OFFICIAL REPORT
AITHISG OIFIGEIL

# Health, Social Care and Sport Committee

Tuesday 22 March 2022

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

---

# Tuesday 22 March 2022

## CONTENTS

---

## HEALTH, SOCIAL CARE AND SPORT COMMITTEE

**12th Meeting 2022, Session 6**

**CONVENER**

*Gillian Martin (Aberdeenshire East) (SNP)

**DEPUTY CONVENER**

*Paul O'Kane (West Scotland) (Lab)

**COMMITTEE MEMBERS**

*Stephanie Callaghan (Uddingston and Bellshill) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Evelyn Tweed (Stirling) (SNP)
*Sue Webber (Lothian) (Con)

*attended

**THE FOLLOWING ALSO PARTICIPATED:**

Clare Cook (SPRING Social Prescribing/Scottish Social Prescribing Network)
Scott Henderson (Technology Enabled Care Scotland)
Alison Leitch (Edinburgh Voluntary Organisations Council/Scottish Social Prescribing Network)
Roseann Logan (Health and Social Care Alliance Scotland)
Chris Mackie (Health and Social Care Alliance Scotland)
Christiana Melam (National Association of Link Workers)
Dr Paul Perry (NHS 24)
Adam Stachura (Age Scotland)

**CLERK TO THE COMMITTEE**

Alex Bruce

**LOCATION**

The Sir Alexander Fleming Room (CR3)

# Scottish Parliament

## Health, Social Care and Sport Committee

*Tuesday 22 March 2022*

*[The Convener opened the meeting at 09:00]*

## Decision on Taking Business in Private

**The Convener (Gillian Martin):** I welcome everyone to the 12th meeting in 2022 of the Health, Social Care and Sport Committee. I have received no apologies for today's meeting from any member.

Agenda item 1 is a decision on whether to take item 4 in private. Do members agree to take that item in private?

**Members** *indicated agreement.*

## Alternative Pathways to Primary Care

09:00

**The Convener:** Item 2 is two evidence sessions as part of our inquiry into alternative pathways to primary care. Our first panel will focus on social prescribing, the link worker programme and the role of the third sector.

I am delighted to welcome our panel of witnesses. They are Clare Cook, who is regional manager and co-chair of the Scottish Social Prescribing Network; Alison Leitch, who is a community link worker area lead and co-chair of the Scottish Social Prescribing Network; Roseann Logan, who is the links programme manager for the Health and Social Care Alliance Scotland; and Christiana Melam, who is the chief executive of the National Association of Link Workers.

I will go round each of you to start off. Is there potential for wider use of social prescribing in Scotland than there is now? How can we find a better balance between medical and social approaches to healthcare more generally?

**Clare Cook (SPRING Social Prescribing/Scottish Social Prescribing Network):** Morning, everyone.

I absolutely think that there is a place for social prescribing in Scotland. I will just tell you briefly about SPRING Social Prescribing, because my role in that will influence my answers. It is funded by the National Lottery Community Fund, and we help to support adults with their social, emotional and practical needs to improve their health and wellbeing. We do that by connecting them to community support.

We are based in eight community-led health organisations in Scotland, so it is a different model from the community link worker programme. However, we work very well with that programme; we need to recognise that one size does not fit all and that, throughout Scotland, there are lots of different models and lots of experienced and professional organisations that run them.

**Alison Leitch (Edinburgh Voluntary Organisations Council/Scottish Social Prescribing Network):** Like Clare Cook, I absolutely believe that social prescribing should be used more widely. The Edinburgh link worker programme is part of the Scottish Government-funded programme that was in the 2016 election manifesto. In Edinburgh, link workers are employed in third sector organisations in four localities across the city.

At the moment, we have 21 link workers covering 43 general practices, and they are employed by 11 different third sector organisations. We have 21 GP practices that are part of the national programme that focuses on health inequalities and at least 20 per cent of their patient population is classed as deprived. We then have 22 practices that are covered by primary care improvement plan money. That is where we are seeing growth—GPs see the benefits that link workers have brought to those practices in the health inequalities funded programme. It is great to see that other practices are coming on board with the link worker programme and seeing the link worker as part of their multidisciplinary team.

Clare Cook hit the nail on the head: there are so many different models across Scotland and, as part of our social prescribing network, we are trying to map that so that we have an idea of the overall structure.

I am part of the working group on the Scottish community link worker network, which has recently been set up and is trying to gather information about the different programmes. It is not at all about a one-size-fits-all approach; it is about trying to get an overarching picture of what link worker and social prescribing looks like in Scotland.

**The Convener:** I am interested in something that you said, which was that GPs are already seeing the benefits of this. Will you expand on that? What benefits are they seeing?

**Alison Leitch:** A lot of GPs are realising that they are not always the best person to service the needs of some patients. We are all well aware of the pressure that primary care is under, and when you have only a five, seven or 10-minute appointment, you are not going to get to the root of the social problems that the patients are bringing to you. When a link worker can spend an hour with somebody, they can address housing, benefits and employment issues, for example. GPs cannot deal with those things. If a link worker is dealing with those issues, even if the patient continues to attend the practice, the GP will be able to make better use of their time because all the social issues are taken out of consulting time and they can address health issues directly.

**The Convener:** That is helpful. I go to Roseann Logan next.

**Roseann Logan (Health and Social Care Alliance Scotland):** I am a programme manager with the Health and Social Care Alliance. I agree with my colleagues about the wider use of social prescribing.

In 2014, the alliance ran a pilot programme in Glasgow in collaboration with deep-end GPs. That started out with seven deep-end GPs and Glasgow is now sitting with 53 deep-end GP practices. In West Dunbartonshire, we have a model that is quite different. As Clare Cook said, it is important to have different models in Scotland because we have different dynamics across the country—we must embrace that.

It is also important to get the balance right between the medical model and the social model. As Alison Leitch said, GPs and other healthcare professionals have limited time and scope for patients. They do not tend to know a lot about what is going on in their communities, which is where link workers are especially valuable. Coming from third and voluntary sector backgrounds, they know and have links with their communities, and they know what is available. They know about the importance of building relationships in those communities, so they are best placed to support patients whose lives are affected by social issues.

As we move forward, it is important that we have the SSPN and the NALW, because we need to look at our workforce. It is varied across the country, but we must take the opportunity to bring people together to collaborate and share learning.

**The Convener:** Thank you, Roseann. You have hit on the patchiness of provision across the country. You are alluding to the fact that best practice might not be being shared at the moment. Is it fair to say that there is potential for more knowledge sharing?

**Roseann Logan:** Yes, definitely. That is why it is great that we have the SSPN. I sit on the SSPN steering group and on the advisory panel of the NALW. There is real value in us sharing knowledge and looking at what there is across the country. Both those organisations are taking the opportunity to bring together people not only from the third sector but from some health and social care partnerships and health boards that are employing link workers.

We want to bring those different models together to share best practice. Ultimately, we want to ensure that we deliver the right service for the people of Scotland in their communities.

**The Convener:** That is helpful.

**Christiana Melam (National Association of Link Workers):** Hello, everybody. It is lovely to be here giving evidence with colleagues.

The NALW is more focused on the workforce. We are a professional body for social prescribing link workers in the United Kingdom. I will be sharing some experience and learning from our members in Scotland, some of whom are also members of the witness panel, and from the round-table discussion that we held to inform what I would say at this meeting.

First, I pay tribute to the social prescribing programmes in Scotland that have won lots of awards. We run an annual award and we have representatives of those award winners on the witness panel. The first social prescribing link worker of the year award was won by Sean Macfarlane, who is part of Clare Cook's SPRING Social Prescribing programme. The community group of the year award was won by the YAP—young adult project—which is a community project that is run by the alliance. Roseann Logan was a highly commended manager of the year for social prescribing. The North Ayrshire community link worker programme and the Edinburgh health and social care partnership have also been finalists and have been highly commended for their social prescribing efforts.

There is a lot of experience and knowledge to share. At the NALW, we think that it is time to mainstream social prescribing, because general practice is at risk of becoming a crisis service—everybody is chasing, or treating, the symptoms. If we are not going to intervene to address vulnerabilities and get at the root causes, we will have a healthcare system that is all about illness.

We know about the impact of the social, economic and environmental factors that affect our health, so it does not make sense to separate those. The challenge has been that we do not have a mechanism by which we can mainstream the introduction of a social prescribing approach in the national health service.

What we have been able to do, in particular in general practice, is look at whole-person medicine. What is the difference between general practice and specialist services? The former is about the whole person, continuity of care and prevention. We are asking people how they are. With the pandemic, a lot of people are not asking others, “How are you?” That is a big problem, because people need to be listened to.

Listening itself is a treatment. As one of the patients whom we supported through social prescribing described it, a listening ear is worth $1 million. It is very important that we have a mechanism by which people feel listened to and are empowered. It is about social justice and inequalities, and recognising that the way people feel in their community, and whether they feel that they are integrated in that community, has an impact.

People do not have anywhere to go, and they know that the NHS will not turn its back on them. It is not about preventing people from coming forward—it is about what support we have available for them when they appear at our door. Do we have social prescribing opportunities? Are we supporting the link workers? How are we also encouraging social mobility? The people who become social prescribing link workers often have lived experience. People want to help, and there are a lot of opportunities for them to do so.

Social prescribing is the bridge between the community and the NHS. Link workers have a lot of information and knowledge to share with policy makers on what is going on with people, because they can spend more time with them and build up a trusting relationship. That is transformational for people who have, for 20 or 30 years, not had anyone listen to them in depth, which is what social prescribing link workers do, and with no agenda. That in itself is transformational.

We then see communities that are striving and transforming, and which want to help, and that is the way in which we reduce pressure on the NHS. It is about the infrastructure around the person. What are the incentives for that person to look after their health—for example, by going for a walk? If they are not able to go for a walk, who is removing the barriers? Somebody has to take responsibility to enable and empower people to take control of their narrative.

**The Convener:** Thank you, Christiana—I really like what you said about the whole-person approach. When I listen to you, it strikes me that, while we, as elected representatives, have people in crisis coming to us, I often worry about the people who do not come and see me. Everybody goes to their GP surgery instead. Would you agree that it is important to bring services to where people are? I am thinking about the hard-to reach people who need help.

**Christiana Melam:** Yes, absolutely. As I said, social prescribing is not a one-size-fits-all approach. We say that, in any place where there are human beings and we want to reduce health inequalities and social justice, we need to consider social prescribing. It is not just about health—it is a cross-cutting approach. General practice in itself, as a community asset, should be seen as the glue that connects all the services and the professionals, rather than as the focal point where a patient is dependent on a particular GP. There are community-based social prescribing programmes and projects in which marginalised people or communities who do not access GP practices can get support.

The interesting question for us is how to achieve integration. What is the interface between community-based social prescribing services that are not based in general practices and those that are based in general practices? Surely social prescribing link workers can be that glue between those services. How do we develop an integrated approach that enables continuity of care, so that the person is not repeating themselves? That would empower the clinician with a full picture of what is going on, whether the person is supported in the community or by general practice. The medical diagnosis and the whole-picture perspective are then really clear, and that helps to inform treatment.

09:15

**The Convener:** Thank you so much—thanks to you all.

Clare Cook and Alison Leitch want to come back in, and I will bring them back in, but Sandesh Gulhane has a supplementary question.

**Sandesh Gulhane (Glasgow) (Con):** Christiana, I would like to suggest something in relation to what you said—that anywhere there is a human being, we need to have a listening ear, we need the help, and we need to be holistic. What are we doing to help people coming across from Ukraine as far as link working is concerned? The social prescribing aspect will be key here, I think.

**Christiana Melam:** The social prescribing programme models involve funded mechanisms—it depends who the services might be for. Some programmes have a level of flexibility, based on the model. Some social-prescribing link workers in Scotland are specialists, focusing on refugees and asylum seekers. There are migrants groups, too. The social prescribing movement has identified that, where there are specific cohorts needing proactive intervention and support, social-prescribing link workers are focusing on those.

In general practice, it depends on the culture. If the general practice is focused on those who are on its list, the social-prescribing link worker will be focused on those who are on the list, whereas a community-based social prescribing programme or a social prescribing service in the GP surgery will be open to those sorts of interventions involving the community, and if the practice opens up its doors to the community, social-prescribing link workers can support them. For some programmes, there is no closed list; those programmes support everybody who needs support. The challenge is that the social-prescribing link worker is only as good as what is available in the community.

Link workers have information on some of the social and structural inequalities. They can only help people to reduce or remove some of the barriers and inequalities based on the services that are available. When they identify blocks, how do they feed that back to the systems or policy makers so that they can understand what is getting in the way? That is one aspect of the social-prescribing link worker's role that has not been tapped into: the information that they have, which could shape policy.

