OFFICIAL REPORT
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Health, Social Care and Sport Committee

Tuesday 14 June 2022

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 14 June 2022

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
22nd 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)
*Tess White (North East Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Toni Groundwater (Families Outside)
Karen Lewis (The Hub)
Richard Meade (Carers Scotland)
Dr Sharon Wright (University of Glasgow)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 14 June 2022

[The Convener opened the meeting at 09:30]

Decision on Taking Business in Private

The Convener (Gillian Martin): I welcome everyone to the 22nd meeting in 2022 of the Health, Social Care and Sport Committee. I have received no apologies from members.

The first item on our agenda is to decide whether to take item 4 in private. Do members agree to do so?

Members *indicated agreement.*

Subordinate Legislation

Novel Foods (Authorisations) and Smoke Flavourings (Modification of Authorisations) (Scotland) Regulations 2022 (SSI 2022/168)

National Health Service (Optical Charges and Payments and General Ophthalmic Services) (Scotland) Amendment Regulations 2022 (SSI 2022/169)

National Health Service (Vocational Training for Dentists) (Miscellaneous Amendment) (Scotland) Regulations 2022 (SSI 2022/170)

09:30

The Convener: Agenda item 2 is consideration of three negative instruments. The Delegated Powers and Law Reform Committee considered the three instruments at its meeting on 7 June 2022 and made no recommendations in relation to them.

The first instrument is the Novel Foods (Authorisations) and Smoke Flavourings (Modification of Authorisations) (Scotland) Regulations 2022. The negative instrument implements a decision by the Minister for Public Health, Women’s Health and Sport in relation to five novel foods, authorising four new novel foods for placement on the market in Scotland and one extension of use for an already authorised novel food. The regulations also authorise the transfer of authorisation holder for five smoke flavourings.

No motion to annul the regulations has been lodged. As members have no comments on the regulations, I propose that the committee does not make any recommendation in relation to them. Do members agree?

Members *indicated agreement.*

The Convener: The second instrument is the National Health Service (Optical Charges and Payments and General Ophthalmic Services) (Scotland) Amendment Regulations 2022. The purpose of the negative instrument is to increase national health service optical voucher values by 2 per cent, to support more patients with eye problems being safely managed in the community, to enable remote consultations and to deliver other miscellaneous changes.

No motion to annul the regulations has been lodged. As members have no comments on the regulations, I propose that the committee does not make any recommendation in relation to them. Do members agree?

Members *indicated agreement.*

The Convener: The third instrument is the National Health Service (Vocational Training for Dentists) (Miscellaneous Amendment) (Scotland) Regulations 2022. The regulations amend the National Health Service (Vocational Training for General Dental Practice) (Scotland) Regulations 2004, first, to change the employer of dentists undertaking vocational training from training practices to NHS Education for Scotland and, secondly, to continue an exemption from vocational training for dentists who hold certain European diplomas.

No motion to annul the regulations has been lodged. Do members have any comments on them?

Sandesh Gulhane (Glasgow) (Con): On vocational training and the fact that it will now be NES that pays rather than individual employers, does that mean that NES will also pay pension contributions? I assume that it does. Will the regulations also allow dentists who are on vocational training to access NHS benefits, including the cycle-to-work scheme?

The Convener: We can write to the minister and ask for clarification of that.

As members have no other comments, I propose that the committee does not make any recommendation in relation to the negative instrument but that we write to the minister on the points that Dr Gulhane raised. Do members agree?

Members *indicated agreement.*

Health Inequalities

09:33

The Convener: We move on to the substantive item on our agenda, which is continuation of our evidence taking on health inequalities. This follows the series of informal engagement sessions that we undertook on 20 and 23 May to help us to understand people’s experiences in relation to health inequalities. They were very good and very intensive sessions where we heard from people with lived experience. This session is our opportunity to examine some of the issues that we heard about. We were all in different break-out rooms, so we should have a good spread of questions to ask the people who are in front of us today, and we will be able to dig more deeply into some of the things that we heard.

We have four witnesses on the panel to answer our questions and give us more information. I welcome to the committee Toni Groundwater from Families Outside, who is with us in person; Richard Meade from Carers Scotland, who is with us in person; Karen Lewis from The Hub in Dumfries and Galloway, who joins us online; and Dr Sharon Wright from the University of Glasgow, who also joins us online.

I believe that all four of you would like to make brief opening statements. We will hear from Toni Groundwater first.

Toni Groundwater (Families Outside): Thank you for inviting us to highlight the inequalities that the people whom we support and represent face. At Families Outside, we work solely on behalf of children and families who are affected by imprisonment. It is clear that the challenges that families face when someone goes to prison are considerable. Worry for the person who is in prison is alone enough to merit support, let alone the multiple challenges that they face for their health and wellbeing.

Imprisonment of a household member is one of 10 adverse childhood experiences that are known to have long-term implications for health and wellbeing. The research continues to support the links between imprisonment of a family member and poor physical and mental health for the family—it has an impact on health that is even greater than divorce or bereavement.

One of the common inequalities that our families face is that they are not identified or supported to get the help that they need. Greater awareness is required across the board about the needs of children and families who are affected by imprisonment. Families Outside, in collaboration with partners, has published a framework for the support of families who are affected by the justice system. That was updated at the end of last year and it can be found on our website.

There are just over 8,000 people in prison in Scotland on any given day, and each year around 18,000 people are released from prison. It is estimated that around 27,000 children are affected by the imprisonment of a family member, but the actual figure could be much higher, given the challenges that we face in identifying those children and families.

The fact that someone is in prison increases health inequalities for them and their families. Health inequalities are widespread among our prison population. Almost every health problem is overrepresented, including people with problem drug use and mental health problems.

Prison should be viewed as a unique opportunity to address health inequalities. The potential benefits of effectively engaging with people in prison and their families on their health are immense. However, people describe to us—and we heard through the informal sessions that the convener mentioned—that there are difficulties in accessing basic healthcare in prison and there are significant problems with continuity of care on release. In many cases, that has led to serious and traumatic consequences, all of which are felt to be avoidable if treatment and better joined-up approaches are provided.

We have heard about instances of medication not being made available for people with existing conditions on arrival in prison, sometimes for a number of weeks, and hospital appointments being missed due to staff shortages and escorts not being available. We have also heard about someone missing multiple visits to hospital in relation to a leg injury, which resulted in long-term disfigurement and on-going problems. We continually hear about the long waiting times to receive support.

We would like to see parity in policy and practice between justice and health agencies, greater involvement of families, and families being recognised as carers with significant and valuable information and support to contribute. The Mental Welfare Commission for Scotland’s report on prisons echoed that point in April, highlighting that the mental health of prisoners and families could be significantly improved with responsive communication protocols between mental health services, prisons and families through which families could report their concerns.

We recognise the on-going challenges that prison and healthcare staff face, but what we have heard about the experiences of the people who we support and their families are unfortunately not isolated incidents or one-off failings in the system or in practice. That chimes with much of the available evidence. Royal College of Nursing Scotland reports, prison inspection reports and independent prison monitoring all highlight clear themes relating to health centres that are not fit for purpose, long waiting lists, challenges with staffing and escort services, and barriers to communication and collaboration between prison and healthcare staff.

The transfer of healthcare from the Scottish Prison Service to the NHS in 2011 was driven by the need to reduce health inequalities for people in our prisons. However, a review in April 2021 of the prison inspection reports into health and wellbeing concluded that,

> “While there is much to admire and transfer in the way health promotion is operationalised in Scottish prisons ... it is apparent that this is not universal across the prison estate. The rhetoric of the health promotion in prison seems to be ahead of the reality of practice.”

