The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

EQUAL OPPORTUNITIES COMMITTEE

Thursday 2 April 2015

Session 4

Thursday 2 April 2015

CONTENTS

EQUAL OPPORTUNITIES COMMITTEE
7th Meeting 2015, Session 4

CONVENER

*Margaret McCulloch (Central Scotland) (Lab)

DEPUTY CONVENER

*Sandra White (Glasgow Kelvin) (SNP)

COMMITTEE MEMBERS

*Christian Allard (North East Scotland) (SNP)
*Jayne Baxter (Mid Scotland and Fife) (Lab)
*John Finnie (Highlands and Islands) (Ind)
*Annabel Goldie (West Scotland) (Con)
*John Mason (Glasgow Shettleston) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Laura Alcock-Ferguson (Campaign to End Loneliness)
Danny Boyle (BEMIS)
Grace Cardozo (LGBT Plus)
Sheila Fletcher (Community Transport Association)
Alison Love (Royal Voluntary Service)
Natalie McFadyen White (Impact Arts)
Karen Nicoll (Aberdeenshire Signposting Project)
Jenny Ridge (ACE IT)
Liz Watson (Befriending Networks)

CLERK TO THE COMMITTEE

Ruth McGill

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Equal Opportunities Committee

Thursday 2 April 2015

[The Convener opened the meeting at 09:30]

Decision on Taking Business in Private

The Convener (Margaret McCulloch): Welcome to the seventh meeting of the Equal Opportunities Committee in 2015. I ask everyone to set their electronic devices to flight mode or to switch them off, please.

I will start with introductions. We are supported at the table by clerking and research staff, official reporters and staff from broadcasting services, and around the room by staff from the security office. I welcome the observer in the public gallery.

I am the committee's convener. I ask members and witnesses to introduce themselves in turn, starting on my right. I ask the witnesses to restrict their introductions to their name and their organisation.

Sandra White (Glasgow Kelvin) (SNP): I am the MSP for Glasgow Kelvin and the deputy convener of the committee.

Laura Alcock-Ferguson (Campaign to End Loneliness): I am from the Campaign to End Loneliness.

Danny Boyle (BEMIS): Good morning. I am the parliamentary policy officer with BEMIS Scotland.

John Mason (Glasgow Shettleston) (SNP): I am the MSP for Glasgow Shettleston.

Grace Cardozo (LGBT Plus): I am from Dumfries and Galloway LGBT Plus.

Alison Love (Royal Voluntary Service): I am from the Royal Voluntary Service.

Annabel Goldie (West Scotland) (Con): I am an MSP for West Scotland.

Sheila Fletcher (Community Transport Association): I am from the Community Transport Association.

Natalie McFadyen White (Impact Arts): I am from Impact Arts.

Christian Allard (North East Scotland) (SNP): I am an MSP for North East Scotland.

Karen Nicoll (Aberdeenshire Signposting Project): I am from the Aberdeenshire Signposting Project.

Jenny Ridge (ACE IT): I am from ACE IT.

John Finnie (Highlands and Islands) (Ind): I am an MSP for the Highlands and Islands.

Liz Watson (Befriending Networks): I am from Befriending Networks.

Jayne Baxter (Mid Scotland and Fife) (Lab): I am an MSP for Mid Scotland and Fife.

The Convener: Thank you very much.

Agenda item 1 is a decision on taking business in private. Do members agree to take in private item 4, which is consideration of our approach to the race, ethnicity and employment inquiry?

Members *indicated agreement.*

Age and Social Isolation

09:32

The Convener: Agenda item 2 is an evidence session for our inquiry into age and social isolation. If witnesses or members wish to speak during the discussion, please indicate that either to me or to the clerk, Ailsa Burn-Murdoch, who is on my left.

We are restricted for time today and we have a large number of witnesses. I will do my best to ensure that people are given the opportunity to speak. I ask our witnesses to keep their answers focused so that we can get round as many people as possible.

I will begin the questions. What have the witnesses found to be the impact of social isolation and loneliness among older people? Is the impact of social isolation understood in the third sector and among service providers such as health and social work services? That is a good start to the morning. Who would like to answer first?

Karen Nicoll: There are very definite impacts from isolation and loneliness on physical and mental health. We find that third sector and statutory sector referrers are very good at noticing those impacts and taking steps to do something about them by referring the person, whether to us or to someone else. In a lot of our cases—208 out of 282 in 2013-14—clients were identified as having isolation or social contact issues by the service that referred them to our project. From our perspective, isolation and loneliness are being picked up.

Laura Alcock-Ferguson: I agree that there are serious health impacts from both loneliness and isolation. Loneliness and isolation have been equated to smoking 15 cigarettes a day and to being worse for us than obesity. There are cyclical and negative links between depression and loneliness and isolation, and an increased risk of dementia—people who experience loneliness and isolation are 64 per cent more likely to develop dementia.

That is something that the Campaign to End Loneliness has been emphasising to the statutory bodies, particularly in England. Even after three years of work with a number of partners in England, we do not feel that enough is being done there. At the last count about half the local authorities had prioritised the issue in their health and wellbeing board strategies. We focused on England because we have only three members of staff and when we started four years ago we had to narrow down. We recommend that local authorities take on a leadership role for the issue.

We should not forget the personal impacts and the community impacts—it is not just about health impacts. There are other problems that can be caused by loneliness and isolation that need to be unpicked in order to solve the issue.

Jenny Ridge: ACE IT provides computer training for the older person and has been running since 2001. In our organisation, we see more of a positive sign. For older people, learning about computers and internet use has enhanced their quality of life and their mental health and wellbeing. Having more information and knowledge, and mental stimulation, keeps people going. From our point of view, we see positive signs, although I agree that there are issues.

We also run the moose in the hoose project, which involves our team of volunteers going into care homes. Our volunteers help older residents to engage, using Skype and that sort of thing—again, it has a positive impact.

Grace Cardozo: I agree with my colleagues about the impacts of loneliness on older people that they have described. We must also not forget the impacts of loneliness on our health and social care services, and the financial cost of loneliness when long-term health conditions result in older people relying more on services—that is an important point. People are beginning to understand that loneliness is now one of the major public health concerns for older people.

However, from our perspective at LGBT Plus, statutory and voluntary services do not fully appreciate that older people come in more shapes and sizes than just “older”. For our population group—lesbian, gay, bisexual and transgender older people—there is a complete lack of understanding across all sectors, and a complete lack of visibility. There is no acknowledgement that LGBT older people are out there in our communities. Where there are intersections between age, rurality, LGBT and ethnicity, there is more risk of social isolation.

Natalie McFadyen White: I will carry on from what others have said. Through the Craft cafe, there is an obvious reduction in medication for depression and an increase in quality of life. What is important about the third sector approach—such as the Craft cafe approach—is that it is open to all. It is not just for people with existing conditions; it is a preventative approach, and it is about people in the community coming together and supporting one another. That is a key value that the third sector can offer.

The Convener: I know that a lot of people want to come in, but we are working to a tight timescale and we need to move on to the next set of questions. If we have any time at the end, we can

come back to any issues that people want to bring up that have not been covered.

John Mason: I hope that my questions will follow on from and overlap with what has already been said and link with other questions that are coming up.

My first theme is about how to reach people. Do people who are isolated and lonely know about services in their area? If there are services in an area, are people connecting with them? If people know about services, are transport issues preventing them from engaging with them? Is the biggest problem that the services are not there at all?

Liz Watson: I speak on behalf of befriending services across Scotland—we are the umbrella body that supports them. Our information is that it is not that potential service users are unaware of befriending services but that there are long waiting lists for them, because in general the services are underfunded and overstretched. Although the services are out there, they are patchwork, piecemeal and not always located in the areas of greatest need, and most of them have really long waiting lists.

