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Official Report

EQUAL OPPORTUNITIES COMMITTEE

Thursday 23 April 2015

Session 4

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EQUAL OPPORTUNITIES COMMITTEE
8th 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:

Yvette Burgess (Housing Co-ordinating Group)
Jane Kellock (West Lothian Council)
Joe McElholm (North Lanarkshire Council)
David Rowland (North Ayrshire Health and Social Care Partnership)
Professor Graham Watt (University of Glasgow)

CLERK TO THE COMMITTEE

Ruth McGill

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Equal Opportunities Committee

Thursday 23 April 2015

[The Convener opened the meeting at 09:30]

Decision on Taking Business in Private

The Convener (Margaret McCulloch): I welcome everyone to the eighth meeting in 2015 of the Equal Opportunities Committee. I ask everyone to set any 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 observers in the public gallery.

I am the committee's convener. Members will now introduce themselves, starting on my right.

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

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

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

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

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

The Convener: We have apologies from Jayne Baxter, who is unable to attend the meeting.

The first agenda item is a decision on taking business in private. Members are asked to agree to take in private item 3, which is consideration of petition PE1372, by Friends of the Earth Scotland, on access to justice in environmental matters. The reason for that is that we will be discussing legal advice.

John Finnie: I know that the committee wants to be open and transparent, and I understand the protocol that has had you asking for the matter to be considered in private. Given the long-standing protocol, I am content with that position, but the matter has been on the committee's agenda almost from day 1 of the session and it is a manifesto commitment of the party of Government, so I hope that we will see some action today rather than just more words.

The Convener: Okay. Do members agree to take item 3 in private?

Members *indicated agreement.*

Age and Social Isolation

09:32

The Convener: Agenda item 2 is an evidence session in our inquiry into age and social isolation. I welcome our witnesses and invite them to introduce themselves and to outline briefly their current work.

Joe McElholm (North Lanarkshire Council): I am manager for older adults services in North Lanarkshire Council. In that capacity, I have responsibility for the strategic and operational management of older adults services across the council, including areas that are relevant to today's subject.

Jane Kellock (West Lothian Council): Hello. I am interim head of social policy at West Lothian Council. Social policy, in partnership with other council service areas, delivers a wide range of social work and social care services. We cover children, young people and their families, adults, older people and carers, and the criminal justice service area. The services that we provide are mainly targeted at people who are made more vulnerable by their age, health and life circumstances.

David Rowland (North Ayrshire Health and Social Care Partnership): Good morning. I am head of health and community care at the newly formed North Ayrshire health and social care partnership. In that role, I have responsibility for all community health services in North Ayrshire, adult and older people's social work services, and the planning and delivery of those services, with close linking with the third sector and the independent sector.

Yvette Burgess (Housing Co-ordinating Group): Hello. I am unit director of the housing support enabling unit and am representing the housing co-ordinating group, which was formed a couple of years ago. The group brings together various housing organisations, including the Scottish Federation of Housing Associations, the Chartered Institute of Housing, Care and Repair Scotland and the Association of Local Authority Chief Housing Officers. We try to bring a co-ordinated, cross-sector voice to the housing world.

Professor Graham Watt (University of Glasgow): I am a professor of general practice at the University of Glasgow. I have spent a lot of time working with deep-end practices, which are the 100 practices that serve the most deprived populations in Scotland.

The Convener: Thank you very much.

We have heard that a range of factors—poverty, bereavement and mental illness, for example—can contribute to social isolation and loneliness among older and younger people. We have also heard that feeling socially isolated and lonely can have quite a significant impact on individuals. Is the impact of social isolation understood clearly by social providers in health, social work and housing? If so, what sort of action do they take when it is identified?

Who would like to answer first? David Rowland is smiling, so I will pick on him.

David Rowland: In all honesty, I think that we are beginning to scratch the surface. I think that there is an understanding that social isolation is a major issue that affects the health and wellbeing of the individuals who experience it.

We are not as good as we should be at identifying individuals who are suffering from or struggling with social isolation and therefore I do not think that we make the connections particularly well for those individuals in terms of how we can address the issues that they face. There are a variety of things that we can do to get better at that. If we can understand how and why individuals use our services in a particular way, we might have a better understanding of those who face social isolation and we will then be better able to make the connections that they need.

For example, I was looking at our recent data on people who use our community alarm systems in North Ayrshire. There is a small number of people who use the alarms three, four or five times over the course of a month. Sitting behind that, there is a small number of issues that are genuine and which need to be addressed. However, often, the issue is more about making contact and looking for a bit of reassurance that they are okay. I am keen that we use that data in a different way, so that we begin to understand the true needs of the individuals who use the alarm system in that way.

We are undertaking a review of our care at home service, and I am keen that that should be part of that. We are looking to how we can provide something that is more than a befriending service and which offers reassurance to people who are living alone and are feeling vulnerable and isolated. For me, that is all about digging beneath the traditional data sets that we have, understanding what is happening behind all that and using it in a positive way.

Professor Watt: We need to steer clear of defining social isolation and loneliness as a problem that people either have or do not have and as something that professionals identify and then process and solve. That is not a good way of approaching the issue. Individuals are unique in terms of their circumstances.

The statutory services are limited in what they can do to address societal problems. There has

been a loss of institutional activity through work and trade unions, for example, and there has even been a loss of family activity. All those things have to be replaced by a different type of social institution that gives people a role and a purpose in their lives.

One institution that still works in terms of connectedness is the health service. By virtue of the health problems that people have, at either a young age or an old age, they have contact with the health service. That is a really important resource. One of the strengths of the health service is that, within general practice, there is continuity of contact and coverage—everyone is included. With the exception of the Post Office, no other service has that to the same extent. It is not exclusive to general practice and it is not consistent within general practice, but it is a hugely important resource because what comes from that is cumulative knowledge of individuals and communities, which cannot be gained elsewhere. One of the challenges is to share resources differently, so that power, resource and responsibility are more based in communities, because only the people who work in communities—particularly the streetwise people who work in primary healthcare teams—are able to imagine how things could be improved.

What everybody needs, especially as they get older, is access to a small team of professionals whom they know and trust and who will see them as individuals and not as problems and will therefore be in a position to do something about their issues. I hope that I will get the opportunity later to talk about the problems in the system but, in essence, the system that I describe, with continuity, contact and coverage, needs to be better connected to a lot of other resources in the community, especially in the third sector.

Building all those relationships is a task. Doctors build up a relationship with patients over time and, similarly, the relationships between agencies in communities require trust, knowledge and experience. In many ways, the health service needs to be reimagined as a social institution that addresses the problems of the future rather than continuing to do what it currently does, which is to operate in rescue-in-dire-straits mode. The centre of gravity needs to shift away from out-of-hours care, accident and emergency and hospital beds and move upstream in the community, with the aim of helping people to live well and long with whatever problems that they have.

Obviously, healthcare is not the solution to that, but it is strategically importantly placed. It is a huge resource that we do not have anywhere else. The danger is that we have taken it for granted somewhat and it is in a rather weak position to address the challenges that clearly lie ahead.