**Clare Cook:** I want to touch on the hardest-to-reach people in our community. The benefits for SPRING Social Prescribing and Alison Leitch's programme are the same. Our social prescribers are hosted within community-led health organisations. They know their communities really well, and they know where the hardest-to-reach people are. Those are people who traditionally might not approach their GP for certain things. For us, meeting a social prescriber in the community almost normalises that engagement, and it encourages participation.

On support for Ukraine, we would definitely be providing that help. We will be discussing opening up referral routes. Post pandemic, we changed our referral routes. We were previously accepting referrals from GPs in primary care only. As people were not attending various different professionals—for the right reasons—we had to change our referral routes. We now open to a full range of different places and organisations, such as pharmacists. The community link worker programme refers to us, and we are open to housing associations and carers centres. I imagine that anyone coming from Ukraine would get that support—absolutely. They do not need to be with a general practice; they would get support in community-led health organisations.

**Alison Leitch:** I will follow up on what Clare Cook has said. Our statistics show that GPs see 70 per cent of the population over the period of a year, so general practices are the ideal place where people can gain knowledge of what is happening in the community and the third sector.

As Clare Cook said, our link workers are embedded across the four localities. They are employed by locality-led third sector organisations that know their communities, their needs and the issues that the public face, and they bring that knowledge. GP leads sit on our programme as the experts, so they are fully aware of what is happening in the third sector.

Building bridges between primary care and the third sector—for example, by getting GPs involved in funding decisions—is essential. In Edinburgh, we have a trust fund, which involves primary care and third sector organisations, and there have been a few successful grant applications for it. We have also had third sector organisations hosting protected learning time sessions. It is about sharing knowledge so that, when somebody comes to reception, or when somebody answers the phone, everyone knows which organisations are on their doorstep.

On Ukraine, Edinburgh does not have a huge number of asylum seekers, but we work with anybody who is registered with a GP practice and holds that status. We have a unique link worker—I think that they are the only one in Scotland—who works with the homelessness practice. When the pandemic hit two years ago, we totally changed the way in which we work. We became very responsive, because the third sector has the flexibility to change overnight. We changed from delivering food parcels to delivering prescriptions, and we opened up the whole service to every practice in Edinburgh. We also helped with the Government signposting helpline and the City of Edinburgh Council helpline. When there is a need among the wider general public, link workers and third sector organisations can shift with that need.

Clare Cook and I have had conversations with Niall Taylor, who sits in Maree Todd’s team, and with the Scottish community link worker network, about how no one, sadly, is taking charge of social prescribing. That is where Scotland falls down. In England, there is a head of social prescribing in the NHS; in Wales, that is dealt with through public health. I know that Niall Taylor and Katie Biesty, who is on his team, are in discussion with people in England and Wales. There is also the All Ireland Social Prescribing Network. The Government is aware of the issue—it falls within the portfolio of two ministers.

We know what happens at the grass roots, and we know that social prescribing is in the Scottish Government’s strategies and polices, but there is a gap of knowledge when it comes to feeding back. We all want the strategies and policies to work, but we also want our programmes to work. Therefore, we need to see evaluation return, because we know that there will be increasing pressure on state money. We need to be able to show and evidence all the good work that we can do. If there are GPs who are a bit doubtful, we have the evidence base, which gets fed back to the Government and is shared.

In relation to sharing best practice, new link worker programmes on social prescribing are coming on board, so let us not reinvent the wheel. We have been cutting our teeth on the issue for a few years now. Different things are coming on board; for example, the Edinburgh health and social care partnership has just made a huge investment in Elemental Core, which is a social prescribing management tool that talks to the GP’s Vision system. That will give us huge evaluation opportunities. I think that West Lothian is also on board with that, and Highland is taking it on. Perhaps we could implement that on a national scale, so that we all undertake evaluation that proves that what we do is worth while, meaningful and worth future investment.

**The Convener:** That is very helpful information. I saw a lot of members making notes about questions that we might want to put to the Government on the issue.

Roseann Logan wants to come back in, and then we will move on to questions about public perception from Emma Harper.

**Roseann Logan:** I will go back to the important issue of linking primary care with the third sector. A lot of GPs do not know much of what is going on in their local communities. Before the pandemic, we were carrying out, especially in health centres across Glasgow, an initiative that involved bringing the community to people. Link workers would link with third sector and statutory sector services, such as smoking cessation services and Macmillan Cancer Support’s transforming cancer care programme, and invite them to attend health centres or GP practices once a week. They would set up a stall and get to meet patients who were coming to the practices. The link workers would also encourage GPs and practice nurses to come out during their tea breaks and meet those providing the services. In that way, they get to know exactly what services are provided in the communities. It is really important that we continue to forge those relationships between our primary care and community services.

We have found that space in primary care is another big issue—I am sure that that will not be a surprise. Space is at a premium. New health centres are being built, but there is still a lack of space, especially in relation to moving forward with our multidisciplinary teams. We are bringing pharmacists, musculoskeletal physiotherapists and welfare rights officers into primary care, and we also have our links workers. Where will we house all those individuals? Where will they be? We need to consider community space.

It is really important for a link worker that they are visible in their practice so that they are not forgotten about and can receive referrals, but, to see people, it is often important for them to make links out in their community. That can be with the local housing association, through asking to use one of its community rooms. Other community venues and libraries could be looked at. As Clare Cook said, it is important that we consider utilising other spaces in our communities, because they will be comfortable for some individuals. That is very much a person-centred approach. For some people, the GP practice is a place of trust, but, for others, meeting out in the community could be a really valuable resource.

On the situation in Ukraine, a large percentage of asylum-seeking refugees are across Glasgow in particular—again, that is no surprise. We are based in three practices in Govanhill in Glasgow, where there is the largest Roma community in Scotland. We are used to working with local community groups and networks, building relationships with those organisations and looking at how we can link in interpreter services, which can be a challenge. If we are going to take an abundance of individuals from Ukraine, we need to ensure that, as a nation, we are equipped with interpreter services so that we can work closely with individuals whose first language is not English. We need to ensure, as we have done during the pandemic, that resources are made available in other languages so that individuals can easily read them and know how they can access their GP practice. For a lot of people, when they phone their GP practice, the response is in English. If English is not the person's first language, how will they get through the initial barrier of contacting their GP practice?

As we move forward, we need to be mindful of how we can remove all barriers to access for everyone who will come to or live in Scotland.

**Emma Harper (South Scotland) (SNP):** Good morning, everybody. I am interested in what the public know about social prescribing. There are a few papers out there that say that social prescribing has been around for years, but we have started to have more dialogue about it. We know its value, especially during the initial lockdown in the pandemic, and especially for addressing mental health and social isolation and in relation to befriending.

I know of two local projects in Dumfries and Galloway: the Listening Ear project in Stranraer and a project by the Dumfries and Galloway third sector. What is your understanding of the public's knowledge of social prescribing as a pathway for treatment, not just for men's sheds or mental health. What do the public understand about social prescribing?

**The Convener:** Who would you like to answer first?

**Emma Harper:** Alison Leitch.

**Alison Leitch:** We do not take self-referrals—the referral has to come from somebody in the practice team. That decision was made because of risk. Somebody in the practice team has to be aware of any risks, because we have had a couple of near misses with link workers being in a room with patients who should not have been there.

We also have an obligation to assess risk before referring people on to community organisations. We do not have posters or leaflets in practices; we rely on GPs. It is all about having a trusting relationship.

It was touched on earlier that people go to their MSPs about issues, but GPs are put on such a pedestal that people trust them so much. It is about GPs educating their patients about other services and alternative pathways that are available in the practice, whether that is a physio, a pharmacist or a link worker. When I had a case load in a practice, I found that when a GP said to a patient, "Let's look at alternatives, because I'm not the best person to help you", and then directed them to, say, a link worker, the patient trusted them and would agree to see the link worker.

09:30

We have a handbook guide for our link workers in which we suggest that they should work with a person for between four to six sessions. That is not set in stone, but it sets expectations right at the beginning and makes it clear that we are not support workers and that the service is not endless but has boundaries. However, because those expectations are set quite early on, you can spend the initial hour-long appointment getting to know somebody and building trust, which means that when, at the second or third appointment, you start suggesting support services or group activities, you have buy-in from the patient. The issue is not necessarily one of public awareness; instead, it is about the trusting educational process that begins in the consultation room with the GP suggesting that they might not always be the best person to deal with something.

That will vary according to the generations. Our practice has a lot of training doctors, who get this sort of thing right away and will make those suggestions. The approach just works, and you can see the trusting relationship move from the GP to the link worker and then to the community organisation. That is the best outcome that you can hope for.

**The Convener:** I should probably have said to the other witnesses that, if they want to come in, they should let me know by using the chat box.

I see that Christiana Melam wants to make a comment.

**Christiana Melam:** It is a great question. Social prescribing is about social change, so it cannot be rushed. We need a national campaign, but the challenge in that respect is that access to such services is not universal in Scotland. Indeed, in some areas, there is no social prescribing link worker at all.

In introducing such a change, we must have the mechanism for communicating it, and that is what is lacking. Instead, that sort of thing is left to individual social prescribing programmes. We need education across the board in introducing a social change that, as some of our GP colleagues have said, is the biggest cultural shift in healthcare and medicine that we have had.

In fact, it is such a huge change that it will require changes to the way in which clinicians are trained and how they see things. There are voluntary, community and social enterprise organisations that might have had certain elements of social prescribing or might have been doing social prescribing activities, but they will now need to understand the philosophy that lies behind it. Indeed, if it is mainstreamed, that will create certain expectations among patients. We are concerned that, although social prescribing is based on local need and tailoring to local circumstances, there still needs to be some consistency. If someone in a certain area needs a link worker, there cannot be a risk that they will see only a GP or a clinician instead. In fact, some of the views from the survey highlighted that.

The question is how we give people the trust that they need. That is actually what the NALW is trying to do. We have a code of practice that our members sign up to—that is all voluntary. We have a continuing professional development network, and we are beginning to have conversations with NHS Education for Scotland on the issue. I hope that we can encourage NES to take ownership of it, because, in other nations, the issue is overseen by statutory education bodies.

In short, the training and education needs of link workers are not being catered for enough, and we need a comprehensive framework in that respect in Scotland. Such a framework is being designed in Wales, and England has just got its own one, too. We must ensure that there is no postcode lottery and that there is a baseline with regard to what people can expect.

A survey that we carried out last year highlighted that the biggest challenge faced by our members is a lack of understanding of their role and its boundaries. That is a UK-wide problem that needs to be addressed, and we need to specify some standards and ensure that there is basic understanding of the specialism. Interestingly, in some engagement work that we carried out with the National Association for Patient Participation, the chair of one of the patient participation groups actually said that.

We are trying to explore their understanding. The report of that survey is not yet published—it will probably be published before May, and I am happy to share that with the committee. How the patients describe social prescribing is really surprising. Some of them said, “I used to compile a list of all the singing groups and walking groups in my area, even before we had a link worker in our area.”

There is an understanding of the activities. Some people actually described what they felt those activities meant, and we thought that that should perhaps be the new description that we use. We should not underestimate the fact that some patients really understand and appreciate the approach, because it is what they have been doing.

A patient participation group is a community group and is one of the groups that we would connect somebody to. Those groups listen to and support their members. Our concern is about how we help those groups, which are mostly reliant on volunteers to be sustainable. If the social prescribing link workers’ work is very narrowly focused and a bit medicalised, we forget that it is about community assets, thinking about where the gaps are and setting up new groups, and community integration. That means that, if somebody is feeling lonely or a bit down or just needs to get somewhere, they have a kind of neighbourhood where everyone knows everybody else.

It is about the social prescribing workforce. It is not just about link workers; it is about the community and all the assets around it. There is a lot of good will. Patients do not just ask for appointments; they are also part of the social prescribing workforce and want to help. Some PPGs and community groups are no longer in existence, because we have had Covid and people are fearful. What remobilisation plan do we have to rebuild communities and PPGs?

We collectively have a social responsibility to raise awareness. It is about social justice and reversing the impacts. That is not just for my group. The Scottish Government, as an anchor organisation, can help with that. Everybody needs to raise awareness, from patients and clinicians to VCSEs, businesses and everybody else who is interested in reducing inequalities and social injustice.

**The Convener:** I want to bring in Clare Cook, Roseann Logan and Alison Leitch again. I know that you want to come back in, but I will first go back to Emma Harper, who has a supplementary question to throw into the mix.

**Emma Harper:** My question is kind of about what Alison Leitch and Christiana Melam said. I am interested in the barriers to people to picking up a social prescribing pathway. Alison talked about people seeing a GP first and then having one, two or three further visits in order to be enticed into joining a walking group, visiting a men’s shed or participating in the Listening Ear programme. Under the community empowerment legislation, community asset transfer has enabled communities to get together to create community hubs and centres and to feel empowered, which has helped. What are the barriers to people saying, “Okay, I will do this,” instead of seeing their GP again and again? What is the particular thing that prevents people from progressing?