Karen Nicoll: The Aberdeenshire Signposting Project exists to link people to services, organisations and groups in their local area that will be of benefit to them. We often find that people are unaware of the services that are available to them in their local area, partly because they do not know how to find out about them. That is particularly the case with older people, who are perhaps not information technology literate and do not know how to use the internet to search for things. In addition, services and groups erupt and then disappear: things change, with contacts moving on. It can be very difficult for people to know where to go and to negotiate the barriers.

Transport is a constant issue. We can find things for people but we cannot necessarily get them there if they have mobility issues or are reliant on public transport. That is the case in a lot of rural areas in Scotland.

Ideally, there would be a magic database that contained information about all the local services and groups, but the minute that the information is written down it is out of date, so a constant updating process is required. People tend to come to us either when they find out that the thing that they were planning to go to does not exist any more or because they do not know where to start. A perfect example is a local camera club that we were trying to get someone to access. We contacted their local library, which gave us the contact details, but it turned out that the club had folded 15 years previously. We come up against that kind of thing daily when we are trying to find things.

There is a piecemeal approach to some services—they may be available in one town but not in another, which might mean a trip of 60 miles or more for someone who desperately wants to access something.

John Mason: There are at least two issues: first, the provision of some services is patchy; and, secondly, when services are there, people do not know about them. Do you have any suggestions about how we can get over the information issue?

Karen Nicoll: That is our bread and butter; it is what we do. We work a lot with other organisations. We do not just take self-referrals from clients. If an organisation contacts us and asks us whether we know of something that exists for their client or patient, we will give them that information ourselves.

John Mason: Is your service available nationally or is it purely local?

Karen Nicoll: It is purely an Aberdeenshire service; it covers the whole of Aberdeenshire.

John Mason: So that service is not available elsewhere.

Karen Nicoll: Variations on the theme are popping up all over Scotland, but the service that we provide is available only in Aberdeenshire.

Sheila Fletcher: I am from the transport side of things. One of the biggest issues is short-term funding. We know that there are significant benefits to people of travelling even on the bus, because they build up social networks through the people they travel with to various different things.

Highland has seen a big loss of lunch clubs—I think that that has happened across the piece. They are being rebranded as wellbeing centres that are run by communities. Short-term funding is making it problematic to keep them going.

Transport is the biggest issue. A consultants' report that was carried out for Transport Scotland was issued yesterday. It showed that 89 per cent of respondents found community transport to be fairly important or very important in getting to social activities. People who use community transport really value it, and 50 per cent of the people who do so have no alternative. We must not forget that in vast areas of Scotland there is no transport provision at all. We realise that there is a lot of isolation in those areas.

09:45

Laura Alcock-Ferguson: I want to shed some light on the situation involving people who are not aware of services. Back in 2011, we asked older

people whether they were aware of services that could help them if they became lonely, and 42 per cent of them said that they were not. That was despite our reaching out to those people through service organisations.

John Mason: Are you saying that the situation might be worse because there are people whom you are not even aware of?

Laura Alcock-Ferguson: Yes. There are other people who may not be being reached. We did subsequent surveys with general practitioners, who have a high number of visits from older people. Anecdotally, a number of GPs said that they think that older people are visiting them primarily because they are lonely, rather than for health reasons. Around 50 per cent of the GPs said that they do not have the necessary tools or knowledge to help those older people and refer them on.

However, some organisations might not be reaching out. Again, back in 2011, we asked more than 100 organisations how they identify and reach out to those who are lonely. The lack of response to that led to our developing a range of ways in which organisations can identify those most at risk of loneliness. That includes working with local authorities and utilising their risk data, although that should not compromise any personal data; and/or targeted promotion within certain local areas so that organisations know that they are reaching those who live in areas of most risk. Those approaches can be coupled with basic word-of-mouth information, which is one of the best ways of bringing people in and ensuring that they stay and enjoy a service.

Jayne Baxter: I believe that accessible, appropriate and affordable transport is fundamental if we are to address isolation. I am also aware that older people can become very isolated in urban settings. Sometimes that is because of the design of sheltered housing, which can be at the back end of the village or town, from where older people cannot walk to the shops and where the buses never go. Does anyone want to comment on whether isolation is designed in? For example, a lack of benches, lighting, signage and paths and the existence of muggers' alleys make people reluctant to go out. Is that a common experience? Do you think that that is a factor for older people?

Natalie McFadyen White: Yes. That is not what I was going to talk about, but I think that it is a valuable point.

I am just back from an exchange visit to Japan, and when I was there I asked whether their environmental design was changing because they have a super-aging society. I also asked whether they had taken into account how older people interact with the environment and the fact that that there will be more of an impact going forward. I was told that they have increased the number of public toilets, for example, and made them more user-friendly for older people. However, I think that things such as benches in places where people can sit and better lighting are valuable.

We have found that we connect and interact with older people through our work with social housing partners. That work has been a vital link for us. The social housing partners go to people who feel isolated in their home and connect them with our Craft cafe service, which is provided in sheltered housing and care home space. We bring the community in, so it is about having a space in the care home that people from outside the care home can access, bringing people together and breaking down isolation in that way. Of course, people can be isolated in a care home as well as in their own home.

The Convener: Alison Love wants to come in on John Mason's initial question.

Alison Love: Yes. I agree with some of the other comments that have been made, but I want to highlight two difficulties. Staff changes in the referral source—in council and health and social care settings—can sometimes be a difficulty. People can be willing to be referred to services, but because of changes in personnel there might not be a continuous referral process. To assist in the uptake of services and ensure that people become service users, we have put in place a person-centred approach. We send in one of our specially trained volunteers to speak to the older person about what would make their life better and easier and what we could do to help with that. We then work with other organisations in the area to put together a support package to reduce people's isolation and loneliness. The first difficulty is that we need people to let us know that an older person needs help. The second difficulty is that the older person has to be able to access our service and others in their area.

John Mason: Annabel Goldie will come in on referrals later. Shall I go on to my next question, convener?

The Convener: Yes.

John Mason: Grace Cardozo mentioned LGBT and ethnic minority communities, which relates to the other area that I am interested in. Are people from those backgrounds particularly isolated? I am thinking about not only individuals, but communities. For example, somebody from a Pakistani community might have a lot of Pakistani friends, but no friends outside their community. Is that isolation? Is it a problem, or something that we can be more relaxed about?

Danny Boyle: I will answer that question along with your previous question.

One of the most important factors that we take into account in working with people from ethnic minority communities who suffer from social isolation is that, although they will receive the statutory health services for their circumstances, that is not necessarily the full picture. When we are developing avenues for tackling social isolation, we take into account the cultural characteristics of people. Sometimes it is best to deliver services within communities, because those communities are best at expressing which particular characteristics may fit the needs of an individual in tackling social isolation.

There are some good examples. We went down to Leicester, which is one of Britain's only plural communities in that there is no majority ethnic group. We saw that in areas of high immigration such as inner-city Leicester—which has followed the patterns of immigration across Britain, with the Irish community and then the Pakistani community and so on living in areas of the city including Northfields—there is great crossover between local service providers and the voluntary sector. If people are aware of an individual or a pocket of a community existing in an area of multiple deprivation—given that social and economic disadvantage, and the health inequalities that go alongside it, exacerbate loneliness—a partnership approach comes into play. Health services are provided by statutory bodies, and the cultural aspect is delivered by the community, which results in a holistic approach.

John Mason: Is that not happening so much in Scotland?

Danny Boyle: It does happen in Scotland—I think that it was mentioned in the committee's previous round-table session in January. There are some great examples in inner-city Glasgow, where there is a high concentration of ethnic minority communities. There is a lot of partnership working between mosques and temples and community groups and organisations.

