed. However, various systems still operate in social care and healthcare and neither of the two tends to talk to the other all that much.

As I said, an issue in social care is that crisis intervention seems to be the focus, because of eligibility criteria. Social support is not really featuring and people are not getting the support that is essential to reduce isolation. Such support can also help people’s mental health and prevent them from becoming ill. We need to address that issue pretty quickly. Finally, we still have two separate systems, one of which is universal and free at the point of need and the other of which is chargeable. While those two systems exist, health and social care will never quite be able to deliver joined-up provision when it is needed.

Fiona Collie: I echo what Pam Duncan has said. In many cases the joined-up system does not exist for carers. Social care exists in one silo and health exists in another. Not only is the carer trying to cope with their own circumstances; in many cases they are trying to manage the care and support of the individual for whom they care. The systems are very complicated and difficult for people to manage. We talk about carers experiencing depression, stress and anxiety, and caring often results in mental health problems. However, a lot of carers say that the biggest stress is dealing with services and with the bureaucracy between different services. If we could do something to make the journey smoother for individuals—integration may help with that—it would be welcome.

I will briefly mention NHS Education for Scotland, which is doing work on equal partners in care, which is a programme about health staff having awareness of carers. The programme currently has two levels: a more in-depth level for staff who will be on the front line dealing with carers and a more generic programme for all health staff. As with not just disability awareness training but disability-led training for staff, it is important for staff to have a clearer understanding of what expectations there should be.

Derek Young: In response to Richard Simpson’s question, I think that the whole-person approach is the right one to go for. If we are ever to reach the goal of adequate prevention, the aim must be to adopt that approach.

We mentioned gatekeepers. A GP will have training in geriatric medicine, so they will understand what the symptoms are of particular conditions that affect older people and how they are to be treated, but they will not necessarily instinctively have a feel for the social causes and social consequences of those conditions. That is potentially where social care has to come in but, as Pam Duncan and others have said, it is patchy and inconsistent. Moreover, some social causes may be hard to spot. It is understood that mental health issues are harder to detect than physical symptoms. Equally, if older people are drinking alcohol to excess, for example, many of the understood consequences of that—instability and falling over—are also associated with general issues of ageing. It sometimes requires quite an acute sense for an individual doctor to be able to spot the social elements of particular health conditions.

We have talked about loneliness and isolation. The third sector has a very good record in that respect; it excels in connecting people to their communities and offering activities locally. It will not automatically be the case that doctors in surgeries will know what third sector services are available and, of course, that is a picture that is changing, especially as there is uncertainty around the ending of the change fund.

10:45

The Convener: I am noting ways forward for the Scottish Government and the NHS boards. Many of the themes are familiar, although they might impact on some groups more seriously than others. It is about developing clear policies that highlight these issues.

I pick up on Derek Young's point about the importance of the personal approach and seeing people as individuals. Do you want to say anything about that?

Dr Jackson: Yes. I have a background in the NHS and have worked a lot with nurses in my career. My feeling is that much of the work on this issue has been done, but the guidance needs to be really clear. As Nina Murray mentioned, the rhetoric and the broader issues around migration are so toxic that they permeate society, and it becomes cloudy for staff in the NHS and for the people who approach them.

It is difficult to work out how the issues play out in reality, but there can sometimes be a feeling that it is necessary to protect our NHS. There needs to be clear guidance about the decisions that we have made at a high level about who can access the health service and how we want people to engage with our health service for all. Many of the policies are in place but, because of the dominant rhetoric around migration, which—as it is in the rest of the UK—is currently so anti-migration, it would be very helpful to give clear guidance, and that would not be too difficult.

The Convener: Looking at the other side of the issue, we have found when we look at elderly care that people find it difficult to challenge the other perception of the NHS, which is that it is always talked about in glowing terms—we describe it as wonderful and say that the staff are all angels and so on. However, individuals do not always experience such a high-quality service. There are lots of policies—I have looked at how we treat older people when they arrive at a hospital and things like that—but we are not meeting the standards that are set in them. Is that where we should start? Should we be saying, "You have got all these policies and vision statements, but we are now looking at the delivery stage"?