We want the health and healthcare of people in prison and their families to be at the forefront of open political debate in order to reduce health inequalities. The people who we support often simply ask for compassionate responses. Instead, many feel stigmatised, excluded and that they are guilty of a crime by association. Through joined-up approaches between the health and justice sectors, there is an opportunity to reduce health inequalities for many people across Scotland. People in prison and their families cannot remain unseen and unheard in that context.

The Convener: I ask Richard Meade to speak on behalf of Carers Scotland.

Richard Meade (Carers Scotland): Good morning. I thank the committee for having me along today. The idea that informal unpaid caring should be considered as a social determinant of health was first raised in the United Kingdom in a Public Health England report that was published last year. There is now growing UK and international evidence that makes the case for recognising caring as a social determinant of health.

The World Health Organization defines social determinants of health as

> “the non-medical factors that influence health outcomes.”

It says:

> “They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.”

A carer can be defined as someone who provides care to ill or disabled family members, friends, partners or neighbours. They are unpaid and are often family members, friends, partners or people in the community. They are usually described as unpaid or informal carers.

The vast majority of existing research shows that unpaid carers experience poorer quality of life, including poorer mental and physical health outcomes, when compared directly with those who do not provide care. Carers experience higher levels of carer burden, depression, anxiety, distress and stress. They are at greater risk of premature death, and the prevalence of disease is greater among them. For example, they are at greater risk of muscle or bone conditions, heart disease, cognitive deterioration and poor sleep.

The Public Health England research suggests that, compared with non-carers, carers are 16 per cent more likely to be living with two or more health conditions, with arthritis and high blood pressure being the most common.

It is likely that those poor health outcomes will be exacerbated by social isolation, poor support, inadequate information and the financial pressure that carers often face. The higher the intensity of the caring that is provided, the poorer the outcomes are. The longer a person has been a carer, the greater the impact on their physical health, which deteriorates over time at a greater and faster rate than the rate for those who do not provide care.

In Scotland, 14 per cent of carers provide more than 50 hours of care a week. Neglecting their own health is a common practice among carers. Compared with non-carers, carers are less likely to own their homes, less likely to be employed and more likely to be in poverty. Some 7 per cent of carers are forced to give up work, and more are forced to reduce the number of hours that they work.

Supporting carers' mental and physical health is essential and it makes a difference. On average, carers who have access to services have better health outcomes than those who do not. However, many carers struggle to access any support or statutory services, and many go unidentified for any support.

Carers are more likely to be women—61 per cent are women—and, on average, women carers care for more hours a week than male carers. That means that unpaid care has a disproportionate impact by gender.

The health inequity gap that is caused by caring has not been closed since the establishment of the Scottish Parliament; it is actually growing. The Covid pandemic has exacerbated many of the issues that carers face and has led to many carers experiencing poorer outcomes. During the pandemic, more people provided care than ever before. We estimate that about 1.1 million people in Scotland provided care during the pandemic, and the number of people providing care has not returned to pre-pandemic levels.

09:45

We know that more than 70 per cent of unpaid carers did not get a break or any respite during the pandemic. Many have failed to access services for themselves and those for whom they care; they have struggled to get appointments to discuss their own health concerns, which has exacerbated their conditions. Many are still shielding, despite the lifting of protections. They are worried about the impact of Covid and the failure of local authority and other services to return to pre-pandemic levels.

All of that is happening at a time when those unpaid carers, as a whole, are contributing £11 billion a year to the health and social care system. Quite simply, the health and social care system would collapse without unpaid carers.

The level of unmet need for carers is likely to grow as more and more people need care and there is more reliance on unpaid carers to meet the increasing gap in the provision of statutory services for ill and disabled people.

There is emerging evidence of the difference in health outcomes between carers and non-carers. When all other factors are accounted for, carers are at greater risk of ill health. That is why caring must be considered a social determinant of health, which should be reflected in all national and local public health policy and strategies that are designed to tackle health inequalities. That should be a focus and a priority of Public Health Scotland.

There is a lack of research into unpaid care and its consequences and complexities, and into interventions in that regard. That is particularly the case in Scotland, as much of the research that exists comes from other parts of the United Kingdom or is international. A substantial research programme is needed if we are to better understand the complex nature of unpaid care and the adverse consequences that care can bring. Such a programme should also test new models of care and support for carers, reflecting an understanding of the complexity. We would love a research centre for carers to be established in Scotland.

There needs to be increased investment in existing interventions to support carers, particularly breaks from caring and financial support to ensure that carers do not fall into poverty—and that carers who are in poverty are lifted out of it. For example, we would love to see another doubling of the carers allowance supplement in December to help carers at a time when their energy bills are likely to be at their highest and Christmas is on the horizon.

The failure to provide systematic support for carers has created a public health crisis. I urge the committee to reflect on that during its inquiry and, above all, to recognise and state in its conclusions that this Parliament sees caring as a social determinant of health and a public health priority for urgent action.

The Convener: Thank you. Next, we will hear from Karen Lewis, from the Hub in Dumfries and Galloway.

Karen Lewis (The Hub): Thanks for inviting me.

The Hub is a community anchor organisation in Dumfries and Galloway, and we deliver a range of social justice products and services, one of which is the regional rent deposit guarantee scheme. I am here to give a presentation on that.

The rent deposit guarantee scheme assists people who are on low incomes and in housing need to access the private rented sector. In Dumfries and Galloway, we deal mainly with small-scale landlords, for whom being a landlord is not a business model; they have one or two properties. They might have jobs, and often they have only recently got a work-based pension, so their properties are pension assets for the future. Those are the people whom we deal with.

When we talk about health, wellbeing and social justice of any kind, it is a given that one of the basic needs in life is a home where a person feels that they are secure and can put down roots and build a life. Another great need and determinant is self-agency, so that a person has options and can make active decisions about their life. I think that we all agree that those are important building blocks for good mental health and wellbeing.

We need to challenge the assumption that everyone who faces homelessness or is homeless has complex needs or a chaotic lifestyle. There are many households that have such issues and there are support mechanisms, such as the housing first model, whereby the multi-agency approach works for such people.

However, we think that the issue for the people we work with in Dumfries and Galloway on the rent deposit guarantee scheme is, quite simply, poverty. They are poor. We are one of the lowest-wage economies in Scotland and we have a lot of people who are in-work poor, underemployed and perhaps on minimum wage rates. We need to accept that that is happening: people are in housing need due to poverty, not complex needs.

Rather than give you a lot of statistics on the people whom we have supported, I thought that I would present a couple of case studies that demonstrate the inequalities that people experience in health determinants and how the system works if you are poor, on a low income and having to live in the private rented sector.

I will give an example of somebody we work with. She is called Sue, and is 30, unemployed and lives in a private rented flat that she obtained through the rent deposit guarantee scheme. We provided the deposit bond to the private sector landlord and a short-term rent-in-advance loan to enable her to access a home to live in. Her rent is £395 per calendar month. Dumfries and Galloway has the lowest shared-room rate local housing allowance—which is part of universal credit—in Scotland, so she gets around £260 in her universal credit towards her rent of £395 per calendar month.

You can replicate that for anybody in Scotland who is under 35, on basic universal credit and has no other added benefits. The local housing allowance shared-room rate is available throughout Scotland, and the level that it is set at is assessed on a local authority level.

Sue has to make up a shortfall of £135.70 a month out of her personal universal credit of £76 a week to maintain her home. I put it to you that the level of stress and anxiety that people experience about those issues absolutely affects their mental health and wellbeing and undermines their capacity to build a life, because they are constantly worrying about them.