If you are asking whether there is an element of isolation within isolation, with ethnic minority communities polarising themselves in some respects, I would say that there is not, from the example that I have just given.

More broadly, following on from our previous discussion in January, BEMIS, in conjunction with the Scottish older people's assembly, will be looking to address the gaps that we have identified. As we have acknowledged, we are looking at the demographics of the areas that we are servicing, and it is clear that people from ethnic minority communities are not using the services as much as they could. There is a great opportunity for cultural crossover in that environment to progress that element of our work.

Grace Cardozo: LGBT older adults are much more likely to live alone, to be estranged from their families of origin, not to have had children and not necessarily to have had a relationship or a partner. If they have a relationship, they may still be very isolated from family and communities.

We have to remember that homosexuality was not decriminalised in Scotland until 1980 and was still considered to be a mental disorder until 1992. We work regularly with older adults whose reality was imprisonment and institutionalisation with electroconvulsive therapy and hormone treatment, which makes LGBT older people much more reluctant to trust services, because they have been brutalised by services in the past. It also makes older people in general much less likely to be tolerant of homosexuality, because they grew up in an era in which it was criminal. LGBT older adults can therefore become significantly isolated, and if we add to that the rurality aspect in Dumfries and Galloway, the situation becomes even worse.

In response to John Mason's question about whether we are isolating communities even further by pigeonholing them as LGBT or Pakistani, I would say that in some ways we probably are. Our best-case scenario would be one in which an LGBT or Pakistani older adult can go in to any lunch club or day-care centre for older people and feel integrated, happy, welcomed and supported. The fact is that we are not there yet, and it will probably be several decades until we are.

We are making huge legislative and cultural changes in Scotland, with the equal marriage bill—now the Marriage and Civil Partnership (Scotland) Act 2014—and so on, but we still have to make a hearts-and-minds shift, not least among the older generation.

I see specialist services for LGBT older adults or other LGBT members of the community very much as a stepping stone that should operate in tandem with mainstreaming work to make the rest of the communities in the sector as inclusive as they possibly can be. We are now finding that the older adults in whom we are investing time and support to bring them together with a social group to make friends are now, as a group, feeling more confident about accessing the social, cultural and leisure opportunities in Dumfries and Galloway. Without the LGBT hand-holding bit first, they would not necessarily have been able to do that.

Jenny Ridge: I want to pick up on the point about being isolated in a care home. I agree with Grace Cardozo in that respect. As part of our moose in the hoose project, in which we help residents to use the internet, we held an

awareness training session for our volunteers that was run by LGBT Plus.

We found it very interesting. For example, a gay resident in care might have had a partner who has died, and might hide their photographs because they are embarrassed. That learning curve was great for our volunteers in enabling them to understand that there are other people in care who are isolated. The more training and awareness that we have from LGBT folks like Grace Cardozo, the better the situation will be.

Going back to John Mason's original question, I will comment quickly on what Liz Watson and Sheila Fletcher said about attracting more people. If ACE IT had more funding we could do more, but as has been said, funding is certainly a restriction for us.

Annabel Goldie: The committee is very interested in where referrals come from. You are all doing a power of work in your own spheres of activity. The question is relatively simple, but the answer may be a little less straightforward. We have heard that the majority of referrals are probably self-referrals. I would like to know, very briefly, where most of your referrals come from. I realise that Karen Nicoll's organisation is a signposting project, so the question is less relevant to her. Until I listened to Natalie McFadyen White's comments a moment ago I thought that the question would be less relevant to her too, but I now realise that she is getting referrals from social housing landlords, or something like that. We want to know where the people come from. Are they self-referring, or do they come through social work, general practitioners or housing professionals, or from somewhere else?

Natalie McFadyen White: Because we partner with social housing to deliver the Craft cafe service, the majority of people come through that route. We ask that all partners commit to being open to the whole community and not just their tenants.

There is a focus around doctor referrals. In Govan, we were part of the ALISS—a local information system for Scotland project—pilot of therapeutic prescriptions. We have not yet had time to analyse the results, but it will be interesting to see whether that project has increased referrals from the national health service.

Organisations such as Carr Gomm also refer people from a mental health perspective, and there are referrals from other local services in each area, but the majority of referrals come through social housing. That then generates word-of-mouth referrals, which I think is the biggest key to success.

Liz Watson: Befriending services across Scotland find that they get a mixed bag of referrals. At Befriending Networks we do not run befriending services ourselves, but because our phone number comes up when somebody Googles "befriending", we get a lot of enquiries from people who are lonely and just want a befriender for themselves.

That leads us to believe that people are aware that befriending is out there, but they cannot necessarily get the services that they want. There are a lot of self-referrals and referrals from family members who have to move away from their elderly relative for work or other reasons, and who feel deeply guilty about leaving that person isolated. Quite often we get anguished phone calls from people who say, "Please—is there something out there for my mum and dad?" as their parents may be 90-something and living on their own.

10:00

Befriending services also get referrals from health and social care and from social work departments. After taking soundings from such services—not only services for older people but those for people with mental health issues, learning disability issues and so on—we have found that referrals are becoming increasingly more complex. The social worker will lift the phone and ask for a befriender for someone who has extremely complex needs, has complicated mental health issues or is a sex offender, which are things that are probably beyond the scope of the average befriending service because, after all, the befrienders are volunteers—they are well-trained volunteers, but they are part of a service that is not necessarily set up to cope with such complex cases.

Karen Nicoll: Self-referrals are the minority of referrals that we get. The majority are from primary care staff—GPs, practice nurses and community nurses. We also get a lot of referrals from local area co-ordinators and care managers. Community hospital staff refer people who are about to be discharged so that we can put things in place before they get home. Referrals also come from other council services including visual impairment teams, community psychiatric nurses, mental health social work teams, social workers and from other voluntary organisations. We have been steadily growing our referral base over the past few years and we get a vast range of referrals now. However, as I said, self-referrals are the minority.

Alison Love: I echo Karen Nicoll's point—the experience of the Royal Voluntary Service is similar. However, in addition we receive referrals from housing officers, housing associations and

occupational therapists and we deal with people who are discharged from hospitals.

Laura Alcock-Ferguson: I apologise if I am about to throw a spanner in the works, but I would like to be clear about the definitions of isolation and loneliness that we have been using. When we are talking about referrals, especially those that involve people referring other people, it is useful to bear in mind that someone can be isolated but not lonely and that someone else can be lonely but not physically isolated. Talking about loneliness is really stigmatising for a lot of people.

I apologise for raising something that I probably should have said at that beginning. It is important to remember, when we are talking about all the wonderful avenues for referrals, that investigation that we have done into first-contact schemes—which involve people such as GPs and workers in the fire service, who come into contact with people who are isolated, and can easily see the isolation—has shown that they are very thorough in identifying older people's practical needs but do not use the depth of questioning that is needed to determine whether someone is lonely, which is a matter of whether a person is unhappy with the quality of the relationships that they have. Isolation and loneliness are both problematic. They can overlap, but one does not necessarily lead to the other.

We have done work on two reports in that regard. The one that has been published, "Promising approaches to reducing loneliness and isolation in later life", identifies the need for referrals and identification, and the other, which is about to be published—it is based on our hidden citizens project—talks about first-contact schemes and the gap that exists around helping GPs, occupational therapists and so on to talk about loneliness in a way that will help them to overcome the stigma. I hope that we will be moving along that path and offering some tools in that space quite soon.

Annabel Goldie: The committee has heard some evidence that older people might be slightly apprehensive about seeking support from social work services or their GPs because they fear that they might lose their independence or might end up in a residential home. Do any of you have evidence to support that view?