Dr Jackson: I know from having worked in the NHS that people have the right ideas about what should happen and want that to be done, but implementing the policies can be hard. I have worked with staff on the ground, and it is really hard work to make that happen. Our submission states that one approach is to get the different parties together so that we all understand the situation. Given that migration is relatively new, there is not a long, bitter history of problems; it is just that this is something that we as a country are now engaging with. We should go into the issue in that way, look at how the systems are functioning and see how we can address it, now that people who come from lots of different places live in Scotland. We should look at how the policies that we have could be implemented.

The Convener: Would the delivery of the policies that we have represent progress in tackling the inequalities that we have all described and in addressing the impact on individuals of the attitudes that have been mentioned?

Fiona Collie: Yes. We have some really good policies and if we got them working, we would be making great strides. For example, every board has a hospital discharge policy, yet time and again we hear that those policies are not working and that people are discharged without adequate support, which has a direct impact on the carer and on readmission. Earlier, Pam Duncan mentioned housing and adaptations not being available. There is a good policy on that, but it is not being enacted.

Part of the problem is to do with how different policies rub up against one another, and that needs to be considered. In particular, delayed discharge rubs up against the hospital discharge policy. We want a good discharge policy. It is all very well to say that we do not want someone to stay in hospital when they are physically well enough to be at home or if they no longer have a clinical need, but if they are put into an environment where they are not secure, safe and healthy, the chances of their being readmitted are very high, which would mean failing. There is a need to consider how different policies interact.

Nina Murray: I agree that we need to deliver the policies that exist. To achieve that, we need a certain level of awareness raising and training. We have been talking about a holistic approach and understanding what else is going on in people's lives. That is what we were talking about in our written submission in relation to mitigating the impact of asylum destitution, for instance. That involves professionals working with the person, understanding what else is going on in their life and how that affects their engagement with the person. Various options can be considered—as Lexi Parfitt was saying—such as referring people out to community groups and services that can help them.

I do not intend to go on and on about the Immigration Bill, but we must be aware of the wider policy context at a UK level and the impact that it could have on the delivery of policies here in Scotland. We strongly recommend that the Scottish Parliament considers what the impact of that policy will be. In effect, the bill puts in statute a requirement for landlords and health professionals to become de facto immigration officers. That is a frightening prospect, which will have an impact in Scotland, whether we want it to or not.

As I say, the issue is about delivery of the policies that we have, while being aware of the wider context that we are working in.

Pam Duncan: We have some very good policies and legislation, which we should probably promote further and make a reality. There are some things that need to become duties. There is a lot of guidance around that I think is too easily left to gather dust. We need to consider strengthening the hand a wee bit on some of these things. I could be more specific on that if we had more time.

It is important for us to consider broader policies, rather than just specific policies for the health service or social care. We have some very good policies on housing. The "Homes Fit for the 21st Century" document contains a lot about adaptations, disabled people and independent living. That kind of stuff would be really good.

There is also the broader stuff that is contained in the United Nations Convention on the Rights of Persons with Disabilities. We need to start asking about its implementation and questioning ourselves about it. Scotland will be examined on its progress towards UNCRPD compliance at the end of the year, which provides a timely opportunity. To help that happen, we need to work with disabled people's organisations so that we can find the solutions to make it happen.

Most of the time, people do not design things in order to keep us out of buildings, for instance—although perhaps it happens now and again. It is often a matter of knowing how to make things happen and how to implement the good intentions of current policy and legislation. Working much more closely with DPOs, including through disability equality training, will be essential.

Derek Young: Some of our policies and ambitions are certainly robust and valuable. If they could be effectively implemented, that would be a success.

For example, we have an ambition to eradicate fuel poverty in Scotland by 2016. That is a great ambition, but we are certainly not on track to meet it, and there is very little prospect that we are going to meet it. That is partly because the challenges that we are taking on are tough in the policy context; it is partly also about money. That point has been raised before.

The Social Care (Self-directed Support) (Scotland) Act 2013 comes into force in a week's time. However, the ambition of choice and control will not be realised if local authorities increase the charges for the services that they provide. If a person has control over the cake, but the cake is shrinking or each slice needs to be bigger, that will prevent the policy from being realised.