Joe McElholm: I endorse what the two previous speakers said. They are correct that we do not currently identify people who could be connected and better supported, and that general practitioners and GP practices are often in touch with people.

I will give an example from the national health service. Some of the pressures in hospital emergency departments relate to people who turn up frequently because they are feeling isolated and lonely and they have established a pattern of going there. However, we often do not find alternative approaches. The third sector is vital in that. An example from the Lanarkshire partnership area is that we have used reshaping care money to create and continue to fund a post to give the third sector a presence in the acute hospitals. It is just one post, but that one person has already demonstrated the effectiveness of connecting the many people who come through hospital for whom social isolation is identified as an issue. We can now pick that up. Statutory services do not—and probably cannot, even in the longer term—take on that responsibility, but an emphasis on prevention and early intervention by connecting with the third sector is an important part of what we need to do.

Annabel Goldie: It would be interesting to have more information provided to the committee about that, Mr McElholm.

Joe McElholm: Absolutely—I can do that.

The Convener: It would be interesting to know where people are referred to. Do you have information on how often people have been turning up at hospital and whether, once they are referred, they actually stop coming? Perhaps that is asking for too much detail, but it would be interesting to know that to see how effective the scheme is.

Joe McElholm: We can provide a report for the committee on that.

Yvette Burgess: Although we are talking about health and social care, I am conscious that people who are homeless, including young people, and older people who are looking to move, come into contact with housing organisations, so front-line housing staff are often well placed to identify isolation and loneliness. Many housing associations and some local housing departments deliver activities and other services that help to combat and prevent that. As we have heard, we need to move upstream and act before people get to the stage of being lonely and not getting out or getting the services that they need—before it becomes a problem. Housing organisations are well placed to connect with voluntary services or to provide services themselves.

The Convener: Do housing organisations give staff training to raise awareness of the issue when

they meet and speak to people? Is identifying the issue on their radar?

Yvette Burgess: As we have heard, isolation and loneliness tend not to occur in themselves; there will also be issues to do with homelessness, social connection and social networks. There is an increasing recognition of the importance of social networks in helping people to be resilient in times of transition and change.

To answer your question about training, that is very much part of the thinking for front-line services. The issue is that there is not always awareness about how to deal with it. I am sure that there is an issue around ensuring that up-to-date information is available about the local services that people should be referred to.

09:45

Jane Kellock: I agree that we need a whole-systems approach to tackling social isolation. However, I view the issue more as a societal one. For me, the issue is that everyone requires to be socially connected—that is part of our human condition. When systems break down in such a way that we disconnect from others, or when life circumstances come along—we might lose people we are close to, for instance—we need to be able to respond to that in a human way, rather than stigmatise people or further isolate them by treating them as if there was something wrong with them as individuals.

All the agencies in the partnerships around the country need to be responsive to that and to consider the structures of how we deliver services, how we make contact with people and how we speak to them on an individual basis. That is all very important for keeping our communities connected.

Sandra White: That question produced some very interesting issues. We know that there are services out there, but the problem is with people being able to find them. I refer in particular to hard-to-reach people. Graham Watt and Joe McElholm referred to statutory services and the potential need to replace them with something else.

There are two initiatives that I am very familiar with. One is the links worker programme, to which others have referred. The question is how we get the aims of the links programme out to hard-to-reach people. There is also the deep-end practice. When I was a member of the Public Audit Committee, we looked at that practice, which reached people in disadvantaged areas. How do the services that are provided by you, the links programme and the deep-end practice reach out to the folk who are not aware that those services are there? Is that difficult to do?

Professor Watt: I am never comfortable with the phrase “hard to reach”, which is sometimes recognised as a synonym for “easy to ignore”. We often have contact; the issue is what happens or does not happen with that contact. That is certainly the case for deep-end practices, which involve plenty of contact with patients, although they often lack the resources, the consultation time and the links to other services in order to address need. There is a big mountain of unmet need there.

You have asked so many questions, Sandra—we could spend the whole morning answering them. The links programme is an important and topical development. There is a story behind it. As regards the deep end, we started off asking practices about the extent to which they were involved in social prescribing, or using local community resources. Practices varied according to what people knew. In the past 10 years, general practice has become introspective, for all sorts of reasons—it has not been looking out. However, we moved on, with Government support, to do a links project, which tried to build on the previous work.

Then there was the bridge project, which was carried out in three practices. It sought to link a practice’s knowledge of elderly patients with community resources for social and physical activity. Two interesting things were learned from that, one of which was that every locality is different. The project has to be imagined and developed locally; it cannot be done from a centre.

I will share this anecdote. A GP in Ruchazie identified six elderly patients who she thought would be ideal for the project, but none of them thought that it was a good idea. That makes the point that it is not just a question of shifting people along. There is a relationship, and there is a person. Because the doctor was working in general practice, it was not a once-and-for-all opportunity. The relationship exists, and it can be returned to, although the link to community resources did not happen on that occasion.

It is a bit like smoking—everyone wants to give up smoking, but sometimes they are not ready so we come back to it in six months’ time. It is important to have the continuity and to have a service that has the flexibility to work in that way. If we have an outreach programme in which everything is determined by someone whose job it is to go out, we may lose that flexibility.

I turn to the links worker programme, which the Government is sponsoring and evaluating in seven practices. The programme implants a community links practitioner within general practices that are in the deep end. Their job is to do what their practices cannot do, which is to spend time making links with the community resources. The

practices are finding their own ways of using those links.

The important issue is that this is not just about information. Some people just need information to be signposted—people with agency and education just need to know where something is and they will go and find it. However, particularly in deprived areas, people often lack the knowledge and articulacy to do that, especially if they have mental health problems, which are twice as common in deprived areas. Many people have attachment issues throughout their lives, because of emotional damage early on. Such damage is characterised by difficulties of attachment, never mind with services but with friends and family. Those people need a long-term relationship to enable them to make a bit of progress. It is not just about links, signposts and information, but is about relationships over a period of time.

My understanding is that a lot of what the links workers do is not signposting, but is helping patients who are floundering to deal with rather impersonal, dysfunctional and fragmented services. The way in which services are configured often makes it difficult for patients to find their way around them, especially if they have more than one problem. That is called a treatment burden.

I have a slight worry that the links worker initiative is not addressing the fundamental problem, which is that services are fragmented, dysfunctional, impersonal and difficult for some patients to find their way around. If a practice has a links worker, that may solve the problem for the individual patient without solving the problem in the system.

It is early days for the links worker initiative. In a sense, every practice should have one, but it is an expensive solution, so every practice could not afford one. The challenge is to translate what is being learned through that project into something that is sustainable at every level. Essentially, that is building social relationships within local communities, not necessarily with expensive professional salaries, which is unaffordable. As I said, because of the contact, continuity and coverage, general practice is a very good place to start, but it is not a good place at the moment, because it is under such pressure. I can talk about that more if you wish.

Sandra White: Thank you. You seem to be saying that it is great, but that it should not all be down to general practitioners, because there are other ways of doing it.