Sheila Fletcher: I also work as a trustee for a community centre that has a wellbeing centre in it. There is a great fear among the people there that they have to prove that they are independent.

We have talked about referrals, and one of the referrals is for falls prevention. There is a big move towards training people in preventing falls, which is really important for people who live independently.

The other thing that has come out in some of the work that I have been doing recently is to do with the language that we use when we ask about isolation. We have to go round the issue carefully, and maybe just ask, "Are you fed up?" An outcome of that work has been that we know that it is better to offer people help than to expect them to ask for it.

People are frightened of being put into a box and being expected to do something, and of being referred to things that they do not want to do. They value their independence very highly.

Annabel Goldie: It is interesting that, with the exception of Sheila Fletcher, no one has any evidence of that scenario.

Natalie McFadyen White: We do not have specific evidence of it, but we find that, at first, when we do our evaluation work with our members, they are unwilling to talk about their medical conditions, money or whether they smoke or drink. It takes a long time to build up trust. Quite often, it is when we go back and redo the paperwork six months on that people feel more relaxed and more able to talk about what is troubling them and what issues they have. At that point, we can support them with what they need, but it takes time.

It is about the person's trust in us, and the person-centred approach whereby people have someone they can talk to and trust—not just a doctor in an office.

Annabel Goldie: It might be more a question of personal pride than fear, but it is still inhibiting.

Natalie McFadyen White: Exactly. It is interesting that, when we did our social return on investment study, the main topics that people did not want to talk about were money and alcohol. They would talk about pretty much everything else, but not about those two things. We have to respect that and understand it.

Grace Cardozo: Our service users have not specifically said that they are frightened about speaking to their GP because they might be put into a care home, but we know that they are frightened about what might happen if they were in a care home because they do not feel comfortable that care-home staff would be able to deal appropriately with their issues. That is the case not least for transgender individuals, for whom intimate care might be a particular issue if their gender presentation does not match the genitals that they still have.

The vast majority of our referrals are self-referrals. Part of the reason for that is that 99 per cent of services will never ask an older person about their sexual orientation or gender identity, so that will never be picked up. Interestingly, we have

self-referrals and people accessing our services from Ayrshire, the Scottish Borders and Kendal—someone comes up regularly from there, and there are others from Cumbria. That is partly because, in Scotland, there are just four very underfunded groups for LGBT older people. There are the groups in Glasgow, Edinburgh, Inverness and Dumfries and Galloway, and that is all. We have to cast a net wide for people who are trying to access our services.

Danny Boyle: We are regularly contacted by different national health service departments that are concerned about the lack of engagement with minority ethnic communities across a range of policy areas. That might well be reflected in the question that Annabel Goldie asked. It is most likely due to cultural reasons or the prevalence of emphasis on family and community. I am glad that the issue has been brought to the committee's attention. It is certainly something that we will give more consideration to as we progress our work in the area.

The Convener: Thank you for those answers. We move on to questions from Sandra White.

Sandra White: I will look at the bigger picture, following on from what Annabel Goldie said about the integration of health and social care, which became law yesterday, on 1 April. I was surprised when you mentioned that most of your referrals come not through word of mouth but from the health service. Previous witnesses said that GPs do not have enough time to spend with people who go to see them and do not recognise the loneliness.

Is there a bigger role for GPs, the health service and social work services to prescribe not necessarily medicine but going along to some of your clubs and that sort of thing? Should it be part of the model for the integration of health and social care that they can send people there?

The evidence that you have given suggests that we are touching people who are already in the system, whereas the people who are not in the system, who really are isolated and lonely, are not able to access the services. What are your thoughts on that?

Natalie McFadyen White: As I briefly mentioned, we are part of a pilot scheme in Govan for therapeutic prescriptions. That is really valuable. GPs are—rightly—quite locked doors to us as a third sector community programme. We are not really able to get access to a GP and tell them what we want to do. That is absolutely right for patient confidentiality, but it would be greatly empowering to the patient and the doctor if the GP could say, "Actually, there is this service. It's round the corner from you and it's perfect. You should go to it."

Alison Love: I agree. We have been trying hard to get GPs throughout Scotland to work much more closely with the voluntary sector and refer patients to its services. A number of people who present to GPs on a Monday do so because they have no one else for company. Those referrals could come to us to provide services, which would reduce the demand on GPs and the stresses that they go through from having so many patients to deal with.

Liz Watson: At a conference last November, we had a presentation from somebody in the deep-end group of GPs—those in the most deprived communities in the country. The GP was from Drumchapel and spoke about social prescribing. As Alison Love said, GPs are extremely busy and there is sometimes such a turnover of third sector organisations that it is hard for them to keep up with what is available in their community.

The GP from Drumchapel who we heard from talked about a link worker who is located in their surgery and whose job is to connect with community groups, refer patients to them and inform patients about them. That is a more realistic model than GPs keeping up with absolutely everything that is going on in their communities.

Grace Cardozo: I absolutely agree that social prescribing is really important. In Dumfries and Galloway, we have had quite a successful pilot of it.

One of my other roles is as a non-executive director on Dumfries and Galloway NHS Board. Another interesting initiative that I have heard about is the new chaplain listening service. As far as I understand it, that new scheme is not necessarily about religious figures becoming chaplains but about any skilled person in the community becoming an expert listener. Those individuals can be based in general practices. They might have much more time to spend with people when they feel lonely and isolated, perhaps just after a bereavement, and be able to link into social prescribing.

We must not forget that older people do not have to be passive recipients of such services but can volunteer their time in them, which also reduces isolation. Through schemes such as time banking, they can bank voluntary hours and gain things back from people.

All those approaches can work really well in tandem, but it is clear that the third sector must have a critical part in the integration of health and social care. We need to ensure that all the joint delivery plans have a big focus on third sector organisations supporting integration.

Sheila Fletcher: I agree with what Grace Cardozo just said about the importance of recognising what is available. Social prescribing

works well in small communities when the doctor's surgery is close to the community centre where the activities take place.

The big thing is making known what is available. As Karen Nicoll said, sometimes, a service is listed on a website but, when somebody tries to access it, they find out that it is long gone and no longer available. Perhaps there is a place for advertising in doctors' surgeries activities that are available in the community. I know that there is a bit of reluctance in some doctors' surgeries to do that, but it might help to raise awareness of what is available.

10:15

Laura Alcock-Ferguson: I definitely recommend a more strategic approach across health and social care that involves not only raising awareness but commitments to action from the regional NHS boards. That should flow down to GPs and other front-line health and social care workers.

As well as having GP social prescribing, I would recommend having other navigator schemes in communities. Someone mentioned one of those earlier; Health in Mind is one of the organisations involved. The Campaign to End Loneliness is supported by about 1,000 organisations. Organisations represented around this table—and MSPs—are welcome to join our campaign, if they have not done so already.

Health in Mind offers a range of services, but it also offers a navigator role, which means that a volunteer who knows about activities in an area will point people to not only their own organisation but others. That partnership between statutory and voluntary organisations can open up information and overcome problems in knowing what services are available—the example of the camera club that closed 15 years previously was referred to—which might help people to get into activities that they could enjoy.

Karen Nicoll: When our project started, we took referrals solely from primary care, and the project limped along in a very small way. I think that there are 63 GP practices in Aberdeenshire; one or two of them made referrals to us, but the rest did not. It is difficult to get GPs engaged. Anyone around this table who has tried to do that will probably say that it is difficult to get GPs to buy in. However, if we are lucky enough to find one GP in a practice who gets it and uses the service, they will tell their colleagues, who will also buy in.