We can make some changes. I will highlight a couple of aspects that Audit Scotland has monitored recently. The health and social care partnerships that are being set up will do strategic planning, which was formerly known as joint strategic commissioning. It is not immediately clear that they understand and have a common recognition of what health inequalities are or how they plan to allocate the resources that the Scottish Government is giving them to address inequalities. The committee can help to scrutinise that.

Inevitably, not all strategies are comprehensive, but equally well—the health inequalities strategy that has been in place for five or six years—does not address specifically the needs of older people and how inequalities affect them. We want that to be reflected in a reinterpretation or re-evaluation of that strategy.

Colin Keir: My questions are about the difficulties that relate to having some linkage with people who are in prison. I know that the system has changed and that the Scottish Prison Service is now more involved with the NHS. Will someone elaborate on the difficulties for people who come out of the justice system? Perhaps you know of personal experiences. What inequalities of access to services have you found? Will the changes have an effect, or will we have to go further?

Lexi Parfitt: I do not have answers to your questions, but mental health and criminal justice are huge issues and a strong linkage exists between mental health issues and people in the criminal justice system. There are also a lot of myths; in fact, people with mental health problems are far more likely to be victims of crime than perpetrators of crime.

SAMH is working on a piece of research on projects that are happening around Scotland to divert people who are at risk of reoffending out of the prison system and into more meaningful and helpful work. I flag up that that work is happening. Once that report is done, we will be happy to share it.

Nanette Milne: In relation to delayed discharges from hospital, is the main problem a lack of home carers, the training of existing carers or a fairly equal combination of both?

Fiona Collie: It is probably a combination of both. Often, the service does not exist at all—someone is discharged from hospital to the person who cares for them, but no service is there.

It is important to remember that a lot of carers are older people—more than 100,000 carers are 65 and over, and a significant proportion are in their 70s and 80s. Although someone might be clinically well enough to leave hospital, that does not mean that they will be well enough to live at home if no support is available to lift them or help them to access the toilet. It is difficult to say exactly what the problem is. There must be communication with families to ask them what will be needed when someone gets home to make that work, and what is needed must be put in place. However, those conversations often do not happen.

I have personal experience of that. When my father was discharged from hospital, the first that we knew of it was when he appeared at our house in his pyjamas and dressing gown, having got out of a taxi. That was his discharge plan. That example is at the extreme end, but it is not unusual for someone to be told that a person is being discharged on the morning of the discharge day and for nothing to be in place.

11:00

Pam Duncan: The problems are also down to a lack of support and available services, and a lack of funding. As I said, people who are already in the social care system and go into hospital often have their funding pulled back while they are there. They then have to re-recruit, find another agency if they are using one or find people in the system who they have used before. Some people go into hospital and come out needing social care services in a way that they did not before. The issue is partly about communication, as Fiona Collie pointed out, and partly to do with a severe lack of funding for social care services throughout Scotland.

The Convener: Does anyone else wish to respond to Nanette Milne's question?

Derek Young: I agree with both of the points that have been made.

Depending on their circumstances, people may need adapted housing to enable them to be discharged, so they may need a house move. That is a much more complex issue and has knock-on effects. For example, they may have to register with a new GP, which could be a practical problem if they have multiple complex co-morbidities. GPs now often require two forms of written address notification before they will allow people to register, and those may take a few weeks to obtain. If a person has given someone else continuing power of attorney, for instance, the attorney or guardian may receive all their mail.

The issues are complex and varied, which is why a personal approach that involves discussions with people is needed. Pam Duncan mentioned co-production, which is essential if we are to understand and then begin the process of getting things in place so that discharge can be effective and timely.

The Convener: Is it the poorer or the less assertive people who are likely to be in the situation that Lexi Parfitt mentioned? Who waits the longest on a waiting list? Is it the poorer people or the excluded people? Is any work being done on those issues?

Dr Simpson: There is some research that shows that, once someone gets to a GP and is referred on, there is no discrimination at that point. There used to be, but there is not now, so the situation has improved considerably. That may be partly because of the quality and outcomes framework part of the contract.

Bob Doris: On the question whether there are inequalities based on the assertiveness of patients and their families, I will not go into detail about my family experiences but, as a member of the committee, I am aware of what rights patients have. When my family members engage with healthcare services or hospitals, one key question that I will ask is whether the social care package is right before they are discharged. I suspect that a lot of families will not ask that question if they are less assertive or from a background that means that they are more likely to feel intimidated by the professional classes, if you like.