What kind of support is currently available in the private rented sector to help people such as Sue? If Sue had been lucky and had got a social housing tenancy—rent for a one-bedroom flat is around £325 to £330 per calendar month—all her rent would have been met. That stress and anxiety would have been removed from her, but it would not be removed from someone in the private rented sector who is in a similar level of poverty.

What support can Sue currently get? She can apply for a discretionary housing payment to top up that shortfall, and we have done, but here is the issue: the clue is in the title—it is discretionary, not a given. The maximum length of time that you can get that payment is 12 months, and the usual length of time is six months, so how can anybody relieve that stress and anxiety knowing that they are on temporary support to help them to maintain their home? The discretionary housing payment is a sticking plaster; we need to accept that and look for another solution, which I will come on to in a minute as one of my suggestions.

The other thing that I want to flag—credit to the Scottish Government on this one—is the tenant grant fund that was issued to local authorities. That was a short-term support grant to assist people who had got into rent arrears during the Covid pandemic, and it was for them and their landlords to apply to the local authority to get the grant. Again, having that help available would remove a lot of stress from somebody.

I can only talk about Dumfries and Galloway, but we had 352 applications to the fund. How many were from the private rented sector? Fifty-five, of which only 13 were successful. I will say that again: only 13 tenants in the private rented sector accessed the fund. Eighty-four per cent of it was taken by social housing landlords. We asked the landlords whom we work with why there was not more uptake of the grant, and they came back to us and said that it was because of the bureaucracy and the hoops that they had to go through to access the fund, and the lack of the detailed information that they needed about their tenants and their tenants' lifestyles and incomes. It needed to be a collaborative application.

We cannot say that there is a causation there, but there is a correlation. Social housing has paid full-time staff; it has housing officers who know an awful lot of detailed information about their tenants, so it is hardly surprising that they could find a pathway through the hoops to access that fund. I will come on to a possible solution to that.

We were asked to think of solutions to those issues. First, I urge the Scottish Government to use the powers that it now has to create benefits and consider introducing a permanent benefit that, in effect, negates the shared-room rate and makes up the shortfall for people in the private rented sector.

The draft "A New Deal for Tenants" strategy, which has recently finished its consultation period, has a detailed section on affordability. It looks as though one of the recommendations will be that, for the first time, we get a really comprehensive, deep analysis of affordability in the private rented sector in Scotland and, potentially, a rent cap. The potential rent cap would be based on affordability not in a broad brush stroke but on a housing market breakdown and the affordability of rent based on income. Perhaps those two proposals should be dovetailed with my suggestion for a new benefit.

The other side of the equation, which might be more challenging, would be to revisit the tenant incentive schemes that used to be around but are no longer in place. Those would assist people who are in permanent jobs, are perhaps on modest incomes, have a credit reference and might like to move into the owner-occupied sector, which would quickly release social housing for people who need it. Those incentives used to pay people's deposits and the legal costs of buying. Perhaps we should consider something like that.

We also need to think about incentivising landlords in the private rented sector, particularly low-scale ones. It is not a matter of income generation for them. Perhaps we need to support them so that they have better access to the schemes that come out and so that we can increase the uptake of those schemes.

We cannot wait for 2040 and yet another laudable target for more social housing. We had the same aim and target for 2020, which was never reached. We need to be creative and solution-focused now. Otherwise, inequalities and the impact on people's mental health and wellbeing of insecure housing will continue to be a social justice issue. Even worse, by not acknowledging that, we are accepting it. Indeed, some of the support mechanisms that we have introduced—the short-term support schemes—collude with and facilitate the continuation of that issue. In a fair and just society, none of us should accept that as normal.

Dr Sharon Wright (University of Glasgow): My main point is that poverty drives health inequalities and to tackle health inequalities we must tackle poverty. We need to be honest about the fact that death rates in the poorest communities are increasing, so health inequalities are definitely worsening. What is the problem?

My research is about the lived experiences of people who claim social security benefits. It shows that people are experiencing a lot of poverty and hardship—even destitution—while claiming social security benefits. The source of the problem is the UK system, which should be protecting people from poverty and preventing it but is not operating effectively because of more than a decade of cuts and reforms.

Those reforms and cuts have operated as a large-scale disincentive strategy, so people who should claim support are put off doing that. For example, disabled people and people with mental health problems should get adequate incomes but do not. Often, people who have medical evidence for ill health are not able to claim benefits such as universal credit on the basis of ill health and are treated as though they are fully fit for work when they are not.

Several reports and a lot of research show that, rather than alleviating poverty, universal credit is actually driving it. That is because the rate of universal credit is not generous enough—it does not give people the money that they need to cover their basic survival needs—and because of frequent deductions.

About half of all universal credit recipients have deductions made from the amount of benefit that they get. To begin with, it is an inadequate amount, and then it is cut further by deductions. The deductions are for things such as rent arrears, to repay the five-week wait, and to repay previous tax credits to Her Majesty's Revenue and Customs. A lot of the money that is coming in is going straight out to repay existing debts.

10:00

The situation is that unprecedented cuts to UK social security for more than a decade are combining with welfare conditionality to push people towards work, even when that is not realistic for them. Behind that is the world's harshest sanctions regime, which contributes to stigma, hardship and people's need to use food banks.

Our research showed that, in the worst extreme, people rely on survival crime or survival sex, and there is worsening domestic abuse and worsening physical and mental health because of the hardship. Recent research that we did in Glasgow showed that people who claim universal credit still have an enormous fear of sanctions, even though the statistical likelihood of being sanctioned is now less that it was in previous years.

The system that is meant to protect people is not functioning properly, which has detrimental impacts on unpaid carers, whom Richard Meade mentioned. Two actions are required. Cuts to the value of UK benefits need to be reversed. One of the biggest impacts is from the benefits freeze, which went on for several years and brought inadequate incomes down even lower, such that people who were claiming benefits, including those in work, had falling incomes relative to the rising cost of living. To deal with that, the Scottish Parliament could lobby Westminster to increase the rate of universal credit.

The second major issue with social security is conditionality. That is very damaging because it also applies to the partners of claimants, who might be carers, and it also applies to people who are claiming universal credit while in work, such as people who are in low-paid or part-time work. That includes a set of older women who have received less attention; women in their 60s, who would expect to be in retirement.

There is a lot that can be done to improve the system. The Scottish Parliament's powers could be used to increase the carers allowance supplement and the Scottish child payment. What is needed in the long term is a major programme of reform to build support for progressive taxation. In the Scottish spending review, it was clear that there is not enough money for the enormous void between the support that is needed and the support that is actually available.

The Convener: Thank you to you all for those comprehensive statements—so comprehensive, in fact, that you have probably answered the question that I was going to lead with, which was about your main asks in different policy areas.

I will quote our predecessor committee from session 4, which undertook an inquiry into health inequalities in 2015. In its report, it said that health inequalities

> "would not be reduced without action to reduce inequalities in every other policy area and across every portfolio."

We have just heard from Dr Wright that not only Scottish Government portfolios but UK Government portfolios have an impact on health inequalities. I was going to start by asking you all for your main asks, but you have given us a suite of asks that touch on a number of portfolio areas.

Therefore, I will dig into some of what Toni Groundwater talked about. I was in a break-out room with some of the people you support, and I have my notes from that session. After listening to those people and to you, I was taken aback by some of the things that those families are being put through. You led by talking about the health inequalities that family members suffer, and you also talked about adverse childhood experiences, but every person in that break-out room concentrated on the health inequalities affecting their loved ones in prison. That was their main focus, not themselves and not the impact that it had on their families, although that was evident from listening to them. Their main complaint was about their worry and anxiety for their partners, siblings, friends and so on who were in prison or custody and who were not getting access to their right to healthcare. You could see that that was having an effect on those people's mental health.