**Clare Cook:** I will first touch on the public’s perception of social prescribing. I do not think that the language of social prescribing is widely used by the public. Many of the organisations that I support have been doing this for a long time, and it is just the terminology that is new.

Like Alison Leitch's programme and the alliance, we need to take referrals in order to mitigate the risk from self-referrals. However, for the organisations that I support, SPRING Social Prescribing is only one element of what they do. Because those organisations are based in their local communities, anyone can walk in off the street and say, "I need a bit of support." They might get the support not through SPRING Social Prescribing but through some of the other programmes that those organisations deal with.

There are barriers, but there are certainly ways to get round them. People can pick up the phone or access third sector organisations. However, those organisations are only as good as the funding that they have. Obviously, a big barrier is about funding for existing organisations.

**Roseann Logan:** What the public know is really variable. If a GP practice has a links worker based in it, not all the practice population will know that. Our Glasgow programme takes self-referrals—that was agreed early on in discussions with our GP partners—and there has been an increase in those. People talk to their friends and colleagues about the service that they have received, so others will self-refer.

We also have information leaflets about what our links workers do, what social prescribing is and some of the areas that a links worker can support people with, whether that be housing, bereavement or benefits.

Our links workers can access medical records, which is important. Just like anyone else in the practice team, a links worker can see whether there are any alerts for a patient. If someone self-refers, they will do that through the receptionist, who will be able to see whether there is an alert. If so, they assess the risk and perhaps arrange a joint visit in the practice for the individual, in the same way as the practice nurse would. With our programme, there are no exclusion criteria. Anyone who is on a GP practice list can come along and see any of the health professionals in that practice.

On the barriers to individuals accessing services, especially with our Glasgow programme, which is based in deep-end GP practices, many of the people in those areas are not ready to engage, and that was the case even before the pandemic. A links worker has an opportunity to build trust and have a conversation with people. We are not time limited so, although we capture the number of sessions that people have, that can vary from one session to working with someone for months, perhaps because they are trying to access or navigate a statutory mental health or social care service.

Another point is about individuals' lack of confidence and self-worth. We have anecdotal evidence of individuals being told about services in the community. One was a young mum with a young family who was socially isolated—she did not know anybody else in the area. The links worker spoke about a bounce and rhyme class in the local library, but the young mum did not feel that that was for her. She said that she would feel out of place because, as she put it, it was for the yummy mummies on maternity leave and she was not one of them. She thought that she would not have any conversation and would not know how to speak to them.

That barrier was overcome by the links worker saying, "Would it help if I came along to the class with you?" The worker supported that mum to access the service with her baby. She went twice until the young mum realised that the group was very different from how she had perceived it previously. She was then able to continue accessing that group.

That is important. It is not just about signposting or referring people to services; it is about being able to walk alongside someone and to look at the issues in an individual and person-centred way. It is about asking, "What matters to you and what will be the difficulty or barrier?" If it is walking through the door of a woman's centre or men's shed, the links worker will say, "I will go with you if that would help and walk alongside you on that journey." There is much more to social prescribing, and it is important that that is captured as well. We need to look at all the different models across the country.

09:45

**Alison Leitch:** To go back to public awareness, the Scottish Government has an advert out just now about receptionists. When somebody phones a receptionist, she can redirect them to wherever they need to go, whether that is to an optician or to a pharmacy. I do not think that social prescribing is part of that advert, but it is about engaging the whole practice team.

Some places still have receptionists, but my old practice has care navigators or primary care advisory staff. We need to shift the language. If somebody mentions to the receptionist that their mum is lonely, does not speak to anybody or is struggling with her food, the person can tell them that the practice has a link worker. We need to educate people about alternatives to GPs, and that advert is a good place to start. We all know people who say that receptionists are too nosy and ask too much, but that is not the case. It is about them finding the right place for people to go.

A few of my link workers do the social media pages for their practices. My old practice did a big publicity push before the pandemic in which we asked people to follow us on Facebook and Twitter. That was advertised on the television in the waiting room and printed on the bottom of prescriptions. We advertised the local groups and were able to tell people about food pantries, the over-60s social club and what was happening in the local library.

Our model is that anybody in the practice team can refer to a link worker; it does not have to be by a GP. By following on social media, the worried well, who see their doctor but do not need that appointment, can see what is happening in their community. They might be able to pick up the phone and happily take themselves along.

Roseann Logan hit the nail on the head about the people who the link workers see. They are the people who are so entrenched in their illness or social issues that they will never pick up the phone by themselves. They will certainly never be the new person who walks through the door at a community centre to join a group. However, the link worker knows that it is, for example, Mary who runs the group, that 40 people go, that it is half women and half men and that the age group is the over-50s.

Every bit of knowledge that the link worker has about the group reduces the barrier. They set the scene and the patient builds a picture of the group and they think, “Well, if Alison says it’s all right and Mary’s nice and she’s been four or five times, I’ll give it a shot. Alison is even going to come along so, when they open the door and everybody turns around, there is somebody else with me that they’re looking at.”

We get buy-in by providing people with a chum. I am all for my link workers chumming people along, because that is how we will get buy-in. As Roseann Logan says, if it takes a link worker to go along twice to get somebody settled, that is what it takes. Then, when the link worker sees the patient go themselves, it is almost as if they are saying that they do not need the link worker any more, and that is the best result that we can get.

**Emma Harper:** I have a final, short question for Christiana Melam. How can we raise awareness that link workers exist?

**Christiana Melam:** On the previous point, I was going to say that link workers are not glorified signposters, so there is a need to educate the public so that they are aware of what support and services are available. There is a need to have a directory, but the challenge has been in having someone to keep that up to date, for example.

Sometimes, there is a tendency for our public health interventions to increase inequalities because they are catering only for some people. The social prescribing link workers help those who have complex needs and those who cannot make those connections. However, there is a need for signposting, so that we do not overwhelm the social prescribing link workers, which results in those who need support not getting it.

On how we raise awareness, we need to get political buy-in. We need to have a national campaign to raise buy-in, and we also need to have campaigns that embed and embrace social prescribing link workers’ role as part of the team. We now talk about team GP—team general practice—as it is no longer just about the general practitioner. The language that we use is important for how we normalise things and for the education package that we have for clinicians.

Do we have champions? Some areas have clinical champions. We need to have more clinicians championing social prescribing, because general practice is a place where people go to be connected to all the professionals, as well as to all the services. It is not the focal point where a person is reliant on one person alone.

At the national level, we need help from the Government with that. We also need professional bodies such as the Royal College of General Practitioners Scotland to do more to raise the profile of social prescribing among their members. We have been working with professional bodies in providing podcasts, because members of the profession need training and awareness. We also need to raise awareness through working with existing patient groups such as the National Association for Patient Participation. VCSE infrastructure organisations have a role in raising awareness, too.

**The Convener:** I am aware that a lot of members want to ask questions, so we will move on to talk about health practitioners’ use of social prescribing. If the witnesses want to make any other points on the back of Emma Harper’s questions, they should, by all means, build them into their answers to further questions. I am just worried that we will run out of time, but it is incredible to hear the enthusiasm of all the witnesses about their area of expertise.

**Sue Webber (Lothian) (Con):** In 2019, the Health and Sport Committee held an inquiry that highlighted a number of barriers relating to health practitioners’ use of—[*Inaudible*.]—in primary care. Such barriers included a lack of strong evidence on its long-term effectiveness, time constraints, lack of awareness and quality assurance. Has any progress been made in tackling those barriers over the past three years? Perhaps Alison Leitch can start on that.

**Alison Leitch:** Sorry—I missed a bit at the beginning of that question.

**Sue Webber:** In 2019, when the Health and Sport Committee was taking evidence—I was not on the committee at the time—it heard about a number of barriers that healthcare practitioners faced in relation to their use of social prescribing. Those barriers included a lack of strong evidence on its long-term effectiveness, time constraints, lack of awareness and quality assurance, or how they could be assured of consistency in quality. Linked to that is the issue of continuous monitoring of whether services are still available in the community, because we know how transient some organisations can be due to lack of funding. Has any progress been made in tackling those barriers in the past three years?

**Alison Leitch:** Our programme network manager, Anne Crandles, gave evidence to that committee previously. At that time, there were to be more meetings with the Scottish Government, but then the pandemic came along.

On the point about evidence, all that the Scottish Government asks from link worker programmes is minimum core data, which is information on date of birth, gender, postcode, ethnicity, the reasons for referral and a few more things. Every year since 2017, we have produced an annual review and have given statistics on the number of referrals, the number of people who have been engaged, the gender split, the age split and the postcode split, because that fits in with the work on addressing health inequalities. The information is broken down by practice. Every month, we send out stats on engagements, referrals, did not attend—DNA—rates, funding applications and case loads, and that information goes right across our network.

As I touched on earlier, we have two GP advisers in our programme. Previously, one of them did some work to compare the attendance rate of a patient cohort group the year before they were referred to a link worker with their attendance rate the year after they had been referred to a link worker. There was a 30 per cent drop in attendance.

Link workers have also been involved in signposting training for receptionists, who were able to redirect 6 per cent of people who had requested to see a GP to other places.

That is work that we have done ourselves. Professor Stewart Mercer of the University of Edinburgh is doing more work in the area. The Elemental Core system, which will be coming on board, should give us more data to delve into, because we need to start showing our evidence.

Also, we all know that the best evidence that you can get is when you hear from a patient or when a doctor says, “I haven’t seen Mr Smith in four months—where is he?” and finds out that he is at a men’s shed or volunteering or at the walking football.

In September, Clare Cook and I hosted a session for the Scottish Government at which a patient spoke about their experience. That is the best evidence that you can get—when you hear from somebody who is living it.

**Sue Webber:** You alluded to link workers reporting that there is a lack of understanding of their role—[*Inaudible*.]—which impedes progress on social prescribing. You also mentioned some successes. What progress has been made on raising awareness of the role and on making it a much more viable route for care and support?

The point of contact still seems to be the GP practice, and we hear a lot of frustration from people who are struggling to get past the receptionist. It seems that everyone is still having to come in to the GP practice to get a referral. It was interesting to hear from Clare Cook earlier about some of the self-referral pathways. What are we doing to address the lack of understanding?

**The Convener:** Clare wanted to come in on your earlier question, so I will go to her first.

**Clare Cook:** There has been a change over the past few years, certainly in the evidence that we have been gathering. SPRING was the first to use Elemental’s Core software—we have been using it for three years and it has been really beneficial in capturing our evidence.

We measure the impact for people, communities, healthcare and Government. I have an external evaluation, which I am more than happy to share, because it captures lots of evidence. It is not just about the improvements for people—although that is incredibly important—it is about what difference we are making to GPs and the NHS. Are we reducing the pressures? That is really why we were set up, and we have evidence to show that we are doing that. I can share that evidence with you and if there are any questions, please come back to me.

In SSPN, we are asking whether we could consider having evaluation tools across the country. Could we not capture the evidence so that we prove that social prescribing has worked? The four of us who are giving evidence today all know that it works in our individual services, but how can we capture that across the country? That is an ambitious aim in the network.

I am sorry, but what was the second question? Was it about referral routes?

**Sue Webber:** You mentioned self-referral, rather than everyone having to phone the GP practice and speak to the receptionist.

**Clare Cook:** Yes—the GP is the place to go, but it can also be a barrier for some people. Some people cannot get an appointment, for various reasons, and some people are really scared to go into healthcare settings. That is why we changed our model to make it more accessible to people in the community. We are able to do that because, as Alison Leitch touched on, the third sector is really proactive and can adapt quickly. We are always changing our programme to suit the needs of the community and we are open to suggestions about different referral routes so that everyone gets the appropriate support.

**The Convener:** I will bring in Christiana Melam next, and then we will move on to questions from Evelyn Tweed.

**Christiana Melam:** On progress on gathering evidence, the National Institute for Health Research has funded a national evaluation by the University of Manchester, which will look at some programmes in Scotland as well as programmes elsewhere. That will be helpful in building the evidence base. I think that it will be a three-year study.

However, to echo what my colleagues have said, we have a problem with people understanding what we do in the first place. The role glues together the community and the NHS. I worry that we might be measuring the wrong things. It is about relationships and integrating care and social prescribing. The patients say that it makes them happy—how can you quantify that? We have to be careful, because we cannot do a randomised control trial, as there are variables that we would not be able to control. That approach is not applicable to social prescribing and we have to rely on social care research.

10:00

Before this meeting, I had a round table with some of our members, and I was thinking about why I constantly need to evidence that we are doing great work. Some other professionals do not have to do that. Are we measuring the right things in the first place? Some of the services and activities to which we refer people are already evidence based. We know about the impact and value of physical activity, eating well and being connected to your community. Social prescriber link workers are the people who make those links and remove the barriers.