After we opened up our project to other NHS services, councils and the voluntary sector, the GPs started to take notice. Although our service had been available to one GP's practice for about four years, when it was mentioned at a meeting, he asked why it was not available in his surgery; he did not know about it and had never used it, although I had spoken to him in person about it four years before. However, once GPs get it, they really get it and realise the amount of time that the service can save.

I understand what has been said about people who are hard to reach. We have found that the self-referrals tend to be the hard-to-reach people. They are not really engaged with any services, but they find out about us from places such as libraries and community groups, which keep stocks of our leaflets, or they hear about us through word of mouth, and then contact us. They are the ones who really need help with isolation and social contact.

The GPs in the shire and the other statutory service workers seem to be really good at picking up on the service, and we have a good, close working relationship with them. I can honestly say that in our work with Aberdeenshire Council and the NHS we have at no time felt like the junior partner. We are treated on a par with our colleagues in those bodies and have the same respect and regard, which makes for a successful working relationship. That is why our referral base is doubling year on year.

Danny Boyle: I made a point about the experience in Leicestershire, so I agree that we need to provide diverse services for diverse communities and citizens, which is best done through a partnership approach.

The problem of harder-to-reach people is critical, particularly when we consider that the potential for the exacerbation of loneliness and isolation is more prevalent in areas of social and economic disadvantage. Having a place-based approach to tackling any policy issue that looks at driving towards areas of multiple deprivation is all well and good, but we must also consider those who are harder to reach.

The Equality and Human Rights Commission released a report on the harder-to-reach issue that pointed out from an ethnicity and race perspective that Chinese, Indian and Pakistani communities are much more likely to live in poverty outside areas of multiple deprivation. A co-ordinated partnership approach across the country within and outside areas of multiple deprivation is needed to tackle the potential isolation problems.

Sandra White: I have a small question first that the witnesses can probably answer yes or no to. Should the third sector be involved much more closely with the new integration boards? Should third sector bodies have a place on them or be able to have direct input into them?

My next question is possibly more controversial, but the witnesses can answer yes or no to it as

well. Given that funding is a big issue, should some funding come from the new integration boards as well, instead of always coming just from the lottery or whatever? I know that that is a controversial question, but I just put it out there.

The Convener: I will take Jenny Ridge first, because she was trying to come in earlier.

Jenny Ridge: I back the point from Sheila Fletcher and Laura Alcock-Ferguson about strategic planning for advertising in GP surgeries. Most of our learners come as self-referrals through word of mouth and that sort of thing, but we also have a few referrals from OTs.

We had a targeted marketing campaign where we produced leaflets and put them in doctors' surgeries. We did that off our own bat but, as Laura Alcock-Ferguson pointed out, that should be part of strategic planning. Doctors' surgeries should have available some sort of package through which they can see information about ACE IT and organisations like ours and about the services that we are offering, as opposed to a marketing campaign from ACE IT.

The Convener: Could I have a reply to Sandra White's last question? We need to keep this short, because three more members want to come in.

Natalie McFadyen White: On the challenge of funding, the biggest issue that we have in delivering the Craft cafe—it has come up in various guises during the discussion—is how to continue the service. Older people's services are not short-term fixes; they are long-term programmes. The need for them does not go away—it grows. Three-year funding packages do not support us or similar services to carry on and do the work that we need to do, and there is always a fear that the programme will fall away, like the camera club that closed 15 years before. Anything that can be done to address how older people's programmes are funded would be a fantastic leap forward.

John Finnie: I am interested in the witnesses' views about the use of IT. It has been mentioned a lot, and I want to understand what the benefits are. They have been laid out in many of the submissions, but it would be good to have them on the record.

If I could extend the question—with the convener's indulgence—a bit beyond that, I am interested in your views about the use of telecare and telehealth, rather than physical contact, and whether that compounds feelings of isolation. We all want to embrace the technology, and there are upsides that it would be good to hear about, but are there any downsides?

Sheila Fletcher: One issue, especially in more rural areas, is access to a signal. Globally, the biggest issue is the cost of having the services in place—the new smartphones are expensive. A lot of transport operators in particular say that they have an app for this or that, but that is losing a lot of the older people, who do not understand and cannot use the technology and who cannot pay for it. A lot of work needs to be done on that.

Telehealth is usually offered in a centre rather than directly in people's homes, so there is a transport issue in people getting from their homes to wherever the telehealth is available. It is early days, and I do not know whether telehealth will isolate people. Travelling on a bus is usually as important as reaching the destination, especially if people are doing that regularly, because they build up a group of friends who they travel with. If we go down the road of having everything operating as telehealth, I think that it will cause more isolation.

The Convener: I ask everyone to keep their answers short, because we are running short of time.

Laura Alcock-Ferguson: We recently brought together about 30 front-line organisations to talk about how they use technology and how they want to use it in the future to help their beneficiaries—people they work with—to come together. Some of the conclusions from that workshop were common sense. Technology is not a replacement for real face-to-face contact, but it can enhance that, particularly through keeping people in contact with friends and family. The ability to come together through IT training, for example, can enable people to make new friends. There is caution, of course, about replacing direct human contact.

There is probably not enough evidence about the use of telecare to know whether that is pushing loneliness in either direction.

I will throw in a futurology-type question about the fact that people who are in their 60s, 70s and 80s now are using technology in a very different way from the way in which people who will be in those age groups in 10 or 20 years' time will use technology—when, of course, the technology will have changed. The people in the cohort that is coming through are more likely to be technology fiends, as it were, and encouraging them to balance that will be a challenge that we do not necessarily face just now.

Jenny Ridge: The positive things about older people and IT have been pretty well documented. I will pick up on something that Sheila Fletcher said. I cannot speak for all the people who we have not taught—I can speak only for the thousands of people who we have taught—but there are definitely barriers, one of which is cost.

Another barrier concerns the need for an older person to see the benefit of using technology. One of our learners said:

"I think I've bored too many friends going on about the advantages of having a computer. I love Skyping family members".

That picks up on Laura Alcock-Ferguson's point. Services such as Skype and email are important, and we need to get that message across to the hard-to-reach groups that we have mentioned. However, I also agree with Laura Alcock-Ferguson that technology does not replace a face, as such.

Christian Allard: Technology replaced face-to-face interaction when the telephone was introduced. A lot of people in the generation that we are talking about use the telephone extensively. Unfortunately, later generations are not using the telephone any more. If the telephone becomes obsolete, will that create more isolation?

Liz Watson: There are many telephone befriending services in the country. That is partly driven by resources, but it is also found to meet the needs of people who cannot or will not leave the house or who are a bit nervous about face-to-face befriending. Among older people, anyone can benefit from a telephone befriending service, as long as they do not have a hearing problem.

Christian Allard: Unfortunately, the only people who call on the phone these days are people who are trying to sell us something. Families do not phone any more.

Liz Watson: That is true. However, as I said, telephone befriending services are expanding. The telephone is perhaps not quite dead yet.

Jayne Baxter: I want to talk about how services anticipate when loneliness or isolation might be an issue, how they work out when and how to intervene, and how we can get them to intervene earlier and more appropriately. We have heard that health and social work agencies are important. Are any other agencies on the front line when it comes to identifying individuals who might be lonely or isolated? Bus drivers, for example, might be aware of such problems facing people who get on their bus.

Sheila Fletcher: As you were speaking, I was thinking about churches. People in churches can be aware of the problems, and can sometimes solve them within the church. However, they also refer people to services, where they can. The other side of that is the fact that some people will not use services that are created by churches, because of sectarianism—they will not use services that are in the wrong church. I came across that recently in my area. It can be difficult to persuade somebody to use a service that is put on by the community, simply because of where it is situated.

I am sorry that that did not really answer your question.

Jayne Baxter: It gave me food for thought. Does anybody else want to contribute?