In your statement, you said that there should be parity between the justice system and the healthcare system. I want to talk about the change that resulted from responsibility for the healthcare of prisoners moving from the SPS to the NHS. We heard families say that, when they had concerns about people getting access to medication for long-term conditions, the SPS said that the NHS was letting them down, and the NHS then said that it could not get access to the person because of the people running the prisons. Nobody knew who was responsible. Can you give us a bit more information? You deal with these things every day.

Toni Groundwater: You are right in that the people in Scottish prisons whom we support are not getting their basic right to healthcare. I will take what happened in the transfer in 2011 as an example. We embedded a culture in which a prison regime was already operating, and we took healthcare into that regime. There were many practical and cultural barriers to the effectiveness of that. The 2017 Health and Sport Committee report talked about practical things, such as the need for improved information technology systems for prescribing, for example. Such practical elements create massive barriers to people getting access to medication early or to continuous care when they go back out into the community.

We do not think that the practical issues relating to the operation of those systems have been thought through fully and addressed to the greatest degree. The prison regime creates massive barriers to healthcare, and we would like to see many more joined-up strategies for improving health outcomes for people who are in prison and their families.

The Convener: Another thing that was mentioned was the training of prison officers so that they can identify when somebody really needs healthcare. Could you give us a little bit more information and some examples of when the system has fallen down?

Toni Groundwater: We hear a lot about the stigma and discrimination that are experienced by people who come forward to try to access much-needed help and support, but are not taken seriously and not sent on to the specialist care that they might need. People are not getting their basic right to health.

For example, people who need to go to hospital for specialist care are being told at the last minute that they cannot make their hospital appointment because the escort service is not available. That is one of the structural challenges that they face as a result of staffing issues. We know that recruitment and retention of healthcare staff in prisons remains an on-going problem. Structural challenges on the ground mean that people are not getting access to the right care and support.

We work with a family member who, unfortunately, lost somebody—they died—in prison. The fatal accident inquiry made a clear recommendation about staff training, so that people working in prisons are prepared for some of the circumstances that they might face. It also made recommendations on simple things, such as administering and logging of medical equipment in prisons, and people being appropriately trained in the operation of that much-needed equipment should an emergency occur. Unfortunately, in that case, not having that led to a death in custody.

The Convener: Before I hand over to my colleague, I want to ask about the other side of things—that is, the family side. Families experience considerable anxiety about their loved ones in prison, and that has an impact. HMP Grampian is in my constituency—it is quite near me and I have visited it. It has a family centre that provides a lot of support to families. The centre is not run by the SPS; it is led by volunteers. It strikes me that there is an opportunity here. You mentioned that prison visits are an opportunity to get help to families. Those centres seem to be a way of getting a lot of care and wraparound support to families when they come to visit their family members. That is certainly the case with the one that I visited. Are there such centres across Scotland? Do all prisons have family centres, or is provision patchy?

Toni Groundwater: There are 12 visitor centres attached to prisons. Family members who are visiting someone in prison can go there to prepare for a visit, and children and young people can find out a bit more information about what a visit might entail. That is an opportunity for health promotion and to tackle some of the health inequalities that we know face many of the families whom we support.

Provision is patchy. There is still work to be done with regard to the relationships between families and the SPS. The communication to and involvement of families often remains a barrier. We know that families can get involved in "Talk to me" strategy groups and integrated case management to support family members.

However, that issue remains an on-going challenge. There are many barriers. Some meetings are set up at the last minute, so family members who would need to travel a long way cannot get involved. We would like to see an increase in the use of digital technology, although many families experience digital exclusion.

There is an opportunity through the centres, but we do not feel that they are joined up with the prisons enough to fully exploit it.

Sandesh Gulhane: You mentioned that you want an IT system for prescribing. As a general practitioner, I see people who come out of prison because they need healthcare, but I do not know what diagnoses have been made in prison. You spoke in your opening statement about mental health issues. A lot of that comes to the fore in prison, where people are seen and their mental health condition is diagnosed. I do not know what that diagnosis is or what drugs they have been prescribed. Some people come to me asking for drugs that I do not ordinarily prescribe—a specialist usually prescribes them. We are in a completely unsatisfactory situation for the patient, as well as for me, because I simply do not know what to do.

We want an IT system that works and talks to other systems, and we want digital prescribing. What are your needs and asks to make the process of a prisoner coming out of prison and accessing healthcare better not only for the patient but for the healthcare professional? Invariably, that is the same thing.

Toni Groundwater: Absolutely. Your point is really important in relation to continuity of care, which I mentioned in my opening statement. We know that people are often most at risk as soon as they leave prison, because the wraparound support is often lost. We would like much more widespread involvement in throughcare. In some areas, that approach has been very successful. It is about having someone at the gate who can help a person to access much-needed support.

10:15

Some of the other witnesses have highlighted the importance of housing. We know that simply not having an address is a barrier to people being able to register with a GP and get much-needed medication. Joined-up approaches are needed to ensure that people can access much-needed health supports on leaving prison, which we know is a very risky time.

Paul O'Kane (West Scotland) (Lab): Good morning. I thank the witnesses for their presentations, which were informative. All the evidence that we have heard, including in the informal sessions, has been useful and insightful.

I am keen to talk about culture in our public services and in service delivery. In the evidence from the group from the Hub in Dumfries and Galloway, someone talked about

"judgmental and uncompassionate public services",

and they described those as "punitive rather than supportive".

Obviously, we can see direct links to the issues that Dr Sharon Wright talked about in the social security system more widely. Is that also people's experience of other public services that exist, whether in the NHS or in local authority housing provision? It is stark when people say that the network of support that we all want to be there to help people is perhaps doing the opposite, and when they feel that it is judgmental.

How do we begin to shift that culture? We have had undertakings on what the Scottish Government is trying to do through Social Security Scotland and undertakings in the local government sphere, but what more can we do to have a culture shift away from that sort of experience?

Given that those comments came from the Hub, I ask Karen Lewis to start.

Karen Lewis: The experience of people who are navigating their way through statutory services is a very mixed bag. Some services are very person centred and can be flexible and go beyond what is required. For example, if the computer says no, some services will signpost a person or set up an appointment with another service that might be able to help. However, certainly among people who approach homelessness services, experiences are very mixed.

It is a cultural thing. I am not making an excuse, but I think that, sometimes, when you work at the coalface and have to deliver a very inflexible system, you might internally close down a wee bit to protect yourself. You know that what you are saying is not what the person wants to hear, and that is a very difficult conversation to have. The matters of empathy, boundaries and wanting to assist people are about a personal value base, and some people might have to switch off that side of their personality just to be able to cope with the crises that they deal with every day of their working lives with people in need. Unless you work in that field, you do not know what that is like.

Given the hoops that some people have to go through when they present as homeless, and the lack of sending people on to where they might be helped, I certainly think that there is a disconnect. That goes back to what other witnesses have said about continuity of care. If someone comes to me, I have a responsibility to give them an exit to somewhere that might be able to help them, rather than just say, "We can't."

The Convener: Would anyone else like to come in on that no wrong door issue? I think that somebody said in a written submission that it takes a lot for somebody to ask for help in the first place, so wherever they go should be a gateway to that help. I see Richard Meade nodding.

Richard Meade: A lot of unpaid carers go unrecognised, so they do not get the support that they need. That recognition can come in two parts. First, carers do not necessarily see themselves as carers—they might see themselves just as a wife, husband, father or son, so they do not realise that they are a carer and that they are entitled to help and support.

Secondly, we find that, in statutory services, whether in primary or social care, carers often go unidentified by practitioners who could identify them. Practitioners do not see the carer, because they focus on the person who is receiving help and support, so the carer's needs go unmet. It is hugely important for carers to get that recognition.