Another challenge for us is that we need to increase capacity. Some social prescribing link workers are at capacity. Covid has highlighted the needs that people have and that they are not seeking health interventions or support, and it has highlighted to clinicians the value that link workers bring to their communities.

If social prescribing is to be mainstreamed, we need to get ambitious about the numbers. We definitely need to increase capacity, and we need to protect the workforce. We cannot have a cycle of bringing people in but not having plans or standards, with workers getting burned out and nobody looking at their career progression, education needs and so on. That makes the job unattractive.

We need to think about how we increase capacity. The pandemic has not helped us to make progress when it comes to evaluating the approach, because the role of some social prescribing link workers has changed as everyone has had to adapt. The question now is: what is the remobilisation plan for social prescribing in Scotland? How are we going to recharge communities and start groups that are able to provide what is needed? How will we ensure that we have more people who can listen to patients and ask them what matters to them and how they are? At the moment, when people do not feel listened to, there is a big problem. People are being told that no appointment is available, but they need to be heard first. How do we do that?

How do we increase resources so that people do not have to go through the GP in the first place? We cannot manufacture more GPs—it takes a long time to train them and other clinicians—so what we have at the moment is community. It is non-clinical roles and community assets that can help, and those can be deployed immediately.

**The Convener:** That takes us very nicely on to our next theme, which is community organisations.

**Evelyn Tweed (Stirling) (SNP):** Good morning, panel. To what extent does the third sector have capacity to deliver more socially prescribed activities? I will direct the question to Alison Leitch first and, if anyone else wants to come in, they should do.

**Alison Leitch:** The third sector has been massively impacted by the pandemic. Everything shut down right away, and the sector is only slowly coming back out of that.

We have touched on a couple of the issues already. The third sector can be very responsive—it can respond to almost anything that is asked of it—but it needs to be properly resourced. As someone said earlier, social prescribing is only as good as the resources that we can prescribe for people. That is the biggest challenge that we face.

Since our network was set up in 2017, we have said that part of a link worker’s role is to highlight gaps in services. They should also highlight the services that work well. We have a couple of success stories about joint funding applications for self-management courses, so that people have not had to wait for funding to come through the statutory route, but such courses are few and far between and they are always short lived, which is not what we want. Things have to be sustainable.

Link workers do a great job, but they place extra demands on the third sector, so there needs to be investment in the sector. It would be ideal if we could get primary care involved in the funding decisions, to firm up collaborative working and acknowledge the good work that the third sector can do in supporting state services.

**Roseann Logan:** To echo what Alison Leitch said, especially during the pandemic, a lot of third sector organisations changed and adapted what they delivered. In Glasgow, when other services were not available, a lot of small local organisations really stepped up, took hold and supported communities. As we move forward, it is sad that a lot of those organisations are no longer being funded, so we will lose them. It really saddens me that a lot of our links workers will not have those valuable resources to link in with.

We are really fortunate that we have been able to work collaboratively with other third sector organisations on funding bids and supporting funding streams. We have also looked at getting spaces in health centres to allow some national organisations from further afield to offer services, so that individuals do not have to travel to other areas. That is not just in the city. For example, we linked in with the Moira Anderson Foundation, because we had a number of individuals who, due to childhood sexual abuse, required support and services. However, for a lot of people, travelling to Airdrie was outwith their comfort zone and financial capability. Therefore, it has been invaluable for us to be able to support those organisations to offer their services on people’s doorstep in Glasgow.

This is going back quite a bit but, in 2016, Kathryn Skivington at the University of Glasgow published a piece of research on the impact of links workers on the third sector. That was primarily around the time when the Glasgow service was a pilot. She looked at the impact of links workers referring to third sector services. The research found that, although there was an increase in referrals because links workers were referring into the services, the referrals were more likely to be appropriate so, in the long term, that took up less time.

Previously, services would get inappropriate referrals, so they would have to work through that process and realise that the referral was not appropriate. Although the links workers made more referrals, they were appropriate, so more time was spent with individuals rather than on the process of referring someone back or trying to link them in with another service.

Moving forward, we need to look at funding streams for our third sector. Maybe we should not call it the third sector, because it is not third—it is just as important as any of the other statutory sectors, so we need to give it the same place at the table.

**The Convener:** That is a good point.

I am looking at the clock, and some members still want to come in on other themes, so I ask Evelyn Tweed to direct her supplementary question to somebody.

**Clare Cook:** I will comment quickly. I will not go over all the ground that Alison Leitch and Roseann Logan covered, but I absolutely agree with their comments.

As part of SPRING’s work, to alleviate the capacity issues that organisations face, we built in a capacity fund to cushion the blow when lots of people are referred for different services, so that they can put on more activities and groups.

I also want to comment on a solution. The organisation that I work for, Scottish Communities for Health and Wellbeing, has written a “Blueprint for a Healthier Scotland” proposal, which talks about capacity and offers a solution for the issues that we have. I do not have enough time to go into that today, but I will send the proposal to the committee, so that you can comment on it and maybe get back to me. That solution is definitely there for the Scottish Government.

**Evelyn Tweed:** To what extent does a lack of reliable up-to-date local information about services hamper the ability of health practitioners to use social prescribing? That question goes to Roseann Logan.

**Roseann Logan:** That is really important. Links practitioners, links workers, care navigators and community connectors all need to know what is going on in their areas. In Glasgow, at the start of the pandemic, although we did not have links workers in every GP practice in each cluster where we were based, we realised that we could have a resource to support all those practices.

At the start of the pandemic when we went into lockdown, we allocated a particular links worker to each cluster. Every week, they would look at resources and take time out of their working week to link with the organisations and ensure that information was up to date. That was a real time constraint for links workers who are based in practice and have benchmarks of referrals that they need to achieve. We need to look at how we can have much more robust links with the services that are available.

Some of the responsibility also goes to the organisations to ensure that they keep up to date. Within the alliance, we have the ALISS—a local information system for Scotland—programme. I know that one of my colleagues is going to speak about that in the next evidence session. Across the country, there are different directories, but they all take time. A digital directory might be great for some individuals, but there is the issue of digital exclusion, which is a completely different theme that we have not even touched on yet. We want to make sure that resources are available for everyone to access, so we need to get that message across and keep on top of the changes that are taking place in services and service delivery.

**The Convener:** My colleague Paul O'Kane will touch on digital exclusion later on in the meeting.

I will take a quick supplementary question from Stephanie Callaghan. I am aware that Christiana Melam wants to come in on that theme but, in the interests of time, I will put Stephanie's question into the mix.

**Stephanie Callaghan (Uddingston and Bellshill) (SNP):** Thank you, convener. I want to pick up on some of what Roseann Logan said and I was going to direct my question to Christiana, although both of you might want to comment. How widely is the ALISS database being used? Is it the right system? Should we be investing in it and ramping it up, or should we look at whether something more local would work a bit better?

**Christiana Melam:** When we were preparing for this evidence session, I met some of our members in Scotland. A few of them who were not using ALISS said that it does not fit with their locality because their needs are different from what is available. They still use their own local directories. There is a role for a national directory in which people can find information, but it will not take away the need for local information databases. Some of the groups that link workers find might be small community groups that are not very formal and are known about by only a few people.

We need to recognise that this is all about social change. We need to fund a whole social prescribing service. Some social prescribing services are robust, and they will have a project management officer or somebody who looks after their internal directory of services. This is the same as the challenges that GPs have always had—who is keeping the directory of what signposting options are available? We cannot just have a social prescribing link worker taking responsibility for that because, again, we need to meet people's needs. Some people need information and signposting, and some have not identified what they want to do in the first place, and that is when they need a social prescribing link worker or they meet a barrier. We need to empower people to know where they go to find reliable and up-to-date information, but the social prescribing programme will still have its own database.

To go back to my point about reducing inequalities and social justice, part of the social prescribing link worker's role is to identify gaps and, in doing so, identify marginalised communities or communities that are at risk of marginalisation and show that services are not available for those people. The challenge has been around who takes responsibility for that. That is not something that you bring up at a MDT meeting. The MDT meeting is focusing on a different thing.

This is how we truly begin to reduce inequalities. When there is nothing available for some groups, if you feed that back to the infrastructure VCSE organisation, does it take that on board? Short-term funding also becomes a problem. I will give you an example. I attend a walking group for women of colour, but now, because it is volunteer led, it is no longer sustainable and it is not putting on a lot of walks. That is a good case study of a group that an infrastructure organisation should be able to support so that it is sustainable.

10:15

We are doing that, but what is the role of the VCSE in that? Is its funding mechanism a hindrance that means that it is not very outward looking and is not able to capture intelligence from the social prescribing link workers? Is there no mechanism to feed that intelligence back?

It is about creative disruption. Everybody—whether that is a GP practice or a VCSE—needs to wake up to the times that we are in. We need a bit of creative and disruptive thinking to ensure that we are proactively meeting needs and are evidence informed, and that we are not just replicating the same service over and over again.

**The Convener:** Alison Leitch wants to come in on that, and then we must move on to questions from Sandesh Gulhane.

**Alison Leitch:** In the Scottish community link worker network that has been set up, we have been discussing the sources of information. ALISS is not used by a huge number of authorities; authorities spend money on setting up their own online resource. In Edinburgh, we have the red book—we are having that linked up to the Elemental Core system, but I know from my link workers that there is already an iThrive directory and the long-term conditions directory. Even within Edinburgh, therefore, there are four different directories that my link workers check, in addition to using their local knowledge and social media.

That is an issue, and it is always a challenge to keep those directories up to date. I am constantly asking my link workers to let us know about changes to the red book. In addition, as Roseann Logan touched on, there should be some responsibility on local groups to keep the directories up to date. Those online resources are not just about health inequalities; they are for anybody. We know, through the increased number of link workers in primary care improvement plan surgeries, that loneliness can affect anybody, so those resources need to be accessible for everybody. We have touched on digital exclusion, which was highlighted at the start of the pandemic. I know that that will be discussed later, so I will leave it there.

**Sandesh Gulhane (Glasgow) (Con):** I want to pick up on something that Alison Leitch said at the beginning of the session, about how much GPs like having link workers. As a working GP, I can tell you that I love my link worker, because they take a lot of work away from me around social issues, navigating benefits and so on. I simply cannot do those things, because I do not have time, so I absolutely love my link worker.

I have two questions. One is on recruitment and the other is on retention. The Scottish Government was looking to recruit 250 community link workers in GP surgeries by 2021, but there are areas such as Aberdeenshire, Forth Valley, Midlothian, Highlands and the Western Isles without any link workers. What assessment have you made of the efforts that have been made in that regard? How can we stop areas from falling further behind?

**Alison Leitch:** That is one of the challenges that the Scottish community link worker network has been tasked with addressing. The Scottish Government has funded Voluntary Health Scotland to run that project, and there is a mapping exercise just now on tracfking where those 250 link workers are. I think that there was an article that said that there were currently 210 link workers. Voluntary Health Scotland is working on that. There is a steering group with various representatives, and I am on the working group. We are also looking at the training of link workers. There have been two peer support sessions, this month and last month, to ask link workers what training they would like.

I am sorry—I have forgotten the second part of the question.

**Sandesh Gulhane:** What can we do to stop other areas falling behind?

**Alison Leitch:** We need to map the existing picture to see how many link workers are actually out there. We plan to get information on what each programme is—for example, is it a health inequalities programme or a general one? What evaluation has been done? We need a mapping exercise of what the link worker programme looks like in Scotland, so that we can build on it.

There is a commitment to 1,000 mental health link workers, and last year the Royal College of General Practitioners put out a manifesto pledge seeking to have link workers placed in every surgery, concentrating on areas of deprivation first.

First of all, we need to see exactly what the scene is like in Scotland. That will be complemented by the work of the Scottish Social Prescribing Network, which will map all the social prescribing programmes that are not funded through the Scottish Government, such as Clare Cook's programme, to see what the overall social prescribing picture looks like. That will be our starting point.

**Sandesh Gulhane:** My other question is about retention. I am a bit concerned about that, because a report in 2020 suggested that one in three link workers planned to resign within a year due to a lack of support and supervision. To what extent are those problems undermining the shift to social prescribing? What can we do to reverse that?

**Alison Leitch:** If that was the National Association of Link Workers report, the response to that report in Scotland was minimal. The establishment of the Scottish community link worker network has highlighted the huge differences between the programmes that are set up. We had a leads and managers meeting just the other week, and in Edinburgh we are adamant that the link workers should be paid a salary that is equivalent to band 5 in the NHS. Every time our service level agreements are up for renewal, that gets tightened, but we know that, where people are paid the lowest rates, they will jump to where the pay is higher as soon as a vacancy comes up.

We were told that Dumfries and Galloway's link workers are paid only at band 3 and that that is constantly being squeezed, so recruitment is hard there, whereas in Edinburgh we have hardly lost anybody. The people we have lost have either moved away, gone back to studying or taken a career break. We do not have a lot of turnover because we are passionate about link workers being seen as being on a level with the multidisciplinary teams in practices.