David Rowland mentioned links, but he also talked about working together in an alliance. Housing and, in fact, every other aspect are very important and should be more joined up, but the problem is how to do that. Do you have any ideas or comments on that?

David Rowland: There are two bits of work that we are looking to take forward this year, the first of which mirrors some of what Graham Watt has just described in terms of recognising the importance and universality of general practice alongside the need to support it. This year, we are putting connector posts into six GP practices in North Ayrshire to trial that links-type model, but Graham Watt is absolutely right to say that that, in itself, is not sustainable. The role of practices must include building community capacity and community resilience to allow us to begin to develop a community network that people will know and understand how to engage with and which will, as a result, be sustainable over time.

The other bit of work that we are doing just now relates very much to housing. We are just starting a major refurbishment programme for our sheltered housing facilities. For each of the sheltered housing refurbs, a community hub will be developed, and we are looking to develop alliances with the third sector so that we can begin to work with local communities on designing the services that will go into those hubs. We will work first with the sheltered housing residents to understand what services they want and get connectedness within the complex itself, and then we will reach out to the community and ask how we can turn the facilities into community-based hubs or centres for connecting the individuals who live in them on their own with individuals who live either on their own or with others out in the wider community.

It is about making those connections at a number of levels. Graham Watt is right that links with GP practices are key, but we also need to find ways of sustaining that in the wider community.

Joe McElholm: Graham Watt made some interesting comments about the link workers who help people navigate complex service systems, but that makes it sound as if link workers deal with people who are very much involved with services. I think that a large concern for the committee and the report that it will produce relates to those who are not involved with any services and how we work in a more preventive way with them.

When we redesigned day services for older people in North Lanarkshire—I will not go into the details of that redesign, as it was quite complex—we realised that many people had been referred to a traditional day-centre model. When we asked why that had happened, we were told that it was because they were lonely. As a result, our systems referred them to a day centre.

As part of the redesign programme, we interviewed quite a big cross-section of the people

on the referral waiting list and asked them what they wanted in their lives. Not one person said that they wanted to go to a day centre. Instead, they said that they wanted all sorts of different things; for example, they wanted to resume the ability to go for a pub lunch, go to a bowling club or go back to church. I do not know enough about the links programme in GP practices to compare it with what we did but in our redesign, we changed some of our posts and created the role of locality link officer. When people are referred to the formal system simply because they are lonely, the locality link officer speaks to them about what in their area could meet what they aspire to having in their lives. The turnover in the number of people that the link officers see is quite significant.

As we developed the service, we became aware that although we had identified opportunities for people, many could not access them for transport reasons or because they needed a carer for very small interventions such as getting them from the house into a taxi and then from the taxi into the centre, the lunch venue or wherever. People would say that they did not need somebody there all the time but that they did need somebody to help with what was preventing them from accessing opportunities. As a result, we created the post of locality support officer to provide those very small interventions. That has given people the chance to connect with the life of their community, removed the need for them to be involved in formal services and allowed those services to concentrate on people with very high levels of need.

The Convener: You are really talking about person-centred care; in fact, everyone is talking about structuring help, support and care around the individual. Did you actually ask the group of people whom you referred to whether they were lonely or isolated? We have heard that people do not like to describe themselves as lonely or isolated, perhaps because doing so makes them feel that they are failures or because they do not want to typecast themselves. Were those people asked whether they were or had been lonely and whether what could be offered to them would help?

Joe McElholm: We specifically asked people about the format of the interviews, but it all happened a little while ago and I am not sure that I can recall what was said. However, people were quite often referred because they were finding it difficult to get out of the house or because their carer was feeling unsupported and was not getting a break. People talk about wanting to take part in the activities that they took part in before and which they miss following a bereavement—say, the things that they did with their deceased partner but which got lost in the grieving process and were never resumed. That is how people articulate their situation.

10:00

Sandra White: I have a small follow-up question. Bringing the voluntary or third sector into the sheltered housing sector—the Bield Housing Association and so on—is an interesting prospect, and I think that someone is going to ask about that later, but I was interested in Joe McElholm's comments about the council's new service. Is it complementary to the day centres, which I presume still exist? Do you charge people who attend the day centres? People sometimes cannot afford such costs. Is there some charging mechanism?

Joe McElholm: The day service, which is now run by health and social work, was integrated to provide a wider range of interventions for people with a higher level of need. I have mentioned waiting lists, but the day service does not have a waiting list, because we are now able to help so many people to get involved in their local communities. Moreover, there is no charge—charging policy is a wider issue.

Sandra White: I will not go into the issue any further. Thank you.

The Convener: Jane Kellock wants to come in briefly. We will then need to move on.

Jane Kellock: This comes back to the point that social isolation is everybody's business. All the staff that we have working for the council and in our partnerships should be in a position to understand social isolation and make connections for people. We do not need separate workers to do that; it should be part of everybody's role. Perhaps we need to raise awareness of social isolation to ensure that it is not ignored but is part of the assessment process and the conversations that we have with people.

John Mason: We have touched on a range of issues including transport, which is what I want to move on to. How much are isolation and loneliness linked to practical issues such as lack of transport? For example, the challenge that my own mother faces is in getting into and out of the taxi as much as anything else. I realise that many factors are involved, but it has been suggested that some older people are fearful of engaging with health and social work services in case they get transported very quickly to a care home, which is not what they want. Is there a connection between the obvious practical issues and the way that people feel?

Jane Kellock: Services have to be acceptable to individuals, and you are right that some might fear being taken into hospital or care. The

outcomes for people who are looked after in their own homes are better, because they are not as disconnected from the world. That comes back to my original point about the need to restructure services and to look at pathways for individuals into and out of care. We must ensure that individuals are supported in returning to or remaining in their homes and that they can receive care and treatment there.

John Mason: People can also feel isolated at home even though they are in their community, and somebody in a hospital or a care home can feel quite isolated, too. How do you handle that?

Jane Kellock: People can feel isolated in any circumstance. We need a range of services and a range of responses within those services to meet people's needs—it is as simple as that. We have a range of mechanisms. The third sector, certainly in our area, is alive to social isolation. For many years now, we have had an ageing well programme; its primary purpose is health and wellbeing, but it is also about socialisation and social connectedness. Such programmes look to particular groups of individuals who might be more vulnerable. A directory has just come out for men who are retired or just about to retire to try to normalise the idea that people need to be socially connected when they are older. Similarly, there are activities in care home settings that help to connect people. Being socially connected is a human need, and in all our services we must address people's need to be connected to others in a way that suits them.

John Mason: Professor Watt, are some of your 100 deep-end practices in rural areas where transport becomes an issue?

Professor Watt: Transport is also an issue in the city. Lack of resources is a part of isolation for some people. The Government targets the 15 per cent most deprived data zones. That is a large part of the Scottish population, and two thirds of those people are registered with about 700 practices across the country, so most general practices are dealing with a bit of deprivation, including those in remote and rural areas. The thing about the deep-end practices is that they are dealing with deprivation in high volumes of between 50 and 90 per cent of their patients. There are a couple of hundred practices in Scotland that do not have any such patients, but they probably have an older patient profile.