There needs to be a culture shift in public services, because carers absolutely need to be seen, valued, recognised and treated as partners in care and decision making. They have a great deal of expertise and understanding, not only of the things that surround them but of the person they are looking after. However, they often feel frustrated, because they feel isolated from the decision making and the practices that are put in place to support the person whom they are caring for. They do not feel empowered to be part of the decision-making process. We would like to see a recognition and valuing of carers and the role that they play, and a real focus on identifying carers.

Dr Wright: The culture of service delivery is incredibly important, so thank you for raising that issue.

The trouble is that a lot of the systems in Scotland—certainly in relation to social security and a lot of housing issues—are controlled by Westminster, so the system is punitive. Karen Lewis talked about housing insecurity within universal credit. The universal credit system is creating something that is very cruel and punitive when people try to access housing but do not have enough money. A lot of people whom I have spoken to about claiming benefits have been very scared of losing their home.

Other research from Iain Hardie, who is a colleague of mine at the University of Glasgow, shows a statistical correlation between universal credit and housing insecurity. The UK system that operates throughout Scotland is creating something that is cruel. The support workers on the ground who are trying to help people have to deliver very unwelcome news, and that interaction is based on a system that is really unfair. That emotional labour also takes its toll on front-line workers.

In one of my recent studies, we spoke to work coaches in jobcentres in Glasgow, who sometimes found it incredibly difficult when, for example, they had to tell European Union migrant workers that they were not eligible for universal credit. They found it really painful and upsetting to have to have that conversation with people. They found it similarly difficult when the system required a lot of people with mental and physical health problems to look for work, despite what is in their medical records. For example, the system still requires people who are on medication for really severe mental health problems to look for work full time. Another dimension of the cruelty of the system is that the front-line workers are stuck in that position. They are caught in the middle between a system that is not right and people's immediate needs.

We also need to be honest about the Scottish social security system. It has deliberately taken a different alternative approach that offers dignity, fairness and respect, but we need to acknowledge that the carers allowance supplement was set at the level of jobseekers allowance. Therefore, in that sense, it mimics and is anchored in the UK system, which does not offer people enough money to meet their basic needs. We could make a different choice by tying our Scottish benefit payments to minimum income standards that actually ensure that people have enough money to live on.

Paul O'Kane: I will comment briefly on mental health. Both your answers alluded to the multiple and diverse challenges that exist for people. I am keen to understand whether the witnesses feel that front-line workers who support people have enough training on understanding mental health issues, particularly on trying to identify and triage someone who might have mental health issues. That brings us back to the no wrong door approach, trying to take a holistic view of a person and trying to meet them where they are when they interact with services. We have done some of that, but I am not sure that we have done enough. I am keen to get a sense of whether people think that we need to do more and how we might do it across the piece.

Toni Groundwater: To create an effective culture, we must ensure that the system is resourced appropriately. That relates to some of the other points that have been made about severe pressures on the ground.

I will pick up Paul O'Kane's point about training. The national prison care network is developing some induction training to better equip healthcare staff who work in prisons. It strikes me that the most important part of any induction training that is intended to feed into the culture that we want to create is that it must include people's lived experience and the impact that the systems and policies that we create has on individuals. Not only must any training have that flavour but, in any more inquiries that we undertake, we must continue to work with people with experience not only to highlight the issues but to help us to develop the solutions.

The final point on culture concerns the right to health. We must ensure that we all shift our mindset. People have a right to health; it is not a "nice to have". We need to continue to keep the rights-based approach at the front of our minds.

Dr Wright: It is absolutely right to say that there is a huge need for more mental health training. When we interviewed work coaches at jobcentres, we found that they felt frustrated as well. The general support offered to them is mindfulness or meditation but, if you have to tell someone who is disabled or has bad mental health problems that they are not eligible for benefits, have to repay money that they do not have or have to go to a food bank because they do not have enough money, a little bit of mindfulness will not help you. You will feel really awful about that. That situation is driving mental health problems among front-line workers as well as among claimants.

The big issues need to be resolved at a systemic level to stop the social security system creating and worsening mental health problems. That needs to happen as well as better training for front-line workers being encouraged. The people working in jobcentres to whom we spoke had some mental health training. It was not much and it could definitely be better. We know that, during Covid, mental health has worsened for workers as well as for people who are out of work. The mental health challenges are enormous and need a lot of attention.

Karen Lewis: Like other witnesses, I work in the third sector. If we are looking for practical solutions through a cultural shift and wider training, statutory agencies need to see the third sector as meaningful partners. There will often be talk about partnership working, but that does not involve cascading training to third sector organisations that deliver activities that progress the statutory agencies' objectives. The third sector is often regarded more as a transactional sector that will just carry out some activities. Those organisations are not involved in planning and are not offered training.

Every time I look at a policy paper or an operational plan that will put a policy into action—from, say, the health board or local authority—there are always impact assessments at the end. We should perhaps consider asking or requiring that mental health and wellbeing, rurality and poverty are part of the impact assessments, so that no operationalised policy has unintended consequences for those who have to live the life.

10:30

Emma Harper (South Scotland) (SNP): Good morning, everybody, including Karen Lewis and Sharon Wright, who are online. A lot of questions have already been answered, and I was struck by what Sharon said about poverty being the cause of health inequality, universal credit not working and about the removal of the £20 uplift that was provided during Covid. That is 80 quid a month. You used really strong language and words such as "punitive", "cruel" and "unfair", and I am sure that even hearing that is demoralising for lots of people. That was just a comment, but I welcome any thoughts on what we need to do to change the situation, such as through a minimum income guarantee or universal basic income, and what we might need to do to progress such ideas, as witnessed in other countries.

I have a local question for Karen. I visited the Hub a couple of weeks ago and witnessed for myself the work that is being done there. Karen should be commended; she certainly helped with my knowledge. I would appreciate further detail on the barriers for people who apply for whatever support they can get.

The Convener: We will go to Sharon Wright first.

Dr Wright: You are absolutely right: universal credit is a major issue. A £20 uplift would be extremely welcome, but it would be important that that was applied to the legacy benefits. One of the hard things with the £20 uplift, when it was in place, was that it was beneficial to people who were claiming universal credit, but for people who were on other benefits such as employment and support allowance or jobseekers allowance and who had not yet moved over, it felt very unfair that they could not have the uplift. It was obviously a terrible decision to remove it.

The uplift was problematic in some respects because, when it was in place during the Covid pandemic, some people did not get the full benefit from it. You would think that, if a £20 uplift is provided, people will have £20 more in their pocket, but because there are so many deductions to universal credit, some of the people who received the uplift were paying out some of that money to repay old debts such as rent arrears or repayments to the Department for Work and Pensions. The DWP has an aggressive debt management strategy and requires people to repay large sums within a short period or to have a regular deduction all the time, which leaves people with very little money to live on.

In the long term, the minimum income guarantee that the Scottish Parliament is currently looking at is promising, but it depends on a number of different scenarios. A minimum income guarantee could be most effective if the Scottish Parliament were to get increased powers over social security, which would be most likely if there was a vote for independence, although it would not be guaranteed. If a minimum income guarantee operated under the current powers or a partially increased set of powers over social security, it could be quite limited. It could be that a minimum income guarantee would operate alongside the universal credit system.

I have two concerns about that. First, it might take a long time to get going—four years at least, but perhaps more. Secondly, it might have to operate alongside major parts of the existing system, such as universal credit.