We then need to consider the additional things that we can do through training and continuing professional development to help to professionalise the role. We have encouraged our link workers to take part in the Scottish network and in peer support sessions so that, collaboratively, all link workers across the country have a voice that can have an influence at Government level.

**Christiana Melam:** There is without a doubt a problem around quality, safety and retention. We also did a survey and we are trying to explore the prospect of a professional register. That work was led by England, but we used that opportunity to consult our members across the UK. Over 70 per cent called for a register, because of the challenges that they have in not being seen as professionals, the pay issues, the lack of training and educational opportunities, and the sustainability of the role.

We also do an annual survey, and some link workers in Scotland said that they had colleagues in the same area who were on another pay band. There is something here about inequality among the social prescribing link worker workforce. How can link workers be expected to help to reduce inequalities and social injustice when they are experiencing those things themselves? I do not think that that is specific to link workers, because other professions also face it, but when a profession is just setting up its identity, it is at risk of those things.

We are developing education standards, which we are going to launch in May. Again, we are having conversations about them with Wales, as well as with Education Scotland. We need to have something that says, “This is what these people do, and these are the levels of experience and knowledge that they are required to have.” People can come in as experts, but expertise is not professionalism. Professionalism is about the way in which people carry out the role. Our concern is that, when we roll something out at scale and use taxpayers’ money to do that, people need to be protected—even though they have previous experience—through assurance that they are doing it as a professional role and not just as a hobby. That will mean that we get away from the postcode lottery.

Standardising the pay is a big challenge, and we need to make sure that link workers get the education and training that they need. That is a national issue but also a global one—there is a Global Social Prescribing Alliance as well.

It is important to pay attention to the ethics of the role and to the professional standards. The work is not regulated, but we need to have some baseline. There are link workers in different areas, and everyone has different levels of experience and expertise, but the patient just knows that they saw a link worker. We need to sort out whether people have the right level. That is the reason why there is the National Association of Link Workers, and it is why we are working with bodies that are concerned with education and workforce development, so that we have a workforce strategy.

What is the workforce strategy for social prescribing link workers in Scotland? That strategy should take into account how we grow the workforce. We do not have the standards at the moment. How do people who want to be social prescribing link workers become one? We are indirectly excluding people. We do not have enough apprenticeships or traineeships, and we are not maximising the opportunity that they bring.

People who have been in the role are not declaring where they are moving on to. Having standards and mechanisms means that people can move on other clinical and non-clinical roles around the system. We have created a profession, but it does not have everything that we need, particularly in Scotland, where things are really lacking. All the other nations are stepping up to the mark, with support being offered for their social-prescribing link workers. At the moment, that is lacking here.

**Gillian Mackay (Central Scotland) (Green):** Good morning, panel. Social prescribing covers a wide range of activities and organisations, as we have heard from all of you this morning. Do community link workers have time and capacity to engage with all aspects of social prescribing? Is there a risk that they are being asked to help people with an ever expanding range of issues, from mental ill health to financial concerns, together with the many other things that you have all detailed this morning, but without any increased capacity and support?

**Clare Cook:** Yes, I think that they have capacity—certainly my social prescribers. They would not do all of that. For money worries or financial issues, they would support the person to engage in services that deal with that professionally, such as citizens advice bureaux or Money Matters. They would physically support the person to get to the right access.

It is not a matter of the social prescriber doing everything; it is about ensuring that they get the right professional support that they require.

**The Convener:** Would anyone else like to come in on that, or are we content to move on?

**Alison Leitch:** If anything, my link workers are seeing huge demand right now on welfare rights. That involves the services that are around to support link workers to do their job effectively with the increase in demand. Link workers have had a say on the money that has come out of the health and wellbeing fund, and we hope that that is directed to areas where it will help to support link workers in referring people.

On the point about their capacity, link workers have an ability to be incredibly flexible as they meet people’s needs while enforcing their boundaries and knowing where they can be effective and where they cannot—where they would do more harm to the patient or to themselves. We have to look after our link workers.

**Roseann Logan:** There has been capacity building for links workers in mental health services, especially over Covid. A lot more links workers have had to hold patients, so to speak, because the statutory services are not there or there is a long waiting list. People are coming back to general practices. Referrals are being made, but patients are being told that there is a six-month or nine-month waiting list for some trauma services. For one individual in Glasgow, it was 27 months from the initial referral before a service was put in place for them.

Those individuals must have somewhere to go, and they come back to their general practice. GPs look to their links workers to support those individuals, and we are looking into some creative ways to do that. There could be locality approaches, in which a few links workers come together to set up a conversation cafe—that means that they do not all have to be available but can attend on a rota—where individuals who are waiting for services to become available have somewhere that they can go and feel listened to and supported. That is important as we start to come out of the pandemic, because there will be even more of a tsunami regarding mental health and wellbeing services and individuals who need support.

10:30

**The Convener:** We have extended our session by around 10 minutes, because we want to give a good airing to the inequalities theme, with questions led by Paul O’Kane.

**Paul O’Kane (West Scotland) (Lab):** A lot of the answers and discussion have been peppered by mention of the barriers that exist to accessing the sorts of pathways and interventions that there are. I am interested in your views about the potential for the exacerbation of inequalities.

Roseann Logan talked about the need for support and for someone to be accompanied to certain activities and have that intervention. In its written evidence, the alliance spoke about some of the challenges in relation to passes for sports and leisure activities. For example, if someone has never had the support to learn to swim and is given a leisure pass that ends after six weeks, would that increase those barriers, because that person would feel like it did not help them? Related to that, is the financial barrier to being able to continue with some of those activities after that six-week period too high? I am sorry—I appreciate that that was a lot. I drew some of that from the alliance’s evidence, so does Roseann want to start?

**Roseann Logan:** Yes, definitely. One of the big barriers that we face when we are linking into other resources is that we have to consider whether there will be financial exclusion for individuals. We try as much as we can to ensure that the services that we are accessing either have a set fee or will consider an individual’s financial status when it comes to access, especially for some counselling services, such as anger management. There is a service in Glasgow that we would link into that has a flat fee but, after talking with our programme about referral pathways, it now offers people the opportunity to pay what they can afford. It is about looking at where services can accommodate that.

It is great that GPs and link workers can get patients access to leisure facilities in Glasgow but, as you say, it ends after six weeks, and £15 a month is a lot of money for some people—do they not have food for a week or do they take on the gym membership? That is before we think about individuals who would not have recourse to public funds. What can we highlight for individuals? We try to link in with organisations or assets in our communities that are free, because we are mindful that, although some people might think that £15 is not a lot of money, for a lot of the individuals we work with, £15 is a lottery win.

There are a lot of great resources in the communities in which we work, and the opportunity for people to link in is very important. In Glasgow, the HSCP has some practice development money, and some of our GP practices have used some of that funding to buy pantry vouchers, because for some people there can be stigma in accessing food banks and they do not want to use them. They may prefer to go to a food pantry where they have more choice; we can highlight that and give them the voucher so that they do not even have to have the £2.50. Anecdotally, we have noticed that that increases people’s self-worth, and you cannot put a price on that—all that it took to do that was a £2.50 food pantry voucher. We need to look at how we fund our community assets and make sure that resources are available in the localities and neighbourhoods that need them.

**Alison Leitch:** The swimming example is a good one. There is a healthy active minds programme in Edinburgh, where people can join a programme and then get access to Edinburgh Leisure facilities for £1 a time. That applies only for a year, and participants cannot be referred to it again, so all the good that can be done by allowing someone to access sports facilities then disappears after a year. We do not know what those people’s situations are or whether they could get into work so that they can have sustainable access to those facilities. I would like to see an overarching social prescribing framework so that all that can be fed back in order to influence the bigger strategies, such as public health.

At the beginning of the pandemic, the UK Government launched an obesity strategy because of the people who were ending up in intensive care. There were initiatives to get your bike fixed and get out and get moving. I would like there to be a collective voice in social prescribing that provides feedback about the challenges to keeping people well, which impact the wider population. Through an overarching social prescribing structure in the Scottish Government, I would like to see link workers and social prescribers being able to influence change at Government level so that we do not find people falling off a cliff after so long, because that just means sending them back to the issues that they came to us with in the first place.

**Christiana Melam:** We would like to see who is benefiting from social prescribing and for that to be broken down by demographic data, because what is beginning to be highlighted is that we need more diversity in the social prescribing workforce. It is important that we look at who is benefiting from social prescribing. If this work is about social injustice and inequalities, then as a society, we need to be prepared to fund social prescribing in order to help people. Some people who are vulnerable and benefiting from social prescribing may not initially have the means to do that, whereas some people, with support, can find the means.

Let us be careful about what social injustice can do. It stereotypes people and by default silences their voices. Those who need help should be able to get that for free; those people who are able to move on should be able to do that and should not be put into a category—“Oh, this is an asylum seeker,” “Oh, this is a BME person,” or, “Oh, this is a disabled person.” Those people can also work and start businesses or social enterprises. People have aspirations and I would like to see how we are supporting those aspirations, as well as considering how we help those who are not capable or are not able to participate in society.

**Paul O’Kane:** Thank you. Those were very helpful responses.

I picked up that we want to avoid any sense that interventions would appear paternalistic, or any sense that things are being done to people. From what the witnesses have said, it is very much about collaboration between the link worker and the patient.

I will go back to Roseann Logan on her point about the pathway into sport. Is any work being done to look at how people who have had an initial block of training to access sports are subsequently encouraged or supported to join a local club that is free? Very often, a lot of the barriers are about having the confidence to join a club that is free and get involved. I wonder whether there is a sense that link workers could train and support someone initially and then help them to access the free clubs that already exist in our communities. I am keen to understand how common that is.

**Roseann Logan:** It varies across areas. I know of areas where we have linked into football sessions. For example, we have looked at football fans and training and walking football for specific individuals. We have also been involved in work on sports such as tennis that people may see as being elitist. There is a great initiative in the Drumchapel area of Glasgow in which we have worked with individuals and encouraged them to become involved. They have started by having free lessons and have then been able to join the club in that neighbourhood. It is free to come along and the equipment that they require has been made available. Those kinds of things are quite few and far between.

Many of the groups that we link with, such as walking groups, are for sports that do not involve equipment and are free. We were fortunate to receive funding from Paths for All and were able to bring walking groups together for celebration events every year and take people to different areas, such as the Kelpies. Our work is about opening opportunities for individuals, but there is still a lot of work to be done to tackle inequalities, especially in the sports sector. Many sports are not available or are not inclusive for many of the individuals who we work alongside.

**The Convener:** I will give the last word to Alison Leitch, and then I will need to round off the session.

**Alison Leitch:** We have quite a lot of activities that are free and accessible, such as walking groups, walking football, street soccer and other different things, but, sadly, link workers report that people do not have the equipment to participate, whether that is a pair of decent walking shoes or a waterproof jacket. Link workers have to then find the funds to get those basics. The few asylum seekers who I can think of that have no recourse to public funds would struggle to engage in any sporting activities because of the minimal income that they have, and link workers are very conscious of that.

**The Convener:** I thank the four panel members for their evidence, which has been very interesting and helpful. We need to round off the session. We will have a 10-minute break before we come back with the second panel.

10:41

*Meeting suspended.*

10:52

*On resuming—*

**The Convener:** We move to our second evidence session, in which we will examine the role of technology in alternative pathways to primary care. I welcome Scott Henderson, who is head of programme for digital front door at the Scottish Government, who is representing Technology Enabled Care Scotland; Chris Mackie, who is digital hub and ALISS programme manager at the Health and Social Care Alliance Scotland; Dr Paul Perry, who is associate medical director at NHS 24; and Adam Stachura, who is head of policy and communications at Age Scotland.

Your ears will have been burning during our evidence sessions, because the role of technology in alternative pathways to primary care has come up throughout our inquiry. I will begin by asking about the awareness of patients and the public of the digital services that are available. Do you think that people find them useful? Do they understand what is available? Do such services give the people of Scotland greater capacity to manage their own healthcare? Obviously, that will depend on the demographic, although I do not want to pre-empt what you have to say.

I would be interested to hear everyone's thoughts on those issues, starting with Scott Henderson.

**Scott Henderson (Technology Enabled Care Scotland):** Good morning, and thank you for inviting me to give evidence today.

In general, there is good awareness of some services and not so much awareness of others. That reflects the nature of how services have developed, with some being more mature than others.

With regard to understanding, I think that there is good understanding of simple services but, with more complex services, more support is required.

As for giving people more capacity to manage their own healthcare, there is evidence to suggest that such an approach is helpful. Encouragingly, some of the evidence that has emerged over the years suggests that that approach, which I guess has been in development for some time now, is starting to show some maturity.

**Chris Mackie (Health and Social Care Alliance Scotland):** Good morning. The development of digital health and social care technologies is really benefiting some people, but there is the risk of inequalities widening in Scotland if, as we are seeing, we leave some people behind. I would urge the consideration of human rights principles when we develop such innovations. There is no question but that innovation and progress are good, but we must not leave people behind.