The picture is multifaceted and we cannot produce a formula. It is based on the individual. Sometimes, it is to do with physical isolation or a lack of links within the family; sometimes, it is just how the person's life has ended up. They might live in a community that does not have many resources for them to use. Then there is the fiercely independent type of person who refuses all kinds of help, with whom we nevertheless need to have a relationship. The key is that everybody is different and people need to be taken on their own terms. That requires pragmatic, flexible decision making at street level that is based on a good knowledge of what is available.

The convener talked about asking people whether they are lonely. In one study, GPs were asked about that in interviews and one replied that it was easier to ask about impotence than about loneliness because we can do something about impotence whereas loneliness is much more difficult.

John Mason: Is that because GPs feel that they have so much to do?

Professor Watt: That is a separate issue, and that is too negative a point, because there are lots of things that we can do. The question is whether those things are being done.

I took a reporter from *Holyrood* magazine to Govan to interview three GPs, and afterwards I asked her whether she realised that there had been 60 years of experience in the room. That is an enormous amount of cumulative knowledge of people, and there is a danger that we will lose that. There was stuff in the newspapers yesterday about GP numbers.

A general point that needs to be made is that, if primary care—including general practice and all the other community-based services—is not strong, patients will fast-track to out-of-hours, A and E and emergency services. That has always happened to some extent in deprived areas because of a lack of resources, but it is beginning to happen more widely because, as the Royal College of General Practitioners keeps saying, there has been a disinvestment in general practice from 11 to 9 per cent of the total health budget. That has had an effect, over time, in that the system is less strong. By "strong", I mean that the system needs a whole lot of horizontal links so that, instead of fast-tracking vertically into secondary care, people can contain a problem in the community, either within a consultation or through a local referral.

There are various bits of information that we simply lack. For example, are the links in a local health system—the knowledge and confidence that are shared between services and professions—weak or strong? We just do not know. Those teams who are streetwise know what the strengths are, but the system tends not to and is not necessarily investing in that issue. We talk about patient-centred care; everyone might be doing that, but somehow patients themselves are not at the centre of it.

John Mason: You have argued that the health service is linked to most people and is better than

anything else that we have. However, is that true for older people but not for younger people? How well are younger people connected to the health service? Is that not such a problem?

Professor Watt: Younger people are generally healthier, but there are still plenty of young people with health problems. For example, single mothers are often isolated and lonely, and younger people have plenty of mental health problems. However, contact rates are much higher for those in old age because the health service probably has a bigger role to play in that respect.

With regard to patient-centred care, the key question is: what is the individual patient's or person's story or experience? What is it like to be old in, say, Knightswood, Leith or Aberfeldy? Is the experience good? We just do not know, and until we have an information system that mirrors activity we will not be well informed and will be unable to improve things. As we move towards more community-based integrated care, we will have to develop information systems that tell us how strong local systems are, where the problems are and how things are going to be improved.

John Mason: There is a lot going on here, and I would like to broaden out the discussion to the other witnesses. Are young people actually a bit of an issue? Although we have been looking at young and old people, we have probably tended to focus on older people, for obvious reasons.

What about other subgroups? Are loneliness and isolation a particular issue for, say, ethnic minority groups? What about lesbian, gay, bisexual and transgender people? Are there other groups that are extra-isolated?

Yvette Burgess: Research has been done on loneliness and the importance of social connection with regard to young people, particularly those facing homelessness. There are also health and access-to-health issues to bear in mind. I know of a couple of projects in England in which homeless people who have come through such situations have been prepared to buddy other young people and encourage them to use the health services that homeless young people sometimes desperately need.

Jane Kellock: We certainly need to think about the principle of early action and early intervention and of the need to get into a problem or issue early in order to make a difference closer to the individuals and their families and communities.

With regard to children and young people, Graham Watt referred to the issue of attachment, and a real focus of our early years work has been on encouraging parents—particularly those who are young and more vulnerable—to be well attached to their children. As a result, quite a lot of our services come in around that time to give support.

We also take a whole-population approach to ensure that no vulnerable person falls through the net. Instead of simply offering a service and expecting people to come to us, we try to be proactive in seeking and reaching out to them.

John Mason: Is that approach working?

Jane Kellock: Yes. In West Lothian, for example, we are working very closely with the family-nurse partnership, which is the NHS's targeted service for teenage mothers, and the council has invested in its own young mothers' service for the other vulnerable young mothers who do not fit into that particular service model.

We are trying to make sure that no mother who is young and vulnerable goes by without one or other of the services making a concerted effort to engage with her and to continue to engage with her, even if it is not the right time for her. We want to flex services that those young mothers might be interested in around them. Some people like group work programmes, some like one-to-one engagement and some do not want contact all that often, so we need to be able to flex the systems to meet the needs of individuals in a non-stigmatising way.

10:15

John Mason: That is very interesting. You have two ways of reaching vulnerable young mothers. Do you feel that you are reaching 100 per cent of them?

Jane Kellock: We are not far off it. I cannot remember offhand how many turn down a service, but we keep statistics to track young mothers through those systems. We are fairly sure that we are reaching out to young mothers.

When we have a particular population that we know is more vulnerable to all sorts of social ills, it is pretty important that we try to reach all the members of that population in a systematic, robust and persistent way.

Professor Watt: I mentioned the bridge project, in which practice knowledge of elderly patients was supposed to be linked to community resources for social and physical activity. There is anecdotal evidence that in Bridgeton—I do not know whether this is widely true—it was felt that immigrant and ethnic groups were much better organised when it came to social activity that could support people and that the vulnerable population was the elderly white population.

The Convener: That is interesting. Thank you very much.

Can we move on to Annabel Goldie?

Annabel Goldie: Yes, convener, you may.

I am trying to sit at the top of a tree and get a bird's-eye view of all this, because the detail can be bewildering. There are two aspects that I am interested in. Professor Watt has referred to the concept of social prescribing, on which we have received evidence. I have a very simple question for all the witnesses: is "social prescribing" a phrase that is understood? Is it in the lexicon of professionals?

Professor Watt: When we looked at that phrase, we felt that it was not in common parlance. Initially, we did an email survey of practices to see who would respond to it, and we got a response rate of about 10 per cent. However, the concept of social prescribing is much better understood now. The issue is not whether people understand the term; it is whether people see it as part of their job to undertake social prescribing.

I am answering the question from a general practice point of view. I am doing so not because general practice is the most important thing, but because it is disproportionately influential in the system that we are talking about. Social prescribing implies that practices will be outward looking, will think about themselves as hubs of a local health system and will use the opportunities that they have to develop that role. However, if a practice is totally preoccupied with dealing with everyday concerns in a reactive way, it will simply not look outside.

The issue is not the understanding of the term or of what would be required, because social prescribing models are being developed all over the place. The real issue is resources and whether we are investing in social prescribing as a substantial activity. Ninety per cent of the work of the health service is in primary care and 10 per cent of it is in hospital care, but 90 per cent of the money goes to hospitals and 10 per cent goes to primary care. The average spend per patient in general practice in Scotland is about £123 a year, while one out-patient appointment costs almost that much. We spend peanuts on general practice, and we cannot begin to imagine developing a strong primary care system with that level of funding.