Therefore, I urge you not to wait to make your recommendations but to just press ahead and ask for increases straight away, because people are really struggling. Many people have very low incomes, and you can see that that is so much worse now than it was a decade ago, before we had universal credit, before the benefits freeze, and before the five-week wait and all these deductions. A minimum income guarantee makes us hopeful for the future, but I do not think that we can wait for that rather than taking action, because while we are waiting for that to come in, health inequalities will worsen and people in poorer communities will literally be dying. Therefore, please do not delay increases in income.

The Convener: The Scottish Government seems to be prioritising getting money to families with children by doubling the Scottish child payment. Obviously, that will miss out a lot of people, so there are other interventions. However, is that prioritisation probably right at this time, Sharon?

Dr Wright: It is hard, is it not, to say that some people deserve money more than others? It will definitely help in meeting the child poverty target, so it is a very good intervention to give more money to children. Therefore, I definitely support increasing the child payment. It could easily double, and that would be a good use of resources. However, as you said, that is difficult for people who do not have children. At least if a household has the child payment coming in, the household has more money, but households with no children are just left out of that transfer. That is an issue for households with no children. There is an increased likelihood of poverty and a deepening of poverty. As times goes on, it gets worse and worse.

Because universal credit is for people in work as well—it replaces working tax credit—there is no escape for those households. Those who are most disadvantaged are doubly disadvantaged. If you are disadvantaged in the labour market—for example, if you are a woman, if you belong to a black and minority ethnic group or if you are disabled—there are employment penalties that mean that you are less likely to be in a well-paid job, you are less likely to progress in work, you are more likely to have low pay, you are more likely to be working part time, and you are more likely to have to claim in-work universal credit, which will then trap you in that poverty. Therefore, it is genuinely a tricky issue.

It is projected that 70 per cent of working universal credit claimants will be women. Within universal credit, the emphasis is on full-time work of 35 hours per week, which is difficult for many women who have caring responsibilities for children or other adults, and women who have health problems themselves and who are disabled. Therefore, it is difficult to find an easy solution, but I certainly support an increased child payment.

The Convener: I will bring in Karen Lewis before I come to other colleagues.

Karen Lewis: The question that Emma Harper posited was about the barriers that people face. However, first, I want to endorse what Sharon Wright said about the fact that the child payment will help those families with children, obviously. However, many of the people we deal with do not have children or are older people. We deal with people on the rent deposit guarantee scheme who are in mid-life with no dependent children, so that payment does not help them.

We have looked at the barriers to people who are in the private rented sector claiming support and help. The tenant support grant that I referred to, which so few private sector tenants accessed, required people to prove a rent debt. That meant that the landlord had to show that they had not received payments from the tenant. The tenant had to agree with that and explain why they had not paid their rent. Many of those tenants might have been getting some help towards the rent—not full housing allowance; they might have been in work and getting some allowance—and had not paid it over. Therefore, the chances of their thinking that they had a positive relationship with the landlord were small. They were frightened of collaborating to claim that help—that was one issue. They then also had to demonstrate that there had been a pre-payment plan agreed between the landlord and the tenant. It is difficult to prove that you have that and that you have developed that.

Those are the kind of things that put private sector landlords and tenants off applying for, or being eligible for, that support. Housing associations already have all that paperwork. They already have things such as debt management processes in play. That is one barrier.

As regards barriers that are faced by people who want to access other kinds of help, we have mentioned universal credit. Someone who is 30 years old, who works 32 hours a week—as I said, a lot of people in Dumfries and Galloway are underemployed—and who earns the minimum wage would not qualify for universal credit. Someone whose take-home pay is about £1,000 or £1,100 a month will get no help whatever—they will not even get council tax benefit, apart from the 25 per cent single person discount. Taking off their rent of, say, £475 and the cost of travelling to and from work, they will probably have £470 a month to live on. That is someone in work, who cannot get help from anywhere else. I think that the differential will grow. Unless a person in that situation manages to work their way out of poverty, get a better-paid job or work more hours, they will always be in chronic poverty.

I want to mention another point that a lot of people lose sight of. When someone is in poverty and is struggling on a very low income, with all the impacts that that can have on their health, which we have talked about, their world view shrinks to just getting through the day, and their capacity to chase, to get through the gateways and past the barriers, and to have the evidence to provide diminishes. Often, people just give up. The system grinds them down. Sometimes the support is there, but the processes that have to be gone through to access it militate against it being accessed by the very people who are vulnerable, who will have a lot of other stress factors going on in their lives, which means that they cannot cope with having to wait for support.

Yesterday, I tried to ring up the benefits section for someone. I was on the phone for 55 minutes before the call was cut off because the office had closed; I was trying from just before 5 past 4 till 5 o'clock. I was using my work phone and I am paid for that time, but if I was someone who was under stress, I would have just given up. It is defeating to have to wait so long.

We must look at simplifying access and having decently funded support services that assist people to navigate their way through such processes. Benefits are not being taken up because there is a lack of such support. It seems to be the case that it is the people with the highest capacity who are more likely to get benefits and support than others. That builds inequality in a group of people who already face inequality. There are different layers of it. From a social justice perspective, that is not acceptable.

Richard Meade: I want to pick up the issue of unpaid carers. A report that the Joseph Rowntree Foundation published this year found that unpaid carers are more likely to be in poverty than non-carers, and that the greater the number of hours a carer works, the more likely they are to be in poverty. Earlier this year, we published a report that looked at carers and the cost of living crisis. Overwhelmingly, carers face greater increases in the cost of things such as energy bills, as well as reduced income.

We welcome the carers allowance supplement, but that is simply not enough to meet all the challenges. We know that, as soon as someone who is working as a carer hits £132, they lose any entitlement to carers allowance. Equally, someone of pensionable age who receives any kind of pension will not get carers allowance, either. In Scotland, carers allowance reaches only about 90,000 carers. Lots of carers really struggle. We need to do a lot more through Scotland's social security system. I hope that the carers assistance consultation will give us a chance to do that, although I have some doubts. We need to do much more to address carer poverty.

The Scottish Government has a child poverty strategy. We are very much in favour of it having a carer poverty strategy, too, to address some of the unique conditions that carers face and to look at how we might use the powers of the Scottish Parliament to address the poverty that they face.

The Convener: The increase in utility bills for heating and electricity is affecting people with caring responsibilities disproportionately.

Richard Meade: Absolutely—it is massively disproportionate. I can give some good examples. Someone who is caring for a person who has medical equipment in the house that needs to be on 24/7 simply cannot turn that off. How will they be able to meet those costs? We have seen examples of carers who face bills of tens of thousands of pounds a month because of those costs. That is extreme, but it is not uncommon that families with people with disabilities and carers are facing huge challenges to heat their homes and to keep their homes running on such limited financial resources.

The Convener: So the carers allowance comes in, but then it gets completely swallowed up by the increase in fuel bills.

Richard Meade: Absolutely. It does not even touch the sides.

10:45

The Convener: Emma Harper has a short supplementary question and then I must move on to other members.

Emma Harper: Thanks—it is a very short question for Karen Lewis. Is the rent deposit guarantee scheme only a Hub Dumfries and Galloway thing, or are there third sector equivalents elsewhere in Scotland that have it as well?

Karen Lewis: There are rent deposit guarantee schemes across Scotland. The majority of them are statutorily run. I can think of a scheme in Ayrshire—that is probably the nearest. Each scheme is run in a different way. For instance, with our scheme, our funding agreement does not allow us to cover rent arrears. That means that, in Dumfries and Galloway, we are putting all the risk on landlords who have a social conscience and who will take the rent deposit instead of a cash deposit. They will run the risk of the rent arrears, which they would normally have been able to keep the deposit for.