At the alliance, we have worked with Scottish Care and Vox Scotland on a number of human rights principles for digital health and social care that we are keen to see embedded in the Scottish Government's approaches to digital health and care, which will, of course, promote alternative pathways. I will quickly run through them.

First, we need to put people, not technology, at the centre. Secondly, we should have digital where it is best suited, by which we mean that digital is sometimes not the best solution. Thirdly, digital should be an on-going choice; in other words, people can and should be able to choose not to use such solutions, but they should also be able to opt into them. Of course, that choice should be a meaningful one, which brings us on to the fourth principle, which is about digital inclusion and ensuring that people have the skills and confidence to use such solutions. That is also about promoting workforce development and ensuring that the workforce is equipped to use those tools. The final principle relates to access to and control of digital data, which is something that we have been considering and talking about with regard to the approaches that the Scottish Government has set out in its consultation on its data strategy.

The digital approaches that we are seeing are good. However, they are not for everyone and should not be applicable to every scenario. It is therefore important that we consider inequalities and human rights principles in developing such solutions.

**Dr Paul Perry (NHS 24):** I am the associate medical director at NHS 24. I should also disclose that I am a GP in NHS Lothian's out-of-hours service, but as far as the remit of today's meeting is concerned, I will be giving evidence on behalf of NHS 24.

NHS 24 is Scotland's national provider of telephone and digital services, and we work with partners and stakeholders to provide information access to urgent in-hours and out-of-hours care for people in Scotland.

In response to the question on awareness, NHS 24 currently provides alternative pathways to primary care, particularly those with a digital angle. Back in 2016, we commissioned a progressive piece of market research that looked at public awareness with regard to the issue of trust and the NHS 24 brand. That work, which was updated in 2020 during the pandemic, showed very high awareness of the help and advice that NHS 24 provides through digital channels. Indeed, 88 per cent of participants said that there were great benefits to those services, both in hours and out of hours. Overall, the research showed that there was increased understanding of NHS 24 digital services, particularly NHS Inform.

Good examples of the digital services that NHS 24 provides include the implementation of the Scottish dental emergency service, and we specifically used NHS Near Me technologies to design, develop and implement that pathway during the pandemic.

Another example is our use of social media. We provide annual winter campaigns via that medium; we have just done that during the recent festive period. We also use social media and technologies to increase awareness of health-related topics, such as the menopause.

In summary, NHS 24 is mindful that there is still a lot of work to do on awareness. There also needs to be further awareness of alternative pathways, particularly technology-enabled care, and how to tap into those aspects of primary care.

11:00

**The Convener:** Awareness is one thing, but there is also choice. Digital care is not for everyone. We see that in our inboxes—we have people emailing us saying, “I’ve been fobbed off” and “I want to see someone face to face”. Are you cognisant of that?

**Dr Perry:** Yes, we are cognisant of that. That is about offering patients and the public choices, not removing them. NHS 24 is very much patient centred. We have a user-centred experience team that looks at user-centred design when we are designing and implementing services, particularly those centred around technology, and they look at that from a service development and delivery angle, too.

When we looked at the NHS Inform platform, we realised that we needed to design a platform that is used in different languages. Another example is the NHS 24 111 service. That telephony service also uses the LanguageLine system for people who do not have English as their first language. NHS 24 is very mindful of reducing inequalities.

**Adam Stachura (Age Scotland):** There is no doubt that, during the past two years, people have been far more aware of digital services and digital access to medical services than ever before. That is largely because, for many, it was the only way that they could access such services. For many people, it has been good. However, for a great number of people, it might not have been so good because they have not had the access to a device, or to the internet, or been able to navigate a whole new system. There have been considerable challenges for people in that regard.

Scotland is not luddite in any way, but about half a million over-60s do not use the internet, and 600,000 over-60s do not have the internet on a smartphone. That is a huge number of people who will miss out.

For many people, their first port of call might be their GP practice’s website. However, how those websites look, how accessible they are and how easy they are to navigate is a bit of a mixed bag.

There are challenges galore for people, but strides have been made in accessing services digitally, and a lot of people have found that to be very helpful indeed.

**The Convener:** I want to pick up on what Chris Mackie said about human rights. Last week, the committee heard from Jess Sussmann, who is policy lead for the Royal College of Psychiatrists in Scotland. She pointed to the fact that a lot of patients who her members see have acute mental ill-health conditions, and that, for a lot of them, doing things digitally effectively cancelled out their access to healthcare because most of them would not do that. Where do we stand on making sure that a spread of services that are right for the individual are made available?

**Chris Mackie:** As has just been said, we should not be closing any doors. We need to open up complementary approaches to ensure that those who do not have devices, data, or the skills and confidence to use them can still access health and social care services.

At the same time, we need to take advantage of the innovations and advances that we have made. We have seen great benefits from the use of the Near Me platform. We need to offer that as a complementary approach so that people do not feel that they have been fobbed off and they are still able to access services in the way that they feel comfortable with.

It is about not throwing the baby out with the bath water. We should make progress and exploit technological advances, but we need to bear in mind that we have a diverse and ageing population, and that lots of factors will play in to whether people can use digital options. Lots of people will not or cannot use those digital options, so we must not close down the other avenues.

**Gillian Mackay:** In its submission, NHS 24 highlighted that, in stressful moments, when people are feeling unwell or in pain,

> “figuring out ... what is available ... can be a new pressure”,

which often results in them reverting to the use of traditional access points such as general practice or accident and emergency.

That suggests that we need proactive communication so that people are already aware of what is available before they reach that stressful point. How successful has proactive messaging been, and what more needs to be done to ensure that people are fully aware of where they should go when they need unscheduled care?

**Dr Perry:** NHS 24 carries out national communications campaigns. Some examples are the campaigns on redesign of the urgent care pathway, which was implemented in December 2020, and on the dental pathway that we set up during the pandemic.

We are very active on social media, where we signpost the public and patients to the right care in the right place at the right time, and we are very mindful of doing that in the best way that we can.

**Gillian Mackay:** As we have picked up on already, not everyone has access to the internet or to electronic devices that will allow them to quickly visit NHS Inform, for example. During the pandemic, we have seen reactive and quick changes to capacity and to where people should receive care. How do we communicate changes in how care should be accessed to people who are experiencing digital exclusion?

**Scott Henderson:** Could you repeat that question, please? I am not sure that I heard all of it.

**Gillian Mackay:** Of course. As we have picked up on already, not everyone has access to the internet or to electronic devices that allow them to quickly access NHS Inform. During the pandemic, places where people receive care have had to change quickly and at short notice. How do we communicate changes to how their care should be accessed to people who are perhaps digitally excluded?

**Scott Henderson:** That is a really good question. Throughout the pandemic, we have been relying on the connecting Scotland programme to facilitate access to devices as well as to upskilling where that is required. There is still a significant amount of work to be done through that programme. Certainly, any programmes that I have been involved with seek to work alongside the connecting Scotland programme to ensure that that access is made available. I do not think that I can speak for NHS Inform on that.

**Dr Perry:** On communicating about care to the public and to patients, we at NHS 24 are very mindful of those digital and public health inequalities and about reducing those barriers as best we can as a nation.

Alongside the digital channels and services that we provide, we offer our 111 phone line, which goes some way towards reducing those barriers for patients who do not have that same digital access.

Our user-centred and experienced team are very well equipped with regard to service development and delivering services with the patient in mind, particularly patients who do not have access to digital services and channels, apps, mobile devices, wi-fi and broadband. We are very mindful of those members of the public who do not have access to those digital ways of accessing care, and that very much forms a part of service development and delivery.

**The Convener:** We will now go to Adam Stachura for the Age Scotland perspective.

**Adam Stachura:** It is a very good question, and I think that the answer is that you go where the people are. For example, we have had nationwide leaflet drops in the hope that people will understand how a community pharmacy can help them more than they might have imagined and why their GP might not be the first place to go. We also hope that will keep the booklets in their homes.

However, those leaflet drops have to be done regularly, because people can move, lose things and so on. Indeed, material should also be available in medical settings for people to take away as a useful and quick reference. We also need television and radio advertisements.

Another challenge is that, depending on where you live, you might have fewer options with regard to where you can go. Indeed, the general practice or the hospital might be the only places within reasonable distance where you can go to access medical treatment or if you are unwell. Therefore, those other pathways might not exist in rural, remote and island Scotland.

**The Convener:** Paul O’Kane has some questions on digital exclusion.

**Paul O’Kane:** Good morning, panel. I want to follow the path that other colleagues have been going down on digital exclusion. We have heard evidence from patient groups—in particular, the Riverside patient participation group from Musselburgh, which noted that approximately 10 per cent of the population has no access to new forms of technology, or does not have the skills that are required to use them. Given that those patients are most likely to have the greatest health needs, what else can we do to protect their right to access primary health care? Would Chris Mackie like to go first?

**Chris Mackie:** Thank you for that very good question. I talked about human rights earlier. We know that some people have no access to technology—they have no devices, no data, no skills and no confidence. In some cases, the answer is to keep other options open for them, and in others, the answer is to provide them with devices and data—the connecting Scotland programme has made great strides in that respect.

We also need to think about who can help. There are, for example, digital champions, who have come to the fore through the connecting Scotland programme. We might also need to consider having what might be called a digital advocate; that person might be a family carer or a social contact who could use digital tools on the person's behalf.

The point is that there are approaches coming on stream through digital health and social care that people can benefit from without their having to access them in person. Regardless of whether the person who helps is a support worker or someone else whom the individual knows and trusts to use such avenues, we need to consider such options to ensure that even when a person does not have a device or the skills and confidence to use it, they can still benefit from digital technologies. After all, we see significant benefits in their use.

**The Convener:** Scott Henderson wants to come in.

11:15

**Scott Henderson:** From a Scottish Government policy perspective, digital services are seen as being additional to, rather than instead of, traditional services. It is about providing the opportunity for people who are willing and able to access services differently to do so, and supporting them in that.

Chris Mackie rightly referred to the connecting Scotland programme, which supports people who want to access services in that way to acquire the necessary means and skills. There is pretty good evidence that suggests that investment in that is worth it. Studies have shown that there is a reduction in the number of people just turning up at services because they have no other option. We need to be mindful that what we design and bring into service from this point forward does not replace provision but instead supplements or complements it.

**Paul O'Kane:** I want to explore that further. Chris Mackie's point about who can support and advise is interesting. I am keen on what we can do in libraries in Scotland. I raised that point previously with Citizens Advice Scotland, which talked about some of its services. I am not sure, however, that there is universal coverage by such services. There is an opportunity to do more on that. Do the witnesses have reflections on that? Do the people whom Adam Stachura deals with through Age Scotland, for example, interact with library services?

**Adam Stachura:** We know how important libraries and community centres are. In the past two years, the doors have been closed at those support services. As they reopen—we need them to reopen—they can become valuable places in which services can be hosted and where people can get the information that they require.

There could also be a bunch of phone services. People might not always want to interact with the NHS. Age Scotland has a national helpline on which our advisers can help by directly referring or signposting people to the services that they need.

We often hear from people who have just not been able to get to services in the first place. To go back to Paul O'Kane's earlier point about what more we can do, I note that the starting position is that quite a lot of people might be unable to go online to interact with services, or to do it on the telephone.

We need to consider how we make sure that doors are open, in general. We can direct people to a digital service if that is appropriate, but doors being closed has been a big challenge. Especially in NHS settings over the past two years, we have almost been trying to keep as many people away as possible unless they desperately needed to be in. That has come through loud and clear.

GPs and other health professionals will want to see anyone who presents, but there has been the underlying idea that people should stay away to protect the NHS. When we surveyed 3,500 over-50s at this point last year, a core theme was people thinking that they were not able to access services. The longer people go without the medical treatment that they require, or that they think they need, the poorer might be their health and the more the challenge is exacerbated.

**Dr Perry:** I want to build on those points. Reducing barriers around digital and health inequalities is about offering choices rather than removing them. At the beginning of last year, NHS 24 was commissioned to do a piece of market, or user, research on digital access. The learning points that were gained from that were about health access—in essence, the public want more information that is tailored to their conditions. As a clinician, I know that every patient whom I see is different from the next patient in my waiting room. Every member of the public wants a journey that is tailored to their condition.

Patient journeys are often multifactoral and have multiple touch points. A patient journey might start off as a face-to-face consultation, but a digital element or other elements might then be factored in. The main things that are factored into design of the healthcare that we are talking about are experience, age, comorbidities and accessibility, which is important.

**Chris Mackie:** Thank you. I just want to say that libraries are a fantastic resource on which we need to build. Our recent report and action plan, "A Collective Force for Health and Wellbeing" recognises the role of libraries in communities. We are at a junction with libraries. They are places for books, but much more is going on in them, which we need to talk about and promote. Staff in libraries are skilled in using digital tools and can signpost people to the digital health and social care resources that are out there.