One of the consequences of the fact that the primary care system has been treated as a sink for years is that it is now full. The current issue with A and E is a bit like a flash flood; it has arisen simply because primary care has lost the capacity to absorb that it always had. GPs are looking to retirement because the job drains rather than energises them.

Annabel Goldie: To follow up on that point, I would like to ask Professor Watt's colleagues on the panel whether "social prescribing" is a term in their lexicon. I just want a yes or no. I am trying to gauge the extent to which people are aware of it.

Joe McElholm: Yes, it is a term and it is associated with healthcare and GP practice. It is not a term that applies more widely. In our local context, it would be associated with the capacity that GPs have to allocate a series of free sessions in the local gym as part of dealing with a diagnosis of a particular health condition. We do have that facility and it is used.

Jane Kellock: In West Lothian, we have an exercise referral scheme that is quite well used and comes under the social prescribing banner.

David Rowland: We have had a number of initiatives over the years, so familiarity with the term has grown, particularly in general practice. Graham Watt and Joe McElholm are absolutely right.

It is not just that a phrase is being used; I see a sea change coming, in that GPs in Ayrshire are starting to want to shape what social prescribing might look like and to take ownership of what the models that they prescribe into might look like. For all the adversity that Graham Watt has mentioned this morning, the GPs recognise that the current model cannot continue and that they need to find a way to promote early intervention for folk who use their services. They are themselves looking to come up with models of what the alternatives might be to a lifetime of illness.

Yvette Burgess: In the housing world, the term is probably not well understood but there is a clear focus on providing activities that could easily be linked with social prescribing. Organised walking groups, craft cafes and other such activities are particularly well suited to helping on the loneliness and health front.

Annabel Goldie: Professor Watt, I have listened with care to your justifiable concerns about problems of structure, resource and the capacity to deliver or implement a policy of social prescription. Going back to what you said about the coverage of the NHS, and given what we now know from the projects of which we are aware, such as deep-end practices and the links project, it seems to me that patients have a confidence in their GP that is possibly born out of a reassurance that the GP is to be trusted and can assist. Does that mean that we should consider a patient protocol of social prescribing for GPs?

Professor Watt: I often quote—

Annabel Goldie: I am just looking for a yes or no. [*Laughter*.]

Professor Watt: Well, no. I often quote Mr Spock from *Star Trek* saying to Captain Kirk, "That is illogical, Captain." So much human behaviour is

not logical that we cannot produce a logical plan, formula or protocol that predicts what is going to happen.

The thing about general practice is that it is unconditional. It responds to whatever the patient brings or to their circumstances. It may be the only part of the public service that is unconditional, and therefore it requires knowledge, continuity, pragmatism and good conscience. A protocol would imply that it is a thing that can be managed, whereas I think that it is as much a cultural development as a managerial development and that it is to do with hearts and minds and values.

Annabel Goldie: Let me rephrase the question. Given that it seems that there is not an even pattern of awareness among the GP profession—that is not a criticism; it is just a statement of reality—could more be done at the GP level? Because the GP is a core asset to the local community, could something more be done to assist GPs in having social prescribing on the radar screen?

Professor Watt: Yes. It is not just information or flags on the screen. Practitioners need to know who they are referring to and have trust in them, too.

Annabel Goldie: I accept that.

Professor Watt: The whole question of trust is based on positive experiences and the confidence that those experiences will continue, so there needs to be continuity. It is a huge resource, and when people retire they take all that with them. That is a real hazard that we face.

The deep-end project has been important in engaging with practices and, within the projects that we have been able to get involved with, it has put practices on the front foot. Practices are not reacting to things that other people have imagined, who have then told them to do this or that, and that is a very important development.

Annabel Goldie: Let me rephrase my question. Could that model be commended to the medical profession in Scotland? I appreciate that the projects to which you refer have been able to cover only certain geographical areas.

Professor Watt: At present, I would be careful not to prescribe more things that general practices should do unless there are resources to help them to do those things. That would be my first caveat.

Annabel Goldie: Can we distinguish principle from practice? I am trying to get at what a good principle is. You are absolutely right that before you contemplate the implementation or application of the principle of course you must have resource, structure and process in place, but I think that the committee is interested in knowing what a good principle is.

Professor Watt: I think that the principle is that, because of the features that have been described, general practices are the natural hubs of local health systems. However, hubs do not go anywhere unless they are connected by spokes to the rest of the wheel—that is, the professions that are represented by the other witnesses round the table—so building needs to be done in that regard.

There is a leadership role for practices that needs to be valued and supported. One issue within primary care is that it is a highly disaggregated system. There are 1,000 general practices in Scotland and often they do not know what is happening down the road in the next practice, never mind on the other side of the country, so the whole issue of sharing and learning from good experience is undersupported. The system operates as 1,000 small boats as opposed to an armada that is sailing in the right direction.

Annabel Goldie: On sharing professional experience and advice, other professions, albeit that the size of practice unit may range hugely, manage to observe some kind of collective fraternity—perhaps I should say sorority, given that we are the Equal Opportunities Committee. It might be done through their professional journal or their professional website. Why are doctors different?

Professor Watt: That is a very deep question. What you say about sharing evidence and experience is most true on the hospital side and in established specialties such as diabetes or heart disease. There are international conferences and gravy trains for all of that. Many of our institutions, our research and our teaching are based on that vertical model—on problems, not people. A GP is an expert in a community. He is an Easterhouseologist or a Partickologist. He knows a little about a lot and his expertise is to make pragmatic decisions—

Annabel Goldie: I hope that he knows a lot about a great deal.

Professor Watt: Our ambition is that people stop saying, “Oh, you just want to be a GP.” Being a GP is a hugely important job on the front line of the health service. However, the nature of the work—its unconditionality and its continuity—is difficult to research and to produce evidence on. That is why the deep-end project, in the absence of much evidence from deprived areas, has capitalised on the experience and views of practitioners.

The gap that we have filled is that of providing the infrastructure that allows people to share experience and views. It is enormously empowering for individuals to find out that they are in the same boat as others, and it is a very

effective intervention because a professional group, within itself, can challenge itself and move forward more easily than if it is being criticised from outside.

Annabel Goldie: Do not misunderstand me—I think that the whole committee is fully supportive of GPs and admires greatly the job that they do throughout Scotland. This is about trying to work out a way in which we can take that undisputed asset and help it to enhance its contribution to the community.

10:30

Professor Watt: Absolutely. I was in Vermont last week, where, 10 years ago, they invented some infrastructure and created a learning organisation for their family practices. The situation in the United States is very different from the situation here, but the interesting point is that they now have an infrastructure that is dedicated to what you have just described.

The health service in the UK has a general management philosophy and infrastructure that, at a community level, is mainly based around managing area-based services. In contrast, general practice has always been independent of that approach, and the system has always had difficulty in engaging with general practice, which is usually on the back foot and does not get involved. The challenge for general practice is to get on to the front foot, which means things such as making protected time for sharing activity and leadership.