Natalie McFadyen White: I would say that people in local shops might be aware of problems. Before they came to the Craft cafe, a lot of our members would go to the shop just for a chat—they did not really need anything; they would buy a pint of milk just to have some contact.

On the bus scenario that you mentioned, one of our members, prior to coming to us, would just sit on the bus all day and travel around the city, because that is all that he had to do with his day and it was free with his bus pass.

10:30

Jayne Baxter: How can the statutory bodies and the third sector tap into all that knowledge and awareness? Is there scope for local partnerships? What can councils and integration partnerships do? How do you make the connections?

Laura Alcock-Ferguson: There has been an interesting trial among local chemists and the third sector in a number of places. They integrated quite basic questions into a questionnaire about prescriptions, which generated interesting results.

I would flag up the separate issue that most of the services that we have identified may not reach men. Men are less likely to go to GPs, for example, so different tacks may be needed. I am not trying to cast aspersions, but we need to consider other places where men are more likely to gather, such as pubs and the bookie's. We are then back to how the issue would be brought up in such settings, because it is a delicate matter to talk about.

The Convener: I am thinking with my town and town centres cross-party group hat on. I was told that post office staff develop relationships with people who come in. Indeed, if someone did not turn up one day, the staff would worry about what might have happened to them. That is a place to consider, as are small, local, independent supermarkets, whose staff also get to know people. Would such places be possible sources of contacts and referrals? I see that people are nodding their heads, so the answer seems to be yes.

Grace Cardozo: In some of the wee-er places, community councils could play an important role. It would certainly be a more important role than talking about potholes all the time.

The Convener: That is an excellent idea.

Jayne Baxter: There is a role for people such as local councillors and those on community councils to take on board responsibility to develop knowledge and feed it in when they get the chance

to do so. They are well placed to do that, but they do not often remember to do it.

I am also interested in the point about services for men and women, which I was going to ask about. The men's shed has been spoken about before in the committee. We are getting a new men's shed in Fife. I am quite excited about that, although I am not a man—that would be a different meeting. [*Laughter*.] How do you tailor services for men and women?

Natalie McFadyen White: For some reason—we are still figuring it out—the Craft cafe is equally popular with men and women. From my time in the field, I think that that is unusual. I need to do more research, but I think that it is about people being able to do what they want to do. No one tells them what to do; instead, they are asked, "What do you want to do today?" If the answer is that they want to build something, listen to music or have a cup of tea, that is their own choice. That is quite an important factor in why the cafe is equally popular across the genders.

Liz Watson: On services being tailored for men and women, it is not necessarily the case that the service is delivered differently; rather, it must be advertised differently. Sometimes, we have to coax men in.

Last year, I did an evaluation in a sheltered housing scheme where, although the befriending service was very successful, it did not touch any of the men. I spoke to the women in the group and they all said that the men would not join because they thought that it was just for women to knit and gossip. Of course, it is a little bit more than that. There is a bit of an image problem.

We also find that it is easier to get more men in if there is a good cohort of male volunteer befrienders. Volunteering develops by word of mouth. Once there is a hard core of men, if you like, it is a bit easier to get additional men in.

Karen Nicoll: A few years ago, in an urban setting in a local town, we had a cluster of clients who were almost all in identical circumstances. They had all been bereaved in the previous 12 months, they had no friends and they had no social contact outwith the relationship that they had with their partner. They were all desperately lonely and very isolated, they needed some form of social contact, and they wanted to build friendships. Between them, they had tried pretty much everything that was available in their local area, but none of it was suitable. We looked about for something different, but could not find anything.

We approached our local change fund for older people and asked for funding to set up a project to offer older people the ability to contact those who had similar life experiences, likes and dislikes, and a chance to make friends—it was not about meeting people at a club; it was about making actual friendships.

The project started in January 2012. The initial group has grown into six established groups and three fledgling groups throughout Aberdeenshire. The original group in Inverurie now has 18 regular members and is starting to take over the venue where they meet.

The majority are men, which surprised us: they did not go to their GPs very often and did not have much contact with statutory services or, indeed, with anyone at all. They came to the project by various means. We were ecstatic that the members included what we would class as hard-to-reach men.

We managed to get the group together and genuine friendships have formed within it. They meet as a group once a week, but they also do things together by themselves when they feel like it. Some members have introduced the others to casinos, and they have gone to restaurants—they have done all sorts of things. Two of them went on holiday to Australia.

It has been a hugely successful venture that offers those people friendship. It does not offer them something prescriptive: they can dip in and out as they want. They can do what they want: we do not tell them what to do or where to go. It is very much about forming friendships in a natural, not a forced, way.

It has been a real learning curve for us. The members are extremely hard-to-connect-with people, but we are seeing them connect with one another. That is ideal: the less input we have to have, the better. It is an organic process and it really works. It is something that we are incredibly proud of, are having quite a bit of success with and are trying to grow throughout Aberdeenshire.

Sandra White: With regard to hard-to-reach people in communities, we have found that, in Partick in Glasgow, for instance, hard-to-reach men avoid anything that is health related, so we brought the outreach into the local community. For example, we used local cafes that the men already used, and held open days. We found that that was the easiest way to reach the men.

On the point about leaflets or a directory, in my area and in others, there are a number of local shops, particularly charity shops, where people spend hours because they are lonely. Would that be somewhere to put leaflets that reach out to people, who could pick them up as they were wandering about? That was not a question; it was just an observation.

John Mason: Some of the things Karen Nicoll said were very interesting. It would be helpful if you could give us a one-page summary of the

project and how it works. I am interested that the project approached the change fund. Was that process easy? Do you have a worker who is enabling all this to happen? Is the project sustainable and, if so, for how long?

Karen Nicoll: We could not find services that provided what was required and we could not put our clients in contact with one another ourselves because of the Data Protection Act 1998. We decided that, because we could not find anything, we had to create something ourselves.

We were already funded by the Aberdeenshire change fund for older people to provide signposting for older people. We went to the change fund with a funding proposal and evidence showing why the project was necessary. It accepted the proposal and funded it.

It was incredibly easy. Aberdeenshire Council has been very supportive and we have been really lucky. We are now being funded through the integrated care fund for the next 12 months. We have a good, strong relationship with Aberdeenshire Council because we have always been able to demonstrate that the project is working, is value for money and is doing good work.

The project did not grow in the way that we thought it would. Our initial idea was that we would match up similarly minded people and they would go off in pairs. Because we had such a large group to begin with, we decided to get them all together to see which pairs naturally formed. However, the group formed, stayed formed and has taken everyone in as time has passed. That is not what we thought was going to happen at all, but we are really pleased.

All of the members tried to join something after they were bereaved. They were put off because they felt that they were excluded, that the group was cliquey, that no one was there to greet them or that things were not explained to them. Everyone had a reason why they had tried to do something and had been put off and just retreated that little bit further.

Every single person in the group knows what it is like for someone to go along to a group where they do not know anyone else and they are the stranger. They are very conscious of that, and they will always—all of them—take responsibility for welcoming new people in. The group is extremely strong and we are very proud of it.

Through the group, we have generated other spin-off groups throughout Aberdeenshire. We had only the one group when the project was piloted, and we still have people who come to that group from 20 or 30 miles away. They like the group that they joined, so they have stayed in it, although a couple of them have spun off to more local groups. Some of them are good recruiters for the other groups, because they tell people about them.

The process has been very organic. We have tried to operate with as little intervention as possible, with the exception of having someone there to ensure that everything goes okay and that people are welcomed in. The groups have been allowed to develop naturally, and we do not interfere.

John Mason: What is the project called?

Karen Nicoll: It is the out and about project. Sorry—I should have said that.

John Mason: No, that is fine—I think that the name was mentioned earlier.