Is there a need for patients and families to be more aware of their rights and what their expectations should be when they engage with services? In my experience, hospital staff are often not aware that there are care issues at home because people do not like to admit to that, so individuals are discharged back into vulnerable environments without the nursing staff alerting the social care staff about the circumstances. That is not best practice, and it brings us back to the issues with joined-up working.

Is there good practice with regard to patients and families being informed about what their rights are and, therefore, what their expectations should be? Where there are inequalities, how can those be addressed?

Derek Young: My colleagues may have evidence of detailed research, but I can give you some anecdotal evidence. We run silver line Scotland, which used to be the Scottish helpline for older people. As you identified, it is often family members who contact us to ask questions, because older people themselves do not want to complain. Their general attitude is that they do not want to impose on others; we face that issue a lot.

Equally, many of those points can be vocalised through routes such as the Patient Opinion service and its website. Such organisations are making innovative use of technology, but family members may, if they are younger, be more familiar and comfortable with such technology. We certainly recognise your point about the general attitude of deference.

I do not know whether this factor is consistent with living in deprivation or poverty but, as Pam Duncan said, when certain older people face an authority, they assume that, if they have told one person in that authority about their circumstances, the whole authority will understand and know about their situation. As you hinted in his question, that may reflect the attitude of someone who does not have enough experience of dealing with professional organisations to understand how they function—and how they fail. The issue may well be worthy of further research—there is certainly enough anecdotal evidence to suggest that you are on to something, but unfortunately I cannot back that up with detailed data.

Pam Duncan: That is a very important point. Advocacy services are crucial in supporting people to understand what their rights are so that they can exercise their rights, either personally or with support. However, there is an issue—which was hinted at earlier—in the sense that all the good policies, rights and rhetoric that exist are not being implemented, and we need to address that, too.

Bob Doris mentioned patient rights and the fact that people need to understand that they have those rights. However, some elements are quite inconsistent. For example, article 19 of the UNCRPD gives disabled people the right to live in the community, but in reality the social care system is under pressure and funding is so strapped that people are not necessarily getting access to support. Although it is important that we support people to understand their rights, we need to look at some of the systems and strengthen them a bit to ensure that those rights are actually entitlements.

Hanna McCulloch: I am aware of some programmes that target the families who are least likely to get the most out of the health service due to a lack of awareness of what is available to them. There are family nurse partnerships, for example, in which young first-time mothers are visited during pregnancy and in the first two years of their child’s life. That is not just about the health of the mother, but about wider wellbeing, sexual health, contraception and even economic self-sufficiency, all of which will improve long-term outcomes for the child. There are examples of good practice out there.

Fiona Collie: I definitely agree that, where people are more aware of their rights and are more assertive, they can get things done. It is a common complaint from carers that, if they do not know something, nobody tells them.

We have been working with the Minority Ethnic Carers of People Project and the Scottish Government on a carer’s rights charter and a set of accompanying standards or guidelines—whatever you want to call them—so that carers have those things up front and get them when they visit the GP or the hospital. I do not know at which level people get copies of the patient rights charter; I have visited hospital on a number of occasions recently and no one has mentioned it to me. Obviously I am aware of the charter, but it is not very publicly available, so we might need to change that.

Nina Murray: I agree with what everyone has said about the importance of people’s awareness of services, which is a huge issue for refugees and asylum seekers. When I facilitated a workshop on women’s health with a group of refugee women, none of them knew of the existence of the Sandyford sexual health service, which is a service that is spread across the NHS Greater Glasgow and Clyde area and which is accessible to all. None of them had ever heard of it, which highlights how low the level of awareness of services is. It is a crucial issue. It is helpful if leaflets are produced and translated, but that is not enough if we want to get the message out that the services exist and to tell people, “This is how you access them.”

Gil Paterson: My question follows on from Nina Murray’s answer. On the barriers that prevent people from presenting, at the other end of the spectrum there is a fatalism attached to people who have low self-esteem and no confidence in themselves. As Lexi Parfitt mentioned earlier, some people have complex conditions but do not present because they think that that is their lot.