Such schemes run throughout Scotland. They are funded in different ways—they are not centrally funded. We are supported by Crisis, which supports rent deposit schemes in Scotland. It was funded to do that; it is not funded any more, but it still does it. I do not know off the top of my head, but I can let you know how many schemes there are.

The Convener: Colleagues, we will extend the session for another 15 minutes, so we have until 11.30, but there are an awful lot of you wanting to ask questions. Please direct them to individuals so that we can get through everyone.

David Torrance (Kirkcaldy) (SNP): The third sector is very successful in reaching families, individuals and communities—in many cases, it is far better than Government agencies. How has the Covid pandemic affected the third sector in relation to volunteers? The sector relies heavily on them and I know that, with two of the organisations that I have been involved in, the volunteers have not returned in the same numbers. I will ask Richard Meade about that first.

Richard Meade: For many unpaid carers, Covid simply is not over and many are still acting as they were during the lockdown. They are still shielding and they are deeply concerned about Covid coming into their household, whether they get it themselves, which might mean that they can no longer provide care to the person they are looking after or, worse, that it gets to the person they are looking after. If that person is clinically vulnerable, there is a risk of severe outcomes and carers have deep concerns about that.

Many of the unpaid carers and people we work with are acting as if they are continuing to shield and they feel a bit isolated from society’s return to normal as protections have been lifted. We have definitely seen a lot less interaction from people than we might have seen prior to the pandemic.

The Convener: Does anyone else want to come in on David Torrance’s question? It might be appropriate for Karen Lewis to speak about what is happening in the Hub Dumfries and Galloway.

Karen Lewis: Yes, there has definitely been an impact on volunteering. During the Covid period, people internalised the isolation and it is going to be a transition for people to feel that they can come back and volunteer again.

During Covid, there were a lot of changes to how we delivered services and how we engaged with volunteers. Some people may need to learn a new role. There has definitely been an impact and I think that people will come back, but it will take time. An awful lot of statutory agencies rely on the third sector and volunteering to deliver activities and services, so the challenge around volunteer numbers needs to be recognised. Many third sector organisations do not have funding to employ a volunteer development post. We have revisited everything around that to maintain our volunteering and to provide the additional support that volunteers may need during this transition period.

David Torrance: Many of the people I represent are in poverty, but they are in work. I have a question for Sharon Wright. What do we need to do to change employment law? A lot of people are on zero-hours contracts, for example, which is forcing them into poverty and they are stuck, because they cannot then go on to benefits.

Dr Wright: That is a tricky question. The living wage definitely helps. Promoting the living wage or a requirement for the living wage to be paid would be helpful. Changing employment law would be quite tricky because of the limitations in Scottish jurisdiction. Zero-hours contracts are problematic—people who are on universal credit can be required to take zero-hours contract jobs that do not offer particular hours but tie people into a contract. I am not exactly sure how you would get rid of that, but I like the intention.

Tess White (North East Scotland) (Con): The Scottish Government has a target to have 250 link workers in surgeries. Toni, do you think that having link workers in surgeries would help people who come out of prison to integrate in the community when they need healthcare?

Toni Groundwater: Absolutely. The key element for me, which I mentioned earlier, is throughcare—engaging with someone while they are in prison and setting up some of the key services and support that they might need. So long as continuity is maintained, along with the relationship, which we know is important for consistency in the community, we would be supportive. The key element is for the relationship to start and be maintained while someone is in prison.

Tess White: Richard, can you talk about link workers in surgeries?

Richard Meade: I think that everyone in health and social care settings should have a duty to try to identify carers. Link workers are an important part of that. However, GPs, practice nurses or staff who are working at reception desks can all play a role. Carers often come in accompanying the person whom they are looking after, but they might sit in the waiting room where no one speaks to them or identifies them; they could be carers and they could be identified at that point. Health and social care staff should have a duty to identify carers, and link workers could definitely be a part of that.

Tess White: So the message could be that the recruitment of those 250 link workers should be sped up.

I have a general question for the panel. The pandemic has exacerbated systemic health inequalities. In your areas, have each of you identified one example of good practice, even if it is a small example, that could be applied more widely across Scotland? I will start with Richard Meade.

Richard Meade: To be honest, I think that there have been improvements with lots of little things, for example, some of the digital stuff—the ability for people to access digital services. However, the problem is with digital exclusion. As I have said, many families still continue to shield and are worried about coming back into society—

Tess White: Sorry, that is a bigger issue. Is there one, tiny, small example of best practice that you have identified that could be applied more widely?

Richard Meade: Digital, whether that is for hybrid working, appointments with GPs, or the other benefits that we have discovered during the pandemic.

Toni Groundwater: This relates to both of the points that you have raised. One of the key things for me is the whole-family approach, which the Scottish Government is committing to as part of the Promise and the drug and alcohol framework. In terms of both link workers and good practice, wraparound support that involves the whole family is a key element, and it could be important as part of the link work that you mentioned earlier.

Dr Wright: My current research is about how migrant essential workers have been affected by Covid. It would be useful for link workers to be specifically dedicated to working with migrant communities. There is research from North America, where link workers are called community navigators. The idea is that link workers are people who are from the community who guide people to health services in a way that is culturally sensitive and appropriate and uses the target language in order to put migrants in touch with the health services that they need.

Karen Lewis: During Covid, a single access point model was piloted in an area of Dumfries and Galloway. People had a single point of contact and were diverted from there to an appropriate agency. There is the kernel of a good idea in that, because it would facilitate the no wrong door idea. However, the model is operated by computer algorithms, so unless an organisation is in the loop and its service is included in the single access point, a person will never get referred to it. There is something in that model that could work and be innovative because it means that people will not be passed from pillar to post and have to tell their story over and over again. People will be sent to the right organisation straight away, whatever sector it is in. However, the model should include a much wider framework.

Sandesh Gulhane: My question relates to the one that Tess White asked. I want to focus on the inverse care law, which says that people who need help most often have the least access to it. As Toni Groundwater will know, that can be seen in the fact that there is a lack of prison medics. There are also areas with high levels of poverty that have the lowest number of available GPs and dentists for people living in them to access. Focusing on healthcare, are there any good schemes, and can they be scaled up to allow people to have more access to healthcare?

Toni Groundwater: When you were talking, some good initiatives that have happened in prisons came to my mind. The roll-out of the Covid vaccine in prisons was a positive initiative, and take-up of the vaccine was good, but it fell down when people returned to communities. Therefore, throughcare and community links are required and important. Blood-borne virus screening in prisons was another positive initiative that worked well in prison establishments.

The third sector plays a massive role in supporting people with their health and in reducing health inequality. Karen Lewis made the point that we need to think a lot more strategically about the role that the third sector can play, in partnership with healthcare initiatives, to get more positive outcomes for people.

Sandesh Gulhane: Existing issues have been highlighted by Covid, and we can now see the big fault lines throughout Scotland quite clearly. In the light of what Covid has shown us, what should be our number 1 priority to tackle, and how could we go about doing that?

Richard Meade: Unpaid carers need a return to pre-pandemic levels of support and services in the community. More than 70 per cent of unpaid carers are yet to have a respite or break as a result of the pandemic. That is because day care and other social care services are not back to the levels that they were at before the pandemic—not that they were particularly sufficient at that point—and, as a result, carers are struggling and have not been able to get a break. That needs to be a priority.

We could look at why self-directed support and flexibilities that were promised during the pandemic were implemented in certain parts of the system but not others. If some of those flexibilities were implemented nationwide, they could support carers. For example, if a carer is eligible for a budget, it could cover how they could use it flexibly to get a break and some support.

For us, getting services back to pre-pandemic levels is a priority that needs to be focused on. That is so that people can get the support they need and to allow carers to have breaks.