Jayne Baxter: I have a quick question. We have heard that the voluntary sector faces barriers around funding, knowledge and awareness. Are there any other barriers that prevent the third sector from doing more or from working together more to address social isolation? The point might have been covered, but I wanted to give people the chance to say something.

Laura Alcock-Ferguson: It comes back to the point about having a strategic view and a leadership role—we touched on that, but I want to answer your question more fully. We are hearing about a range of amazing services, but there needs to be a view of what the pieces look like when they fit together. That will help with things such as referrals and word-of-mouth recommendations. For example, someone may come in and then decide that they do not necessarily want that particular service, but the people working in that service may know of somewhere else for them to go.

There are different levels. There are enablers that wrap around the whole community. That might involve promoting age-friendly views, for example; we touched on the issue of stigma earlier. There are the direct services that we have discussed. There are also aspects such as changing people's mindsets, which we have not really touched on, which can include techniques such as mindfulness, which is a way of enabling people to be more present in their current experience. Loneliness can be seen as the difference between the level and quality of the relationships that people have, and the level and quality that they want to have. Services often try to increase the level that people have to the level that they want, but there can also be an element of helping people to become more accepting of their current reality—I am trying to be as diplomatic as possible about that. Basically, mindfulness involves helping people to be at peace with what they currently have. A leadership role is also needed. That role would be outwith any one third sector

organisation's role; we think that it should lie with health and social care.

Grace Cardozo: I have a brief point about funding. The change fund was great, but it was all about innovation, and that can sometimes be the death of the third sector. We know what we do and we do it well, but we cannot get money to continue to do it because we have to do it differently somehow.

Innovation is important and we need to stay ahead of the game, but we cannot forget that really good workers leave the third sector because they know that their contract is coming to an end in three months and they have to find another job, and we then have to start all over again. That is a wee word of warning.

Christian Allard: My questions are on possible actions. Laura Alcock-Ferguson spoke about the strategic need to plan—for advertising, for example. In a previous evidence session we discussed the idea of a national campaign. We have heard a lot this morning about community boards in GPs' surgeries, or perhaps in the bookie's for men; that is important, as men are very often difficult to reach.

I want to hear about what we could do in the future. Taking Karen Nicoll's example, one of the reasons that we are so well placed in Aberdeenshire—with the men's sheds and other services—is that we have a great deal of plurality. There are people coming from everywhere because the employment level is high, so we have a great mix.

There are people who live a lot longer and who have been very active during their lives, and they want to be empowered to ensure that they are not lonely. They may be much more aware of the situation than people in other places may be, because they are separated from their own families and automatically a lot more isolated than other people. That is perhaps what every community in Scotland will look like in the future. How can we address that? What are the possible actions? Do we need a national campaign?

10:45

Natalie McFadyen White: I do not know whether this answers the question, but one approach that is working really well in other countries involves focusing on people who have just retired. Those people are not old: they are healthy and have a lot to give. There are a lot of schemes running for people who have just retired and are not ready to sit back—they still want to be active, and to take on an active role in the community to support people who are older than them. That may involve volunteering, just being a friend, taking people out or doing their washing. That provision is quite localised within communities, which is the key. It does not involve removing people from familiar places, but instead involves keeping them where they feel comfortable and where their home is, with their existing networks of friends and their familiarity with the space around them.

That approach is working really well, and I want to explore it through our project in relation to voluntary workers who have just retired. That may be a way to provide sustainability for such projects—I do not know.

Laura Alcock-Ferguson: We think that what needs to happen next is the bigger-picture stuff. It is about creating a positive image—despite our name—of people keeping connected in older age, and about changing attitudes in wider society. However, we also need the leadership role in health and social care and in local authorities, which have responsibility for things such as transport.

I have touched on the aspects that people who are currently lonely could be given more help with—for example, changing their thinking as well as supporting them practically and personally one-to-one. In addition, we are helping front-line organisations to reach out better. There are four levels in the framework outlined in the "Promising approaches to reducing loneliness and isolation in later life" report, which we published in January.

I agree that there should be a national campaign, particularly in the areas that I have recommended. I will say—to be very cheeky—that we would love to work with as many Scottish organisations as possible, and with Welsh, English and Northern Irish organisations, to develop such a campaign over the coming years.

Sheila Fletcher: I have two points. First, it is not a statutory requirement to provide public transport or any other form of transport apart from school transport. When local authorities' budgets are being cut, the first thing that they draw back from is the provision of transport for social activities.

I was going to say something else, but I have forgotten what it was. When I get started on transport, I usually spend a lot of time speaking about it.

We have a problem. The change fund has been very good, but—as was said earlier—we need to find ways of continuing that funding.

Danny Boyle: I have two points. We have taken into consideration the fact that we need a much broader holistic approach to organising in order to develop a coherent drive among all the services that exist.

I agree with Laura Alcock-Ferguson about the need for a national campaign, but I would

caution—as I would with any campaign—against reinforcing stereotypes. Instead, a campaign should be about completely changing the image, discourse, rhetoric and culture through which we interpret and engage with diverse citizens. That should include people who are elderly: they are still citizens, and they still have potential and a lot to give to their local communities. They are not a burden, and we need to change that image and the way in which we talk about them.

If a national campaign was able to achieve that and have a trickle-down effect in creating a cultural shift, alongside a more holistic approach across voluntary and statutory services, that would—at least in some measure—be the next stage in progressing the agenda.

Sheila Fletcher: I have remembered my other point. Natalie McFadyen White said that younger older people are able to help, but the problem is that we are now having a pension age increase, so we are not seeing as many younger older people coming along to volunteer. There is beginning to be a crisis, because an awful lot of older people are presenting for help but we are not seeing so many volunteers coming along who are able to help. I would like to find out from people round the table how we are going to address that. It could involve allowing people more time off work to volunteer, but at the moment I think that we are about to hit a crisis.

Grace Cardozo: Building on what Sheila Fletcher said earlier about churches, I note that they play a massive role in supporting isolated older people, but my question would be for how much longer that will be the case. We do not know what the churches will look like in 20 years' time. They are emptying by droves. Who will take responsibility for our older adults in communities, apart from funded services?

As well as considering the involvement of younger older people, we need to consider the position of young people and intergenerational work. We need to narrow the chasm that now exists between older people and younger people, because that will help both groups.

Christian Allard: Should the national campaign address not only older people but all generations? That might ensure that we have a discussion and that people are aware of what is happening in society today.

Grace Cardozo: Absolutely. How many young people regularly visit their grandparents these days?

Christian Allard: Or phone them.

Grace Cardozo: Exactly. Things are changing, and it is going to lead to real problems. I agree that any campaign needs to be targeted to all members of society.

Liz Watson: I echo what Laura Alcock-Ferguson said about a national campaign. If I may say so, there is already a national campaign in England. It is called the Campaign to End Loneliness, and it is absolutely fantastic. At Befriending Networks, we have taken a lot of tools and tips from that campaign. If we are looking at a national campaign, please let us not reinvent the wheel. Let us learn from what works elsewhere and what is already established—the good practice, the suite of resources and all the rest of it.

At Befriending Networks, we are doing two tiny things on a zero budget. We have befriending week in November, which is a national campaign for befriending services that tries to get more volunteers on board and to support smaller befriending services in particular to be able to trumpet what they do.

We have also embarked on what we are grandly calling a health and loneliness roadshow, which has been in planning for a couple of years. Basically, it means that we are schlepping around every health board area in Scotland and talking to anybody who will turn up within a three-hour lunch-time slot about the connections between health and loneliness. The response so far has been incredible. There is another one next week in Edinburgh. If anybody is not doing anything next Tuesday lunch time, they should come along.