I wonder whether we can get in early and in a preventative way so that, although people may still have these illnesses in their lifetime, they will not be so severe. Just last week, I spoke about going to see my doctor. When I am there I can see all around me that people are lacking in confidence and feel that this is their lot. That is a serious thing in deprived areas. Has any work been done on that? What are we doing about it, or what should we do?

The Convener: Gil Paterson is the man with the big questions.

Lexi Parfitt: There is definitely something in the points that have been made. If people do not know that they are entitled to something and do not know that it is their right, how will they know to ask for it or not to leave until it has been delivered? Gil Paterson alluded to mental health and the fact that, if someone is suffering from severe depression, they may already think that they are not worth helping, that they do not deserve to be helped, or however else their feelings manifest themselves. In such situations, it is difficult for them to go and insist on being helped by their GP or whomever. As a result of their illness, they will probably not feel able to get on the phone to find out whether they can get an appointment that day and, if they are told that they cannot, to insist.

On what we can do about that, I agree that early intervention and the preventative agenda are key. For example, it is imperative that, wherever possible, we promote good mental health and wellbeing among children and young people and help them to understand that physical and mental health are completely interlinked, as we discussed earlier. The curriculum for excellence says that health and wellbeing outcomes are the responsibility of all practitioners. We find that the physical side is well understood, so how do we promote physical good health in young people? We look at diet and physical exercise. How we promote mental wellbeing in children and young people is less well understood, but a lot of the same things apply, as physical exercise and good diet are excellent for mental health.

It is important for people to have a better understanding of health, particularly mental health. We need to support adults who have important roles in the lives of children and young people to promote a good understanding of health and positive behaviours—around dealing with the stresses of life, promoting good self-esteem and so on—that they can bring into adulthood.

Supporting people to ask for help has been a priority for SAMH. Our know where to go campaign, which has been running for the past two years, is all about that. We did a YouGov survey in 2012 that asked people whether they could name a source of support that they could go to if they were experiencing problems with their mental health. We were really shocked that 20 per cent of people could not do that, and when we unpicked the results a little, we found that that increased to more than a quarter in the C2 and D social grades and was as high as 45 per cent among people aged 18 to 24. There is something in there about people’s understanding that there are services that can help and that they are entitled to access. There are also obligations around ensuring that things happen in services that mean that they are accessible to people, whether that involves translation or whatever.

I am glad that you raised the issue, because there is a job of work to ensure that people are able to go in and ask for the help, information and support that they are entitled to.

The Convener: I think that Dr Jackson wants to comment.

11:15

Dr Jackson: Part of the reason why I was invited to come here today was to talk about interpreting, given the work that we did in our project on why, despite the policies that exist on access to health, people are still experiencing difficulties. The reason why is unclear.

Obviously, there is a cost for interpreting services and, at the minute, health boards are making decisions around how best to organise those services. One of the things that we notice from our work is that there is very little education of staff about interpreting and how to engage with interpreters. Not having an interpreter has quite an impact on how people access health services and on their understanding of those services, which has knock-on effects such as delay, misdiagnosis and confusion around issues for their future health.

We looked at what could be done and created an education tool that can be freely accessed, so it can be rolled out across Scotland and health specialists and interpreters can engage with the issue of interpreting in healthcare situations.

The Convener: Thank you for that.

Hanna McCulloch: This point is not directly relevant to the question. There is a lot of talk about the prevention of health inequalities, but it is important to keep considering the fact that in the next six years the number of children living in poverty in Scotland will increase by up to 100,000. The issue goes back to the first question of the meeting, which was about whether poverty or ill health comes first.

It is important that we keep our eye on the ball in terms of maximising income for families who are at risk of falling into poverty. There are great examples of health services being involved in that. For example, the healthier, wealthier children project in Glasgow is a partnership between NHS Greater Glasgow and Clyde, Glasgow City Council—and a range of other councils now—and the Glasgow Centre for Population Health. The project involves front-line workers referring families during the first stages of their child’s life to income maximisation services if they think that the families might be at risk of having financial difficulties. That has proved to be a huge success. Within the first phase, 2,500 families were referred for advice, which increased the families’ income overall by £2.5 million. There is a huge amount of work to be done to future proof against increases in levels of poverty.