All our projects are based on the primary care collaborative model, which was the most successful initiative in engaging practices. Under that model, practices work in clusters of five or six on work of their own choosing, with protected time for sharing experience and a role for GP leadership, which allows the practice's experience to be communicated to others. In a sense, that builds a learning organisation, which is an infrastructure that has not existed previously.

We cannot just have 1,000 flowers blooming—they need to be connected in some organised way.

The Convener: I am sorry to interrupt, but we are running out of time and I have two other witnesses who want to contribute on this point. Let us move on to get their input.

Joe McElholm: Important as GPs are, they are not in and of themselves the solution to the challenge and the problem. They are part of the solution if they work well in a locality as part of a whole-system approach and establish connectivity between their practice and other services. Their knowledge and awareness of what is available in the third sector in their locality—Graham Watt pointed to this—can be helpful.

The flow of information and the use of new technologies to deliver information in a readily accessible format are important for all parts of the system. It is also important to have information available so that people can self-manage and find the information that they need without going to a GP or any other service. Many people will not go to a service.

David Rowland: For me, the beauty of general practice is the relationship between the GP and their patient. Those relationships often last 20 to 40 years. If we were to move to protocolise general practice, we would run the risk of breaking that relationship. General practice's open approach to providing care and assessing need leads us to a situation in which practices can truly inform the future direction of health and social care. That is where the new health and social care partnerships come to the fore.

Through the locality planning structures that we will have to establish over the coming couple of years, we will bring standardisation across GP practices by engaging local communities and local practitioners at all levels, including general practitioners, in conversations about what the community's needs are, how they can best be met and how resources can best be allocated to meet them. We hope that that will embed things such as social prescribing within those localities as well, so that they are targeted at and tailored to local need.

Annabel Goldie: That brings me neatly to my final question, which is on social isolation in relation to the integration plans that are required under the Public Bodies (Joint Working) (Scotland) Act 2014. Are you satisfied that social isolation is on the radar screen when such plans are being drawn up?

Joe McElholm: I am satisfied that the opportunity is there; what will be important is how that opportunity is translated into reality and change. The opportunity is there because the national integration outcomes are clear about the importance of wellbeing and the fact that support and wellbeing are not simply about providing care to the best of your ability, but about promoting wellbeing, which is not necessarily about being involved in care.

The national integration outcomes emphasise prevention and supporting people not to be involved in services. That is where they provide an opportunity. There is also a statutory obligation to report on what is happening locality by locality. The opportunity is there to demonstrate that the third sector is fully involved and that it is being resourced to provide the contribution that those in that sector know it can make in each locality.

Yvette Burgess: On locality planning, it is really important that housing is involved, as well as local voluntary services and organisations. We are still watching that to see how it pans out around the country. Housing organisations are clear about the contribution that they can make to the process. They should be represented at the table, and their links with the voluntary sector are important.

Annabel Goldie: Joe McElholm spoke about an opportunity. Are we confident that that opportunity is being recognised by all health boards and local authorities?

Joe McElholm: It is difficult for me to express an opinion across all health boards and local authorities. In the area where I work, I am completely confident that social isolation is very high on the agenda and that it is recognised.

Jane Kellock: I very much agree with that. In the various service areas, there is a range of opportunities for us to provide more joined-up and more flexible services that intervene earlier.

Annabel Goldie: Is that the same for North Ayrshire?

David Rowland: I absolutely recognise the opportunities as Joe McElholm has described them. I want to provide the committee with some reassurance that we have translated that approach into a clear commitment in our strategic plan. One of our five strategic priorities is to improve mental health and wellbeing. When we went out to consultation on the plan, that was the priority that got the warmest welcome from the local population—it was given the highest priority in the feedback that we received from them. Our commitment to the local population is there and it is explicit. Social isolation and loneliness fit right in the middle of that, so it is very high on our agenda.

The Convener: We move on to the topic of sheltered housing for older people.

On 16 March, one of our witnesses described the lack of sheltered housing for older people as a demographic time bomb. The appeal of sheltered housing is that it can provide communities with support without taking away people's independence. Is that possibly a way to combat social isolation?

We have also heard that a person who is in a nursing home and surrounded by people for 24 hours every day can still be lonely.

Yvette Burgess: We need to recognise that the sheltered housing model is going through change, and has been for a few years. Traditionally, we think of housing for older people with a resident warden. The model has really moved on now, with flexible services going in and out and a recognition of the role of those services as hubs, as we have already heard about in relation to North Ayrshire—I know about South Lanarkshire Council's experience, as well. The thinking has moved on to serving communities more broadly.

As for the question whether there should be more sheltered housing, the issue is perhaps bigger than that. It is a matter of analysing people's desires and aspirations as they approach older age. What choices are they likely to make if that option is available?

Traditional sheltered housing has been going through a period of reconfiguration. I suggest that, rather than just reproducing the traditional model, we should consider people's aspirations and needs more broadly, while recognising some of the valuable aspects of the traditional model. People moved in and chose to use that sort of service because they felt that it offered some security, with somebody always on call and a support worker whom they would know, whether they were called a warden, a support worker or a housing manager. There should be some of those elements.

On the option of people being able to socialise near their home, we should not underestimate the importance of the communal areas that typically form part of sheltered housing. We have heard about how much of a problem community transport is and how limiting physical and sensory issues are. As people get older, it is harder for them to go far, so it is important to have the option of a communal area in which residents can organise events and activities and share common interests. We should definitely look at that continuing to be an option.

David Rowland: I very much echo what Yvette Burgess has said. It is about the individual and respecting what they want and their choices in life. For some people, putting them into a sheltered housing complex would be completely isolating for them, because it would take them away from their community network. We must not do that; we must find a way to support individuals at home for as long as possible so that they can continue to access the network that they have established over years.

For others, a move into a sheltered housing complex will be the right decision. They will have a new lease of life and new social doors will be opened up for them. That must also be recognised.

My point is that sheltered housing is not a panacea. We need a multipronged approach to address the issue. It is one real, viable option for us, and it is important that we get the capacity right. The previous witness whom the convener quoted was absolutely correct to describe not getting the capacity right as a time bomb.

However, we should recognise that sheltered housing is not right for everyone.

The Convener: We are running short of time, so I ask the witnesses to condense their answers from now on. Two other members want to ask questions.

John Finnie: I have a question for Ms Burgess about the loneliness and social isolation that housing providers can unwittingly cause when they put young homeless people in inappropriate accommodation or accommodation that turns out to be inappropriate, or when young homeless people are given the tenancy of a house without the necessary skills to maintain that tenancy, door-keeping skills and all the rest. Is there growing awareness of that? How is that being tackled?

Yvette Burgess: We are really talking about the support that people might need, particularly young people who have never experienced a tenancy before and have not had a chance to develop the life skills that are needed to get on with neighbours, for example. Obviously, current homelessness legislation requires local authorities to assess a person's housing support needs when they are homeless. That includes young people. Therefore, there is growing awareness of the support needs that a young person might have at that stage and there is the duty to make provision for that support.