Whether we are talking about libraries, community centres or more mobile options in areas where the geography is challenging, we need to consider such community-based resources and the options for people to access health and social care through alternative means.

We are at a crossroads with libraries. I really hope that we can see them as the excellent resource that they are, because it is a case of use them or lose them, as we can see in communities where libraries are under threat of closure. I endorse libraries and other such resources as highly valuable in communities.

**The Convener:** Scott Henderson wants to comment.

**Scott Henderson:** I agree with my fellow witnesses that community-based resources such as libraries are important, and that their role needs to be considered continually. Libraries are not necessarily a panacea; a person might not want to do their video consultation in a library, where they will not necessarily get privacy, but other services might be more appropriately accessed through that route.

The main point is that we need to understand problems of access and inclusivity, almost on a service-by-service basis, so that we build in whatever measures are possible at that level in order to ensure that everyone who wants to access services can do so.

**Paul O'Kane:** There has been increased demand for the NHS 24 telephony service; people want contact via the phone. I have raised the issue before in this committee. That has led to pressure, so sometimes calls go unanswered, which none of us wants to happen. What more do we need to do to bolster and support the service? Dr Perry, do you think that it is a question of call handling and clinical staff capacity? What else needs to be done?

**Dr Perry:** Was your question about how we can bolster the telephony service to meet the needs of patients? Did I hear you correctly?

**Paul O'Kane:** Yes. I was referring to the challenges over the winter, when calls have, perhaps, gone unanswered. I was asking how we can ensure that that does not happen and about solutions to deal with the pressures.

**Dr Perry:** I suppose that the answer is to increase capacity in our workforce. We have done that; we opened the Dundee contact centre in December last year, which has increased the capacity of our workforce to deal with the volume of calls. Last year, we dealt with 1.6 million calls to the telephony line, which was 10 to 15 per cent higher than the number in the previous year. We have definitely seen demand increase over the period.

We are coming out of the Covid-19 pandemic, which has increased demand not just on NHS 24 services, but system wide. We are mindful of the need to increase capacity in our workforce, but we also need to stand back and see the system-wide issues. It is not just about NHS 24; it is about how the whole system deals with demand—in-hours and out-of-hours primary care, and secondary care—and how we work with partners and stakeholders in the third sector and voluntary sector.

**Emma Harper:** My question is just a wee supplementary.

When we talked about library services, Chris Mackie said that we must

> "use them or lose them."

Perth and Kinross Council introduced dog-friendly Fridays in its libraries in 2018, and City of Edinburgh Council introduced dog-friendly Thursdays in October 2019. Those initiatives tackle isolation and loneliness and ensure that folk do not have to tie their dogs up outside the library or leave them in the car. Are you aware of those initiatives? Are we tracking them to see whether dog-friendly days in libraries are a good thing?

**The Convener:** This is Emma's attempt to get dog-friendly Tuesdays in the committee, which I fully support. [*Laughter*.] Would anyone like to comment? I saw a few of our witnesses nodding.

**Scott Henderson:** I have no awareness of any plans to track or monitor those services in libraries, but they sound intriguing and we would be very interested to learn more.

**The Convener:** Emma, I think that you have made your case.

**Emma Harper:** Yes.

**The Convener:** We will move on to talk about health literacy, with Sue Webber.

**Sue Webber:** Thanks, convener. I hope that you can see me this time. My signal is a bit more stable now.

The Royal College of Nursing has rightly pointed out that people with poor health literacy are less able to identify or label what is wrong with them, and are therefore less able to identify and self-refer to the various alternative pathways that we hear so much about. What is your assessment of the risk that an increase in use of digital pathways will increase the health inequalities that many people face?

Adam Stachura mentioned the scale of the issue, given the number of over-60s who do not have a device, and Chris Mackie said that digital should always be a meaningful choice, so maybe they are interested in responding.

**Adam Stachura:** Thank you for the question, which is a very good one.

We hear quite a lot about that issue through our helpline. In the past two years, we have heard people trying to articulate what is wrong with them, but in many cases they are not really sure. On average, people over the age of 70 are living with three chronic health conditions, and the older people get, the more conditions they can be living with. Sometimes people are not sure what the issue is or where they should go. People might just want to go to their GP, which is the traditional view of what they should do.

It is important to note that, when people engage with services, other things can be picked up while they are there. Those things include malnutrition, which is a real problem among older people; loneliness and isolation, which can be underlying causes of ill health; and mental health challenges, which older people often do not identify as things that they might have. It is very difficult for people to know where to go about those things. If there is just one condition, it can be more straightforward, but it can still be difficult to articulate the issue, particularly if English is not the person's first language or they just do not know what is causing their ill health.

It can be difficult for people to navigate the web and access services, especially if they are living with certain conditions. It can be difficult for people who are arthritic, people who have Parkinson's and people who have sight loss to use digital devices, and they might not want to ask somebody to help them, because they might not want to disclose their medical conditions. Some people will ask for help from friends or family, but that is not always the case because many people are quite private and might not want to disclose the extent to which they might be unwell. I certainly know that from older people in my life. People might not want to give others the full story; which is quite right, if it is a personal thing.

**The Convener:** Chris—do you want to comment?

11:30

**Chris Mackie:** Yes. We need to tackle health literacy. The committee has heard this morning about link workers and social prescribers. They are really good ways to address such issues, but we need to expand the programmes. We need more link workers and social prescribers to help people to articulate what is going on with them. We need to normalise such approaches and expand them into various settings, so that people do not feel that they are getting a special service.

In Glasgow, the alliance's link worker programme initially targeted deep-end GP practices. That was the right approach, but it is important that those types of offerings are made more "normal", so that people do not feel as if they are being given something special or cost driven, or a service that is, in some way, a second-rate service. The evidence that the committee has heard this morning underlines the value of such approaches, but we need to expand them into other settings to ensure that they can help people with their health literacy.

**Sue Webber:** In 2017, the Scottish Government published a "Making it Easier: A Health Literacy Action Plan for Scotland 2017-2025". In the five years since, what progress has been made in improving health literacy? What sense do you get that there has been improvement? Do you think that the plan has contributed to progress? I am not sure whether Chris Mackie is able to answer.

**The Convener:** We can come back to Chris.

**Chris Mackie:** I am sorry—I am not familiar with that report.

What we need to do—perhaps the report does this—is drill down into the communities and sections of the population that are experiencing the biggest inequalities and ensure that those communities are able to access the sorts of support that can improve their health literacy. We need to look at that across the board, and at the intersections of different inequalities, including poverty and unpaid care, for example. We also need to consider people who are not traditionally recognised when we look at inequalities.

**The Convener:** Sue, can I move on to the next theme?

**Sue Webber:** It looks like a couple of people—Scott Henderson and Paul Perry, perhaps—might want to respond to my question.

**The Convener:** I will bring in Scott Henderson. We have lost our connection to the chat—we are having some difficulties.

**Scott Henderson:** On the first point about use of a digital service making health literacy worse, or at least expanding the gap, there is validity there, in that what we have seen is that the people who engage with digital health and care services increase their health literacy. By extension, therefore, the people who are not accessing digital services can be at a disadvantage.

I do not think that the answer is necessarily to find more digital ways of increasing health literacy; it is about finding other more direct ways to improve health literacy. Sue Webber referred to the action plan: I am not familiar with that work specifically, but the suggestions about using link workers, key workers and others in the community to support people in a focused way is more likely to be an effective means of addressing the gap.

**The Convener:** Paul—do you want to say something?

**Dr Perry:** Yes. Thank you, convener. There is a famous piece of medical research and evidence on health inequalities that dates back 50 years, which was published by Julian Tudor Hart. Essentially, he found that the people who needed healthcare most were least likely to receive it. There are things that we can do to improve that and to narrow the gap. That includes reducing variation in healthcare service provision, improving the quality of services, tackling patients' need and increasing supply.

The conversation that we are having today is around digital technology—specifically about data. Data can help us to drill down and do a deeper dive to understand which groups in the population are either overrepresented or underrepresented in various NHS services, so that we can understand who we can help most.

**The Convener:** I will move on to questions on digital health and care information from Emma Harper.

**Emma Harper:** I am interested in how we are communicating what services are available. I have asked questions about ALISS in previous evidence sessions. This morning, we heard about an equivalent tool that is used in Edinburgh called the red book, one in Dumfries and Galloway that is called DG locator and a mental health tool in the Borders that is called SPRING. How are we communicating their availability more widely to people who can direct care? How are we helping people to understand that ALISS exists?

**The Convener:** Given that ALISS has been mentioned, we should probably go to Chris Mackie first.

**Chris Mackie:** ALISS is in my job title, so I should be able to answer that question. I joined the alliance about a year ago. In managing the ALISS programme, I was struck by how many great things there are about it. However, I noticed that, in many cases, the communication was not quite there in promoting it as a resource for people to find information about health and wellbeing. ALISS is a national resource that maps community assets across the country, offering people many routes into improving their health and wellbeing.

ALISS is a crowdsourced information resource. That brings with it a number of challenges but, in my view, that is the way in which to do this type of work. I have had conversations with the Scottish Government and a variety of stakeholders in which people have said that, if we did not have ALISS, we would have to invent it. ALISS has been around for 12 years and has gone through a number of incarnations in that time—the alliance continually seeks to improve it.

One challenge is that everyone has a directory. Even if that is just a spreadsheet on someone's desktop, everyone has contacts whom they know and trust. We need to encourage people to invest in ALISS as a national resource.

This morning, we heard about EVOC in Edinburgh and its red book resource and about a number of other resources that are available. One of the pieces of work that I am keen to do with ALISS is to form partnerships with those who have local directories and to look at aggregating their data and adding it to ALISS.

There are a number of benefits from a public health and policy perspective in seeing what resources are available nationally. We can also empower citizens a bit better locally. I will give you a good example of that. I live in Bishopbriggs, which is in East Dunbartonshire but borders Glasgow. With ALISS, I can see community assets that are nearby, regardless of whether they are in the Glasgow area or in the East Dunbartonshire area. There will be countless examples like that. We can work together with different local information providers to aggregate the information and add that to ALISS, to improve that resource.

It is not just about looking at the technology side, which would require capital investment in ALISS; there is also the people aspect to think about. Of course, we need to promote the resource, but we should also be saying, "Let's work in partnership on this. If we're going to have a national resource, let's improve it as best we can, but let's also respect the work that's being done locally with local directories." Not only does such an approach improve ALISS and its offer, but it does not discredit or take away from what is being done locally.

ALISS requires not only financial but political investment, and I urge the committee to push the Scottish Government to promote it, because the awareness and the communication in that respect have not been what they should be. The Government has funded ALISS for the past 12 years, but we now need to capitalise on what is a fantastic resource of community assets. In my view, it takes all the right approaches, and I am not just saying that because it is part of my job title.

**Emma Harper:** Did use of ALISS increase during the first lockdown phase of the pandemic? The alliance has shown that use of ALISS increased in 2021, and I was just wondering whether Covid had an impact in that respect.

Moreover, are we tracking who is using it? Is it being used by link workers or others? At last week's meeting, we were told by Optometry Scotland and Community Pharmacy Scotland that they had not heard of ALISS, but their members also spend a lot of time with patients. After all, an eye examination can take up to half an hour. Who is using the system?

**Chris Mackie:** With regard to the increase in 2021 that we highlighted in our submission, I should say that, as far as 2020 was concerned, expectations were lower as a result of lockdown. We were in full lockdown for a good period and then went back in towards the end of 2020 and into 2021. When things opened up, ALISS was used more, and I hope that we can build on that.

I am also looking at increasing the number of access points, with access not just through www.aliss.org but through partnerships such as the one that we have with NHS 24 that allows ALISS data to be surfaced on NHS inform. We also have a new partnership with the Glasgow Alliance to End Homelessness, which uses ALISS data on its "Get help Glasgow" web page. One of my tasks is to form those kinds of new partnerships, and we are talking to people about a variety of things, including social prescribing technologies, that can be used to bring in ALISS data.

As for who is using ALISS, we see a sizeable proportion of people coming through Google searches or through the other search engines, but we are also seeing direct use of www.aliss.org. We might surmise, therefore, that citizens are using ALISS, but I would estimate that half of the users either come from the professions or are people searching on behalf of others.

It is therefore important that we make the ALISS resource fit for purpose across a range of devices including mobiles and devices—of course, more professional users would traditionally use desktops—and we have also done a big piece of work on accessibility to ensure that people affected by sensory loss can, first of all, access ALISS and then use it in the best way possible.

We are fighting on a number of fronts to ensure that ALISS is fit for every citizen. Indeed, our aspiration is that it is not just for some people but for everyone.