We find that professionals are really engaged with the issue. Once they know about it, they are keen to do something and to take action. However, in tandem with a national campaign, we need to know where we want to be. There is something to be had in a conversation about assessment and measuring tools. Loneliness needs to be in performance frameworks, possibly as a wellbeing indicator. There is some work to be done on that so that we know it when we get there. We need to be able to describe the picture as it is, and also to know what we are aiming for.

John Finnie: Liz Watson has just touched on the issue that I wanted to raise, which is about performance frameworks and preventative spend. We have heard from Laura Alcock-Ferguson and others about the significant impact that your interventions can have. Mention is made in Liz Watson's written submission of a US study, and there is other evidence. Is enough is being made of that?

Third sector organisations that come here will say that funding is an issue and that that is the key but, regardless of who forms the Administration here, it has pressures too, and it is helpful if it can be persuaded that interventions have preventative

implications. Is enough made of that? Is it understood enough, not just by politicians but by general practitioners? It seems to me that, if we improve someone's wellbeing, we reduce the likelihood that they will be medicated and so on.

Liz Watson: You are absolutely right; those are important points. The third sector has a bit of a problem in terms of evaluation, because robust evaluation is expensive. It costs money to evaluate the services and it takes time. Even then, it is difficult to prove attribution.

In our written submission, we highlight the home-from-hospital befriending service in Kincardine and Deeside, which is a small pilot service. It demonstrates that there is a considerable amount of money to be saved by the NHS. For example, if we can get a befriender to support someone to go home from hospital on a Friday instead of a Monday, that saves three bed nights. There is further evidence that having a befriender or another person coming to the house prevents slips, trips and falls by elderly people, which account for major stress on the health service's purse. The reason why that is the case is that someone can physically escort someone to the shops or down the garden path or do something as simple as reaching into a high cupboard to get a tin or changing a light bulb.

All of those tiny interventions can save huge amounts of money, but it is difficult to absolutely prove attribution. Some befriending services have been asked to jump through extraordinary hoops to prove that they have saved their local NHS X number of pounds, but the situation is not that simple.

Christian Allard: I have to add that the pilot scheme in Kincardine and Deeside is good. One thing that a national campaign could do is go there and show everyone what is being done. I remember some work being done in the local shows. We should be talking not only to older people but to people in various generations so that everyone understands that this is an issue that should be tackled.

Again, the blueprint is very much evident in Aberdeenshire—the best place to live, maybe?

Laura Alcock-Ferguson: There are two ways in which we can measure performance.

We are launching a tool for front-line organisations to help them measure whether they are reducing loneliness, because there are not many usable tools. Frankly, the ones that currently exist can make people cry, because they are often very harsh.

The other opportunity concerns the development of the Scottish longitudinal study on ageing. We believe that that needs to include a more robust and recognised measure of loneliness such as the De Jong Gierveld scale.

We think that those two opportunities are to be recommended. We will be taking up the measurement tool across the whole of the United Kingdom, because our front-line work extends to Scotland as well.

The Convener: Do any members have any final, brief questions?

John Mason: I enjoyed the paper from the Campaign to End Loneliness. Earlier, Sandra White and I were discussing one of its points. In the third paragraph, it says that

"there is relatively little data comparing levels of loneliness in urban and rural areas",

and it notes that, in England and Wales, data

"tends to show that the highest levels of loneliness are to be found in urban deprived communities, with lower levels in rural areas."

Later, it says:

"while some areas of high deprivation also have a high risk of loneliness, there is no correlation overall between levels of deprivation and levels of loneliness".

Can you give us a short comment on that?

Laura Alcock-Ferguson: It will probably be quite a long answer.

The Convener: You could think about it and get back to us in writing.

Laura Alcock-Ferguson: We can certainly do that.

Sandra White: I feel as though I am being controversial today—this will be my second controversial question.

A great number of groups are doing a fantastic job, but do you see any duplication in anything that is being done? Liz Watson talked about the befriending service and, last week, Age Concern Scotland told us about the work that it is doing with Silver Line, which is an England-based charity—they are running a joint service with funding from the Scottish Government. I have often thought about the fact that I can name 10 organisations in my constituency—Glasgow Kelvin—that offer a phone befriending service. Is the issue of duplication something that we should be looking at? Are there too many small groups and large groups doing the same job? It might sound like I am being controversial, but the pot is only a certain size.

The Convener: I know that there are quite a few community transport services out there, so could Sheila Fletcher answer the question from that point of view?

Sheila Fletcher: I would say that the spread of community transport is not equal across Scotland. I do not think that there are very many areas of duplication. Recently, we have been running a project in Sutherland. The Scottish Ambulance Service wanted the groups there to work more closely together, but they are all isolated from one another and work in their local areas, with very few working beyond those areas. It might appear that there is duplication, but I am not sure that there is.

The other thing—which Annabel Goldie whispered to me just now—is that, sometimes, people want to use more than one service. I know that you are asking about telephone befriending—

Sandra White: I was actually asking about all of the organisations that provide a service.

11:00

Sheila Fletcher: A lot of people want to use one service on Monday, another on Tuesday and another on Wednesday, and they will choose which ones they want to use. I think that it is good that we have a lot of people doing the same or similar things. They all have the same aims, and the services that are not successful will collapse. It is down to market forces, in a way.

Annabel Goldie: I did not whisper that bit, by the way.

Laura Alcock-Ferguson: Research shows that people are more likely to stay involved in a group if the group involves something that they are interested in—that has been eloquently demonstrated in case studies that have been discussed today. If the people around this table set out all of the interests that they have outside work, the list would probably run into the hundreds. We think that, to keep people connected, we need a great proliferation of activities and services. Services are important for those who are extremely lonely, but activities are definitely also important. Duplication is probably not the best way to describe that. It is about joie de vivre and choice.

Liz Watson: Although it might seem that there are lots of, for example, befriending services, we know that there are befriending services for older people, for people with disabilities, for families who have suffered incidents of cot death, for people with experience of dementia and so on. There is a spectrum of services. When you look at the number of befriending services throughout Scotland, or, indeed, in your constituency, you think, “Gosh, that’s quite a lot,” but you might find that they cater to different service groups. Further, they are probably all run on a shoestring, so there would not necessarily be economies of scale in attempting to join the services together.

The Convener: Thank you—that concludes agenda item 2.

Race, Ethnicity and Employment (Witness Expenses)

11:02

The Convener: Agenda item 3 is an item on witness expenses. In keeping with the usual practice, members are invited to delegate to me as convener responsibility for arranging for the Scottish Parliamentary Corporate Body to pay, under rule 12.4.3 of the standing orders, any expenses incurred by witnesses as part of our inquiry into race, ethnicity and employment. Do members agree?

Members *indicated agreement.*

The Convener: That concludes the public part of today’s meeting. Our next meeting will take place on 23 April, when we will take evidence from health and social work services on our inquiry into age and social isolation.

I thank each of the nine witnesses who came to the committee today. You have given us fantastic evidence and input. It has all been relevant. I apologise for having to keep things pretty tight, but we have had a lot of good information from you.

11:03

Meeting continued in private until 11:23.

Members who would like a printed copy of the *Official Report* to be forwarded to them should give notice to SPICe.

Available in e-format only. Printed Scottish Parliament documentation is published in Edinburgh by APS Group Scotland.

All documents are available on
the Scottish Parliament website at:

www.scottish.parliament.uk

For details of documents available to
order in hard copy format, please contact:
APS Scottish Parliament Publications on 0131 629 9941.

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@scottish.parliament.uk

e-format first available
ISBN 978-1-78568-334-3

Revised e-format available
ISBN 978-1-78568-351-0

Printed in Scotland by APS Group Scotland