Support is essential. The housing support service will typically look at social skills and life skills development. An important part of that will be looking at whether the person's social network needs to be encouraged and boosted. Perhaps somebody will decide that they really have to move away from their existing social circle because of drugs or alcohol problems. For a young person or anybody else who goes through that, it can lead to a lot of isolation. That is where formal support can really help to see the person through to making other social contacts to prevent the isolation that can often lead to further problems.

I hope that that answers your question to some extent.

John Finnie: It does. Thank you. That is reassuring.

I have a question for the panel generally. We have heard a lot about the use of social media and technology. I accept that there is a range of skills in our community; in fact, there is a range of opportunities because of the technical limitations in some areas. What part can social media and technology play in reducing loneliness and social isolation?

Joe McElholm: There are two strands to that, one of which is enabling people who may be digitally excluded and do not have digital knowledge and experience, or the grandchildren to show them how to do things. It is important to address that piece of work. In each area, there should be access to enable people who currently do not use technology not out of choice but because they do not know how to use an iPad, for example, to stay in touch with relatives or contacts who are a long distance away.

Where we set out to work on that, there has been an uptake of it. It is not the case that people are not interested in using technology and social media. When we speak to people, we find that they understand the concept of being excluded. They feel left behind. Everybody now knows people who use social media in their day-to-day lives. Not being able to do that is an issue for many people.

That offer of enabling people has to be made, and it should not just involve social work. The library's function in any kind of public service is just as important. We need to offer that, so that people can have the capacity to use social media.

10:45

The second area is developing web-based portals to give people access to information. It is too easy to say that lots of people in the group that we are talking about—older people—do not access the internet. That may be the case, but older people are increasingly accessing the internet and their children and families are connections who can help them to do that.

We have a website called making life easier, which gives people a range of options to, for example, access low-level supports. Some people see themselves as consumers of any service rather than users. The point was made earlier that some people do not want to be referred to a social work service because they think that the next thing that will happen is that they will be put in a care home. They will say to their family that on no account are they to contact a social work service. However, those people will be perfectly happy for their family to look up a website through which they can get access to a range of low-level support, without ever requiring to become a service user.

There are two things to consider: giving the capacity to use social media to those people who do not currently have it and having available at local level the information that people need. People should not just be able to access a national generic database. We should show them what is available in Coatbridge, for example, on an up-to-date website for them to use.

John Finnie: Is there a danger that, in cash-strapped times, such websites will become an

alternative to seeing the whites of the eyes of an actual human coming to assist?

Joe McElholm: On the contrary, they allow people who need face-to-face contact to access that more readily. You get self-screening, if you like. Our website can allow self-assessment. At a certain point when a person is answering self-assessment questions, the website can say, "We suggest that you come in and see us, because the information that you have given tells us that a solution is not available without you getting face-to-face support."

Yvette Burgess: Technology is increasingly important in housing support work, particularly from the point of view of the person using the service having support to use the increasingly various bits of technology, whether that be a community care alarm, access to the internet, Skype or information systems.

For some people, their support worker will be a good person to introduce them to all that. It is increasingly important that support workers and care workers feel confident about the range of technology that is available and are able to help people in this situation.

Professor Watt: The ultimate aim is for individuals to be knowledgeable and confident about their problems and in accessing the resources that are available to them. Self-help and self-management are desirable but they are not a starting point for many people. If they are a starting point and people just need to access information through information technology or whatever, that is great, because hopefully it will take them out of the need for services but self-help and self-management are distant destinations for an important and substantial part of the population. They require a long-term productive relationship—a journey, if you like.

Sandra White: Yesterday, we had an interesting presentation at the Scottish Parliament cross-party group on older people, age and ageing. I do not know whether the witnesses have heard about this, but I think that the University of Southampton, the University of Kent and the Royal Bank of Scotland are sponsoring a virtual reality scheme involving an avatar for older people, such as those in care homes. All their information goes on a tablet. I think that there is going to be a prototype by 2020. It seems that people will be able to call up anything from a warden to their doctor. Has anyone heard of that scheme? It was certainly a new one on me. I am sorry to spring that on the witnesses. There is going to be a presentation on it in June. It seems very futuristic. As John Finnie said, if that moves on and is embodied in the health service, there will be costs.

Professor Watt: There is a film called "Avatar". If you have seen it, you will know that the technology and graphics are fantastic but the story is very weak. We need to concentrate on the story rather than the technology.

Sandra White: That is the name of the person—it is called an avatar.

The Convener: We will move on to Christian Allard. I ask the witnesses to remember to bring in young people and social isolation. We have spoken quite a bit about elderly people, but young people are important, too.

Christian Allard: I will ask about how we can find further opportunities for joint working in the third sector to combat social isolation and loneliness, but first I want to go back to an earlier point about joint working. From 1 April, health and social services have been integrated, so I have been a bit surprised by some of the comments this morning. We are not at the time of designing opportunities for integration; we are at the time of implementation. Have we already seen implementation and some of the results? If not, it is maybe time that we did.

Joe McElholm: The process of integration and the delivery of integrated care and support has been an evolving process. It did not start with the legislation. A lot of the things that I have been talking about have been happening for many years, although the legislation takes us into a new stage of the evolution. I agree with Christian Allard that the issue has to be the implementation.

The locality dimension of the legislation is new. It rightly insists that we have to evidence how we respond to the needs of the geographical population not just for a partnership area but for each locality within it. There is scope and opportunity for new design work, and perhaps that will be more to the fore than it has been until now. I agree that we have to move into the implementation stage.

Jane Kellock: I agree with Joe McElholm that moving towards integration and joint working in community planning partnerships is not new to any of us. In fact, I cannot think of any work that our services do in complete isolation from anyone else. We are moving out of the silos that we were in perhaps 10 or 15 years ago and we are very much taking the opportunity to engage and work in partnership. It is an evolutionary journey for us, and it is promoted in new policy and legislation.

To mention children and families again, the getting it right for every child agenda has been around for some time now. We, and other local authorities, have been looking to the GIRFEC principles for a number of years. In particular, we have focused on the notion of centring on the individual, and how we flex our services and

structure our response in such a way that we are centring on the child.

We have had some opportunities to do that recently in relation to young people's mental health and wellbeing. Again, we are thinking not just about young people who have mental health problems, but about those who are made more vulnerable emotionally and mentally by their experiences. We are looking at the whole spectrum of early vulnerability, all the way up to young people who have quite profound difficulties.

The question then is how we bring the services around the table and the child to ask how we can best support that young person. It is not always about putting a service in; sometimes it is about the services coming together and saying, "Well, the young person has a relationship with a particular person, so how do we support that person given the particular level of need that the young person has?" That might involve consultancy or training for the individual member of staff. The approach is about building on the relationships that people have with children and young people, and asking how we can best support that rather than pinging young people off to one service and then another.

Christian Allard: So it is not aspiration-centred but person-centred. GIRFEC is exactly the kind of approach that should have been implemented. Now, from 1 April, there has—as you say—been a lot of collaboration and joint working. We have everything in place, but the system is not working as well as it should be for young people. Is that what you are saying? Are we still lagging behind a bit? Are some parts—GPs, for example—not as involved as they should be?