Derek Young: In response to Mr Paterson’s question, the reinforcing cycle of poor mental health and poor physical health is an issue. In areas that are more deprived, we find more evidence of people leading unhealthy lifestyles, with a poorer diet, less physical exercise and a greater intake of alcohol and tobacco. We know that all of those are drivers of poor health and reinforce levels of depression and anxiety, particularly among older people who feel socially isolated—they are big causes of people feeling depressed and anxious.

If that is the experience of people generally in a community, that is what they will understand to be normal. I do not know how we can unpick all of that, but Mr Paterson is certainly on to something: there is a reinforcing cycle involving many of those elements. Telling people about their rights might be one way of addressing that, but there is the broader issue of demonstrating to people in a way that they can understand and feel in their daily lives that they can have a more positive attitude towards their health, undertake more exercise, improve their diet and cut down on alcohol and tobacco. Doing all of that would help to generate more positive mental health outcomes and perhaps more assertiveness in people about what they are entitled to and can expect.

Aileen McLeod: We have had a good discussion this morning about the various ways in which we can try to break down barriers and help people to access the health services and support that they need.

Obviously, we do not want more barriers to go up so I am interested in people's views on the importance of universal service provision and benefits such as free prescriptions and free eye tests. The prescription charges coalition in England brings together more than 30 health charities and organisations that support people with long-term conditions. It published a new report the other week that stated that more than a third of people that the coalition questioned had reported that the cost of their medication had prevented them from taking it as prescribed.

We have a commitment from the Scottish Government to protect free prescriptions. What are the views of people around the table on the importance of universal service provision and whether it goes some way towards helping us to narrow health inequalities in Scotland?

Derek Young: I am conscious that I have already spoken several times but the debate around universal or targeted benefits and services often revolves around older people because they are oftentimes the beneficiaries of them.

The basic state pension has fallen from 25 per cent of average earnings down to 16 per cent of average earnings in the past 30 years. There are targeted benefits on top of that in the form of pension credit, but the main problem is that there is massive underclaiming of that credit among older people. That may be because people do not know that they are entitled to it or because they do not feel that they want to ask for help. There is a disincentive in that they feel that basic provision was part of the bargain that they made by paying their national insurance contributions over many years.

As a result, receipt of pension credit is not a very robust indicator of who among the older population is poor and deprived. That has knock-on effects for measurement in relation to all kinds of public policy. Certainly, the national concessionary fare scheme, for example, which is a universal benefit, has encouraged people of all social classes to use public transport and has had wide-ranging knock-on effects. A study of the scheme in England—which is broadly similar—suggests that because public transport encourages people to walk from wherever their starting point is to the bus stop and then to their destination at the end of the journey, the scheme encourages more walking, greater levels of fitness and more active travel generally. It also encourages people to meet and talk to other people who are using public transport in their community.

There are positive, virtuous circle effects of universal provision—albeit that it is expensive—which should not be underestimated. Some of the effects are very difficult to measure but they are certainly present.

Fiona Collie: I think that people feel generally positive about universal services. We know that carers have significant challenges for their finances. We know that many of them are in debt. We know that many more—nearly 60 per cent of them—are in fuel poverty. Those are not just the carers who are on the lowest incomes.

It is important to realise that when people within a household have an illness or a disability, income is not the same as disposable income. Once the costs of disability, such as extra heating, special diets and care costs, are factored in, people might have very little left. If they then have to pay a prescription charge or for an eye test on top of that, it might make it unmanageable.

That is why we feel quite positive generally about universal services. When things target people on the very lowest incomes—which is laudable in many respects—sometimes the people who are living on the very margins, because of their circumstances, are forgotten. As Derek Young was saying, the measure of who is claiming pension credit does not necessarily help us to find out how many pensioners are really in poverty. There are similar issues in relation to carers and disabled people.