11:45

**Sandesh Gulhane:** Chris, you said that ALISS has been around for 12 years, and that communication is not what it should be. As a GP, I had never heard of ALISS. No GP that I know has ever heard of it. Organisations who have given evidence to us have not heard of it. It is not that the comms are not what they should be; they are non-existent. After 12 years, I would expect a good data source to be something that people use and know about. Is ALISS value for money, or should we look to use that money for something else?

**Chris Mackie:** Communications need to be made on a number of fronts. From an alliance perspective, the resource that we have is spread quite thinly, and the team that works on ALISS is small. However, as I have said, it is also about some of that responsibility coming to the Scottish Government, partners in the NHS and others to say that the resource exists.

The ethos of ALISS and the technology behind it are correct. However, it needs investment. If, as you said, communications have been non-existent, we need to invest in those. That is the issue.

**The Convener:** Emma Harper, do you want to come back in before I move on to David Torrance's questions?

**Emma Harper:** Yes. It is just a quick question.

In one of my local areas, one of the manager leads of all the GP practices knows about ALISS, so his GP practices know about it; however, they said that it might not be as up to date as it should be. I am aware of some general practitioners who know about ALISS, although Dr Gulhane's point about not knowing any GPs who access it is probably quite important.

It is about raising awareness, and linking to make it work better. For instance, the DG locator, which is run by the third sector in Dumfries and Galloway, is working on collaborating with the GP practices to direct them more towards ALISS and other services. That would involve asking what we need in order to make ALISS work better, apart from just money.

**The Convener:** I come back to Chris Mackie. Again, our inquiry has thrown up points that are all well made. We put them to the Scottish Government as well, so it is all very worth while.

**Chris Mackie:** That issue comes up constantly for ALISS and any information resource of that nature. All the local directories that you spoke of will face the same issues about keeping things up to date. As I said, the ethos of ALISS—the crowd sourcing of information—depends on people keeping things up to date. Using the resource that we have, I hope to alter the focus slightly and to address that data quality issue specifically, because I know that people will go to ALISS, look at information and say, “Well, that wasn’t updated recently, so what confidence can I have in it?”

We need to continue with the crowd-sourcing approach but also to redirect some of our attention to specifically addressing the data quality issue. We plan to address that with staff time, but we also have plans on the technological aspect, such as giving people reminders to keep things up to date. We can do that through automatic means on the platform.

Not a day goes by without the quality issue being raised. We need to look at that from an ALISS perspective but, if we seek aggregation through local solutions, we need to be mindful that those directories also need to be up to date. It is a constant battle. Anyone who has done any work in this sort of area will know that, as soon as something is written, it goes out of date, so the job is never finished.

**The Convener:** I will bring in Scott Henderson before we move on.

**Scott Henderson:** There are a couple of really interesting points in that. The point about the ALISS data set is really important. It will never be perfect, because of the nature of the information that it provides and the fact that the groups to which it refers frequently change.

The point about GPs’ awareness of ALISS is interesting, too. I am not sure that they have been a target audience—they certainly were not 12 years ago. We are now in a situation in which there is much greater interest in social prescribing, so there may be a case for greater promotion to GP practices of ALISS as a service.

We also need to consider that the service must evolve. We know that the post-Covid world is a different place, and we need to think carefully about which services the public will want, when they will want them and in what format they will need them.

Those are just some additional points for the committee to consider.

**Sandesh Gulhane:** Scott Henderson said that GPs were not a target for ALISS. Up to 60 per cent of the things that GPs do are social. In 2018, the new GP contract came in, which had a focus on link workers. I would say that ALISS would have been a wonderful resource for GPs to know about—perhaps not 12 years ago but certainly from 2018 onwards. Why were GPs not targeted? Not doing so seems nonsensical.

**Scott Henderson:** I would love to be able to answer that directly, but I cannot, because I have not been involved in the work to date. It is an interesting question, and we can certainly take that back with us to consider. My point was that ALISS was perhaps not originally marketed to GPs during that time. However, I see that there is definitely an opportunity for it to be more widely promoted now.

**The Convener:** That could form part of our recommendations. The discussions are showing the value of committee scrutiny.

**David Torrance (Kirkcaldy) (SNP):** From a health practitioner perspective, what are the advantages and disadvantages of remotely delivered health and care services? To what extent do remotely delivered consultations and services ease pressures on GPs and GP surgeries? I put that to Dr Perry.

**Dr Perry:** NHS 24 has very much been in the middle of remote delivery of services. The roll-out of Near Me to our dental service last year is a good example. That allowed an increase in the number of consultations with patients who could not access dental care.

With the design and development of any healthcare service, there are always advantages and disadvantages. We have talked a lot today about inequalities, particularly on the public health and digital inequalities sides. We are very mindful of that in NHS 24, and we have a user-centred research team that interacts with the public through public partnership forums, to take their advice and guidance on those aspects.

**David Torrance:** How can we improve online triage systems, so that not only patients but health practitioners are confident in using them?

**Dr Perry:** The use of such systems has increased in the past two years since the pandemic began. Online triage through the use of Near Me in our dental service was one of a few such services that we have rolled out over the past year or so.

Work in NHS 24 is on-going—there is a further scoping exercise—to consider the possible use of online triage systems, particularly remote consultations and video consultations. Phase 2 of the redesign of urgent care is going forward with a particular musculoskeletal focus, and we are working with partners and stakeholders on that. The use of video consultations is one of many examples that we will look at designing and developing with partners, members of the public and stakeholders as we move forward.

**Scott Henderson:** We are currently working on online triage in GP practices with a programme called the general practice digital asynchronous consultation system—or GP DACS—with a very mixed set of messages emerging from the evidence that we have gathered. Some general practices love using such triage tools and believe that they reduce workload in their practice and make excess demand more manageable, while others find that such tools generate a lot more work. There have even been reports of staff wellbeing being affected by the use of those products, and not in a positive way.

For patients, some of the advantages include their being able to contact the practice out of hours and not having to join the 8.30 am telephone queue. However, the fairly limited public engagement that we have done on the issue suggests that the public's view, although generally quite positive, is conditional. For example, people want to know who is looking at their request when they make it.

There are other benefits to the remote delivery of services more generally. A lot of work is being undertaken in that respect on long-term condition management, and I would cite as an example the scale-up blood pressure monitoring programme, which has had the positive effect of reducing the need for face-to-face appointments, improving convenience for patients and shortening the time taken for diagnosis of conditions such as hypertension.

Again, the picture is very mixed with regard to advantages and disadvantages, and quite a lot depends on how things are designed and delivered.

**Emma Harper:** I have a quick question for Scott Henderson. I know that, during the pandemic, pulmonary rehabilitation was starting to be delivered digitally, and the evidence suggests that such an approach works, especially given that these folk are vulnerable and might not want a face-to-face appointment. Moreover, I know—because I am co-convener of the cross-party group on lung health, which has done a lot of work on the matter—that there is also remote monitoring of chronic obstructive pulmonary disease. What are your thoughts on that kind of remote monitoring? Do you think that pulmonary rehabilitation, for instance, could be delivered more widely in that way?

**Scott Henderson:** Absolutely. This is interesting territory, because we are changing the ways in which people work. There is quite a lot of work to be done on designing new pathways for each service. There is also quite a bit of variation across Scotland in the way that people want services to be delivered and whether they want the redesigned pathways to be delivered with digital supports. The scale-up BP programme is a good example of two or three approaches coming together into much more of a national approach. With that sort of approach, we will start to see benefits getting realised at a national level.

There is a lot of work to be done to ensure that we design these things properly so that they produce the benefits that we want and avoid as many of the disbenefits as possible, but we must absolutely continue to invest in the area and accelerate things where we can do so.

12:00

**The Convener:** We come to an issue that has come up an awful lot in our inquiry—the concept of a single electronic patient record. Sandesh Gulhane will lead the questioning.

**Sandesh Gulhane:** The issue of a single electronic patient record has come up a lot. Many of the organisations that we heard from spoke about the great benefits that the creation of a single electronic patient record could bring.

I have two questions, the first of which is for Dr Paul Perry. How useful would such a record be from an out-of-hours NHS 24 point of view? What progress has been made in that regard since December 2021?

**Dr Perry:** To respond to your first question about the usefulness of a single electronic patient record, as a clinician, I know that there is sometimes frustration about the inability to see the whole patient record, covering the whole patient journey. That is the case whether we are talking about an out-of-hours GP or an in-hours GP. At the moment, an in-hours GP can produce a key information summary—a KIS—which can be shared with some care providers. That gives a sample of medical conditions that the patient has been diagnosed with. There is also the emergency care summary, which allows a care provider to see what medications the patient may be on. However, at the moment, unfortunately, we are not able to see the whole record of the patient's day-to-day consultations with their in-hours GP.

At NHS 24, we use the SAP data system, while territorial boards' out-of-hours services use Adastra. There is an element of data interoperability with that. If I was a clinician who was working at NHS 24, I would be able to send an out-of-hours clinician in a territorial board an electronic summary, which would give a snapshot of the patient record at that moment in time. However, at the moment, unfortunately, we are not able to share the whole patient record.

There are lots of clinical systems out there in the NHS, but to overcome that barrier, we need a central cloud-based platform. I am aware that conversations about that are taking place in NHS Scotland. A scoping exercise is being done around those opportunities. When it comes to the patient record, we need to overcome the barriers relating to data interoperability so that that data can be shared and we can increase the continuity of care for patients, which is at the heart of the work in this area. We also want to reduce the need for patients to have to repeatedly tell their story to different clinicians and different care providers.

**The Convener:** Stephanie Callaghan has some questions on this topic.

**Stephanie Callaghan:** I would like to come back on that answer. Dr Perry addressed many of the points that I had written down. It is interesting to hear that work is already being done to look at a central, cloud-based platform.

At last week's meeting, the Royal Pharmaceutical Society talked about the need to be able both to add information to the patient record and to access information on it. Is the ability to do that included in the pilots that are taking place?

**Dr Perry:** You asked about a cloud-based platform and data sharing. I understand that a data strategy engagement programme has been set up and that various partners and stakeholders are looking into the issue.

In relation to the pharmaceutical aspect, work is also being done with NHS National Services Scotland around e-prescribing, which would mean that digital prescriptions could be used instead of paper prescriptions. I do not know what the timelines are for the results of that work hitting the shop floor, but I know that stakeholders and partners are working hard behind the scenes to get that up and running.

**Stephanie Callaghan:** Fantastic. Is it more about having a cloud-based system so that all the different systems that are used by different health professionals—and beyond that, as well, into alternative pathways—can connect into one cloud-based platform, rather than having one system that runs right the way through and is the same everywhere?

**Dr Perry:** The best way of approaching this is probably to take a step back and see it through the whole-system lens of in-hours and out-of-hours primary care that meets the needs of the patients. It is the same with secondary care as well. It is probably one of many options and opportunities, and it is definitely one that is being discussed at the moment.

**Scott Henderson:** A data strategy for health and social care is being developed, which will be publicly consulted on quite widely. The delivery date for that is late summer this year.

Some important points are coming out about a single patient record, but we need to be mindful of the fact that the goal is probably to have a health and social care record, so that we have truly integrated services. That is part of the work that is being considered through the development of that strategy and through the work of the national digital platform.

**The Convener:** I thank you all—you have raised some very interesting things for us to consider, particularly ahead of our session with the cabinet secretary next week.

## Subordinate Legislation

### National Assistance (Sums for Personal Requirements) (Scotland) Regulations 2022 (SSI 2022/70)

### National Assistance (Assessment of Resources) Amendment (Scotland) Regulations 2022 (SSI 2022/71)

### National Assistance (Assessment of Resources) Amendment (Scotland) (No 2) Regulations 2022 (SSI 2022/72)

12:07

**The Convener:** The third item on our agenda is consideration of three related negative instruments. The instruments refer to annual rate changes for charges for residential accommodation.

The first instrument increases the value of the personal expenses allowance in line with average earnings, which is an increase of 5.8 per cent.

The second instrument increases the value of savings credit disregard in line with average earnings, which is forecast at 5.8 per cent. It also increases the lower capital limit from £18,000 to £18,500 and the upper capital limit from £28,750 to £29,750 in line with the consumer prices index, which is forecast at 3.1 per cent—I hope that everyone is following this.

The purpose of the third instrument is to disregard payments made to individuals living in residential care by the Scottish infected blood support scheme and equivalent schemes enacted in other parts of the UK.

The Delegated Powers and Law Reform Committee considered the instruments and made no recommendations to us. No motions to annul have been received in relation to the instruments.

If members have no comments to make, I propose that the committee makes no recommendations in relation to these negative instruments.

As no member objects, we agree to that approach.

At our next meeting on 29 March, the committee will hear from the Cabinet Secretary for Health and Social Care as part of our inquiry into alternative pathways to primary care.

12:09

*Meeting continued in private until 12:27.*

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

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

The Scottish Parliament
Pàrlamaid na h-Alba