Jane Kellock: If we could have got it right easily, we would have done so a long time ago. We are talking about a very complex area that covers social care and health care. The evidence that is available these days highlights just how complex our make-up as human beings is. We are very complex creatures, and social ills do not come alone; there is no easy solution to any of these things. When we have answers and solutions, they are often part of what is going on at the time and they work in conjunction with a range of other things. We require a very complex understanding.

What I like these days is the opportunity to build more of a shared understanding across social care, education and the NHS about the issues and problems that we face. We are not practising our professionalisms in silos, and the challenge—and the opportunity—is about how we make that shared understanding happen on the ground in a way that works for people in our communities.

There is a lot of good practice, but some of it is still in pockets, so the challenge is about how we grow it and offer it around, and how we work in collaboration not just within local authority areas but across Scotland in order to do that. It is a very exciting time to be doing that work.

Yvette Burgess: Thinking about young people and housing services, it is important to recognise that integration will not necessarily encompass all the services with which young people will need to come into contact. I would just make a plea that we should remember that links need to continue with housing. That includes housing support services and hostel services, particularly those that work with young people who are going through transition, whether they are coming out of care or are homeless, or both. That should be the case regardless of whether a partnership decides to include homelessness services and other services that are particularly relevant to young people. We need to build on and improve the existing links rather than expecting that integration in itself will magically deal with the issues.

Christian Allard: Have you been involved with the two pieces of legislation relating to GIRFEC and to the integration of social services and health services?

Yvette Burgess: Yes.

The Convener: I see that Graham Watt wants to come in—can you make it brief, please? I will then bring in John Mason, who should also be brief.

11:00

Professor Watt: GIRFEC does not mention general practice, even though practices have a lot of knowledge about families, which is important.

Health and social care integration is obviously important, but it is preoccupied with the integration of two rather different bureaucracies and it will take a lot of time for that to iron itself out. We often pass the written and fail the practical: the strategies and policies are fine—the problem is in delivering them. I go back to what I said about dysfunctional and fragmented services. Spike Milligan described a man who invented a machine that did the work of two men but took three men to work it. That is health and social care integration. We need to imagine ways of doing the same thing with smaller numbers of people.

At the end of the day, the gold standard will be about the experience of the individual patient. Is the experience good? Does the family feel that their relative is being dealt with well? That will be the test of whether the bureaucracies are working well together.

Christian Allard: You said "patient" again, but especially with social isolation and loneliness it is about the person first and foremost. In fact, the person becomes the patient when the services fail.

Professor Watt: Quite.

John Mason: I agree very much with Yvette Burgess about the importance of housing. I was slightly surprised by one of the comments in her submission, which said that the practices that

"Housing organisations already adopt ... might include helping a person relocate nearer friends, family or support."

That would be great, but my experience is that it does not happen. It is incredibly difficult to get somebody to move to a particular location.

Yvette Burgess: The issue is allocation policies. As we all know, there is huge pressure on social rented housing. We still generally work with points systems for allocating properties, but many housing organisations give additional points for social isolation—for example, Trust Housing Association gives points according to how many times a week or a month the person has a visit from a friend or family member. However, as John Mason said, that does not necessarily mean that everybody who needs to move closer to family or friends is given that opportunity when they want it.

Christian Allard: Another subject that we have talked about while taking evidence—and which is mentioned in West Lothian community health care partnership's submission—is high-profile campaigns, such as the one by Age Scotland, which had a lot of media coverage and was accessible to the general population. Should we have a national campaign like that and, if so, should it be targeted at those who could be affected or should it be targeted more generally at the whole community in trying to build community resilience or something else?

Jane Kellock: National campaigns are often based around the negative. I suggest that a national campaign should be about social connectedness rather than disconnection.

Christian Allard: Does everybody agree with that?

David Rowland: I agree entirely with that. It would be really helpful to have a positive message about social connectedness that would lay the foundations for locality-based planning to understand the needs of communities and how we might respond effectively to them in the light of that wider campaign.

Professor Watt: Politicians have great difficulty in closing hospitals because of the public's emotional commitment to them, but the service that we need in the future cannot be based on hospitals. Therefore, I would like to see a national campaign that engages with the public and says that, in the future, the NHS will not be about hospitals alone but will be about people living well and long in the community, so that when resource is transferred from secondary care to primary care that is regarded as a good thing—not as something being lost, but as something being gained. Unless the public sign up to that, we will be tied in to the wrong model for ever.

Joe McElholm: The challenge for a national campaign is to get a message that is relevant to every part of the target audience. The local level is where some of the answers are to be found for the questions that we are asking, so I sound a note of caution about the national campaign approach.

Christian Allard: I understand that, but I would like answers to the question whether it is possible to run a national campaign that would be positive.

Yvette Burgess: It is all about public image and perceptions, and challenging stereotypes. For example, anything that promotes positive views of older people being active, doing things and making a contribution will encourage older people themselves to do such things, and it will encourage others, including neighbours or grandchildren who are in contact with them, to think of them as having that potential.

Christian Allard: Should a campaign be gender targeted or age targeted?

Yvette Burgess: That is a very good question. A campaign should certainly be wide-ranging, but it is a fact that older men, in particular, can feel isolated. For example, when Queens Cross Housing Association found that a group of men in their 60s were not engaging with any of its services, it realised that that was because they perceived the existing group activities in what was sheltered housing as being predominantly for women. As a result, it set up what it called the stag group to get men involved. Christian Allard has a point—we need to think about which groups in the wider group of older people need particular encouragement to continue to be active and sociable.

David Rowland: To be honest—and to hark back to points that Joe McElholm and I have made—I would not want a stratified national campaign. A high-level national campaign that focuses on key positive messages about social connectedness would be an absolutely great thing and I would really welcome it. However, that national message should be stratified at local level on the basis of local priorities; it should be left to us in the evolving health and social care partnerships to turn it into something really positive locally.

Christian Allard: That is interesting. It is easy for the general population to understand that older

people can feel isolated, but it is perhaps not so easy to understand that young people can feel the same. Is there any way we could do that at national level?

Joe McElholm: That might lead to a national campaign having a theme highlighting isolation as an issue across the entire life cycle. It would be a very high-level message, but other campaigns—on, for example, mental health issues—have pressed home the message that mental health is an issue for everyone and that when you go to| the supermarket you will be standing beside people who have mental health difficulties. Such messages have a powerful emotional content; the kind of campaign that Christian Allard is suggesting could raise the profile of social isolation and make it clear that it is everyone's problem. The purpose of such a campaign would not be simply to raise awareness that such things happen, but to highlight to the wider community the contribution that it can make.

The Convener: I thank everyone for coming along and sharing their information, experience and knowledge with us. Your evidence will be really useful.

That concludes the public part of today's meeting. Our next meeting will take place on Islay on 11 May, when the committee will take further evidence for its inquiry on age and social isolation.

11:09

Meeting continued in private until 11:27.

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