Hanna McCulloch: As an organisation, CPAG is really in favour of universalism. It is not purely because universalism means that anybody can access the same benefit or service as people on higher incomes can access—whatever it might be; it is because people on the lowest incomes, who are most in need of such services, are far more likely to be able to access them if they are universal to everybody, partly because of the lack of complexity. People do not need to understand exactly whether they are eligible. Also, there is not the expense of having to work out whether people are eligible. Increasingly, the stigma attached to living in poverty or claiming benefits is putting people off, especially young people who might have a lack of confidence. We are really in favour of universalism, whether it is for child benefit, free school meals or health-related benefits.

Pam Duncan: I echo much of what has been said, particularly about the extra costs of living as a disabled person. The most recent research that I can think of off the top of my head came from Leonard Cheshire Disability. It found that the costs of living as a disabled person or of having a disabled person in the household are about 25 per cent higher than otherwise. That is very much in line with what Fiona Collie and Hanna McCulloch have been saying.

It would be remiss of me to miss the opportunity to mention that it is also a question of making choices. Universal services involve choices to do with fundamental rights. We in the disabled people's movement and organisations find it odd that social care is not also considered as something that should be universally provided, particularly given how essential it is to the equality and human rights of those who use it and their carers or families. Social care is key infrastructure for the equality and human rights of disabled people, users of social care, carers and families.

Rhoda Grant: In their opening remarks, everyone talked about transport as one of the barriers to healthcare, for various reasons. I represent the Highlands and Islands, which is a very rural area. People might have a bus pass, but they cannot use it because there is not a bus. How much does it exacerbate the problems and the barriers that people face if they live in a place where there is no good public transport?

Pam Duncan: I pretty much echo what we said in our written submission. Rhoda Grant makes an important point. Many disabled people find transport a huge issue. The problem is not just that there might not be any transport in some rural areas; even where transport is available, it might not be accessible to disabled people.

As I said earlier, people might assume that the mobility allowance or the concessionary bus pass can help to address that issue, but that is generally not the case. Accessible transport for disabled people often means using a taxi and the cost of attending healthcare appointments can be prohibitive. Transport is an essential consideration.

Derek Young: Unsurprisingly, as this has been a key focus of Age Scotland's campaigning work over the past year, I agree with what has been said. Unfortunately, we have not yet been able to persuade the Scottish Government and the Infrastructure and Capital Investment Committee that our proposal to extend the concessionary fares scheme to community transport is the right approach. Our broader ambition is to consider community transport as an essential back-up to public provision, especially in remote and rural areas. We have to have a sustainable future as far as funding that is concerned.

Some work has been done. For example, £1 million has been spent on a new minibus fund. That is welcome, but we need to achieve an overall ambition of a sustainable future for community transport so as to provide additional support where public transport provision is not enough to meet people's needs.

Nina Murray: Even where there is excellent public transport in the cities, transport is a huge issue for the people with whom we work. It is a huge barrier to their accessing the healthcare to which they are entitled. There are many people in Glasgow—perhaps not relatively many, but the number is in the hundreds—who are living without access to cash at all. That includes people who are towards the end of the asylum process. That situation is a barrier to everything. They have to walk to the shop; they have to walk to sign on at the Home Office centre; they might have to walk to get to their lawyer's appointments. That is a huge issue for accessing healthcare in particular.

In our maternity research, none of the women to whom we spoke was aware of any support that was available to them to help them access hospital appointments. The support is there, but they were not aware of it, and that was a huge barrier to their accessing healthcare appointments.

11:30

The Convener: Richard Simpson has the last question.

Dr Simpson: I will take away from the meeting the fact that we are pretty good on policy but not particularly good at signposting, as there is a problem with people being made aware of the services.

I will finish with a question about inspection and monitoring, for which the system is fragmented. Healthcare Improvement Scotland does a certain amount of monitoring of the health environment and monitors adult care in acute hospitals. There is a proposal for a peer review system in primary care, but it does not involve patients. We also have the Care Inspectorate and the Mental Welfare Commission for Scotland. What do our witnesses think about where we should go with monitoring?

I will give a specific example. It is 10 years since we passed legislation that says that every carer is entitled to an assessment, yet many carers do not get an assessment, they do not know that they should get an assessment and they do not have emergency care plans, which are fundamental to a sense of security and wellbeing. That is an example of a situation in which we passed legislation and we thought that something would happen, but it has not. Who monitors that? Who decides that the system is not working in your area, your hospital, or your community health and social care partnership? Who does that inspection? What do our witnesses think we should do?

Fiona Collie: First, we need to have a co-ordinated system of inspection of services, be they in health or social care. The current system is very confusing for individuals if they want to make a complaint. It is not clear who people should go to, particularly when it comes to complaints about mental health support. There are some really good examples of individuals being involved and carers who have been involved with the Care Inspectorate as lay inspectors for quite a long time, although they are not involved in the health inspections.

Whatever system is put in place, individuals and carers need to be involved. It cannot solely be for health and social care professionals to assess quality, because our research indicates that carers are very concerned about the quality of support that is available. For example, a key reason for individuals turning down support that would enable them to take a break from caring is that they are not confident of the quality of the service. When they have a problem, they find that it is very difficult to get a complaint through the system.

I think that there was some discussion about what the complaints process might be in the future and whether the Scottish Public Services Ombudsman might have a bigger role so that it can assess professional judgment in the same way that it does in relation to health. It does not currently have the same role in social care, so carers and people who have problems with services find that there is a barrier. Integration gives us a good opportunity to establish an integrated system of inspection that monitors the national outcomes. There is no point in having national outcomes if we do not monitor what is happening and act if things are not moving in the right direction.

Derek Young: I will be brief. I echo exactly what Fiona Collie said about the two bodies and the two sets of inspection standards potentially being a barrier to integration and to the achievement of the outcomes that have been established or are being established as part of the process of the Public Bodies (Joint Working) (Scotland) Bill.

Over the course of the year, both HIS and the Care Inspectorate will review their respective care standards as far as they affect older people. The Care Inspectorate talks about the new national care standards being simpler and easier to understand. I hope that that will encourage service users to become advocates in their own cause. If it is easier for them to understand their rights and what their expectations should be, in many senses they will become their own inspectors. In addition, the standards of care in what was acute care—now hospitals—are being reviewed by HIS. If both sets of standards were simpler and rights based, and they encouraged a culture in which people were more aware of and more willing to pursue their own rights, that would take away from the need to have an army of inspectors looking at every dot and comma of every piece of practice and empower people to become partners in their own care and treatment.

Pam Duncan: I echo what has been said. It is really important that service users, particularly disabled people, are included in the inspection regime. However, we sometimes need to focus our inspections at a different level. Obviously, it is important that we inspect front-line services—that is essential and we do not want to let it slip—but we also need to inspect the delivery or implementation of policy and rhetoric. That has come across during today’s discussion, and it should be a key focus in inspection regulation.

The system for complaints and review, particularly around social care, is unclear, disjointed and, in many cases, quite daunting. That is partly because there is not always easy access to advocacy because it focuses on impairment or has a particular geographic focus. There are gaps in provision for advocacy, which make it difficult for some people to access the complaints process to pursue a complaint. The complaints processes in the health service and the social care service are very different from each other.

We would like to see a much more joined-up system, in which service users and disabled people are integral. We do not know yet whether giving the ombudsman more powers will be enough to achieve that. The variation across local authorities in the provision of social care, standards in social care, eligibility criteria, charging and so on is so massive that it could be quite difficult for the ombudsman to consider it all.

Further work needs to be done on the complaints and review process. We hope that disabled people and their representative organisations will be integral to that.

Dr Jackson: On the idea of migration and how that impacts on accessing health, when I worked on setting up a national structure for the adaptation of international health professionals who came to Scotland, nobody knew—I certainly did not know until I started the job—how all the existing systems around regulation, language and working in the NHS interacted. In fact, my work became how to work out what needed to be done within the system. I am not sure that the issue is monitoring the delivery of policy, because there is first the issue of how the way in which the current system works creates problems of access for migrants. Work is required first to find out how, in fact, the system works.

I do not know whether the existing systems sufficiently monitor their impact. At the minute, however, we do not know how the existing systems are preventing or reducing access.

The Convener: Cluttered and confused.

We have run out of time. I thank you all on the committee's behalf for the time that you have given us this morning and, of course, for your written submissions. It was very useful to hear voices that we have not heard previously in this area. I hope that we will be able to use all that evidence in our consideration of the very broad issue of health inequalities and how we can make a difference in that regard.

11:38

Meeting continued in private until 12:04.

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