11:00

Dr Wright: I have two number 1 priorities, the first of which is adequate income to tackle poverty. That is the best way of tackling health inequalities. However, the number 1 health priority is mental health; after all, we have seen the evidence of the worsening of mental health during the pandemic, with the huge increase in mental health problems. I am not sure how we go about addressing that, but it is a huge problem, and the issue of mental health definitely needs to be tackled.

In my current project, which is on the impacts of Covid on minority ethnic groups, we found in our survey that people working in health and social care had the worst mental health along with those working in essential goods. Therefore, it might make sense to do a bit more research into whose mental health has been worst affected and to target support specifically at those sectors—that is, people working in health and social care and in essential goods. We also found an above average increase in mental health problems among those working in education, but we thought that that was mainly a gender effect, given that the sector is dominated by women, rather than a separate sector effect.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): My first question is for Dr Wright, who spoke earlier about lobbying Westminster for an increase in universal credit rates. I would certainly not disagree with that, but what about the fundamental design flaws in that system such as conditionality—I think that I have said that properly—for employed and unemployed people, the initial long waiting periods of at least five weeks during which people go without money and the length and severity of the sanctions, which, compared with the rest of the world, are incredibly severe?

Dr Wright: You are absolutely right: those are major problems with universal credit. The conditionality aspect is very problematic, because one of the issues in that respect is that people are very scared of sanctions, even if it is not very likely that they will be sanctioned. Indeed, that fear runs really deep. Because universal credit also includes the housing payment, people are really worried that, if they are late for their appointment by even five minutes, they will end up losing their home. You would think that such fears would be irrational, but they are actually rational, because that is how the system is designed. All of these things are interconnected, and people are really scared of losing them.

In recent years, though, the DWP has eased up on sanctions. The system is still extremely harsh by historical standards and in comparison with other countries, but internally the DWP has stopped applying sanctions as frequently as it did at the height of sanctioning in 2013-14. However, although it got rid of the harshest sanction, which was for three years, all the other sanctions are still in place, and it would be extremely welcome if you were able to lobby the DWP to reduce the length of sanctions further and to protect people from being sanctioned. After all, it is still quite easy to trigger a sanction.

The five-week waiting period continues to be problematic, too. There is no evidence of any reason for designing the system in such a way, although the rationale that the DWP has put forward for the five-week wait is that it is because universal credit is paid in arrears. However, it could just make a different policy design decision to pay the money up front and deal with it later if, for any reason, someone turned out to be ineligible. The five-week wait should definitely be changed, as it is highly problematic.

Research that I carried out in 2019-20 for the Joseph Rowntree Foundation in Glasgow showed that about half the people whom we interviewed had applied for an advance payment while the other half had not. Those who did not have the advance really struggled during those five weeks; they found it extremely difficult to have money for food, and had to rely on friends and family to get by and for basic survival. Those who took the payment stored up trouble for later, because they had to repay it, which then meant that they did not have enough money.

The other side of conditionality—it is not just about being sanctioned or the fear of sanction—is the continual pressure to work, which is especially difficult for people with long-term health conditions and people who are disabled, including many claimants who have mental health problems. When universal credit was first released, a lot of people did not realise that it is designed to treat people with mental health problems as if they do not have mental health problems.

In our Glasgow research, we found that people were waiting for as much as a year for a work capability assessment; they were claiming universal credit while being subject to full conditionality, so they were expected to look for a job or multiple jobs for 35 hours a week. In theory, they could discuss with their work coach a reduction in conditionality, but many people felt that they were not able to do that and felt disempowered. Even those who request a reduction are not guaranteed to get it.

The pressure to look for work is intense, and the fear that, if you do the slightest thing wrong, you will not have any money to survive pushes people away from the system. People who are eligible for universal credit do not necessarily claim it, and people might choose to stop claiming it because they are so put off by that intense pressure.

In my big research project about welfare conditionality, we spoke to people who had chosen to, for example, live in a car with their children instead of claiming universal credit. That disincentive strategy is powerful, and it urgently needs to be addressed to make sure that people get the support that they are entitled to. My current research with migrant essential workers shows that EU migrants are very unwilling to access universal credit, and some of those who tried were not able to access it, because it is difficult for people in that circumstance to claim. Universal credit is working imperfectly and has a lot of design flaws but, for those who claim it, it would be extremely helpful to reinstate the £20 uplift.

The Convener: Stephanie Callaghan has a short supplementary question, and then we must move on.

Stephanie Callaghan: I have a different question that is a bit wider. How do we put wellbeing at the centre of approaches to all the issues that we are hearing about around the table? Is there a place for wellbeing plans for individuals that they have power and control over, so that they are looking at their needs, prioritising them and using that as their access to different services across the board?

The Convener: That supplementary question is on a completely new area, Stephanie. We have 20 minutes left, but I ask a couple of witnesses to respond to that briefly before I move on to questions from Gillian Mackay.

Richard Meade: I can be very brief. Under the Carers (Scotland) Act 2016, every carer should be entitled to an adult carer support plan or a young carer statement. Those should be, in part, wellbeing plans; they should be about identifying carers' needs, having conversations about what support they might need in their caring role, signposting them to information and support, and if it is likely that they would be eligible for further statutory support, making sure that they get a carers assessment.

The Convener: I apologise to Karen Lewis; you wanted to respond to Sandesh Gulhane's question about your top asks. I bring in Karen Lewis before moving on to Gillian Mackay.

Karen Lewis: My response figures with other things that have followed since that question. During Covid, there was a flexibility around support. We had the £20 uplift of universal credit, evictions were halted and there were other schemes, which shows that we can do things quickly when we need to. My one ask is that none of those things is short term.

We have seen the fallout from taking away the £20 universal credit uplift. That just feeds in to what Dr Sharon Wright and I have both talked about, in that it builds up insecurity, anxiety and levels of stress in people who least need to be under those conditions. It means that they are never quite sure whether the rug is going to be pulled from under their feet.

My one ask would be that, whatever is developed and delivered to address poverty—as much as we are able to do within the confines of the funding that we have available and the legal framework—is not short term. We need to make sure that we do not build up an expectation that something is going to be there forever and then pull it away from them. We need to ensure that people do not plan their lives on the basis of A and then suddenly, from nowhere, find that it is B.

For those of us on the panel, many of the people who we work with do not have assets; unlike many of us who have been in work, they do not have savings that can help them through a difficult period. They do not have access to credit, and many of them do not have families that they can rely on.

Whatever we do needs to have longevity—that is a fundamental issue for me, so that people do not get into the cycle of constantly being back at square 1, because you can imagine how that erodes people's self-confidence, capacity and health.

The Convener: You are talking about people being on a precipice the whole time—thank you for that description. Gillian Mackay is next.

Gillian Mackay (Central Scotland) (Green): Thank you, convener, and my apologies for being late; there was an additional Parliamentary Bureau meeting that I had to attend. Given the time, I will ask my two questions together.

First, to what extent are health and care services taking a trauma-informed approach, and what improvements need to be made?

Secondly, we have heard this morning about interactions between income and poverty. In other evidence sessions, we have heard about how disability, sexual orientation, gender identity, asylum status, justice experience, being a carer and many other factors interact to present cumulative barriers. To what extent, in each of your areas, are health and care services equipped to take an intersectional person-centred approach?

Toni Groundwater: Prison needs assessments are undertaken. The previous assessment was done in 2007 and we are waiting for the most up-to-date one, which I understand is under way. That is looking into the physical and mental health needs of prisoners, including in relation to substance use.

We urgently await the assessment so that we can design person-centred and trauma-informed services in prisons. We welcome that as a key opportunity, and we would urge that any findings are clearly linked to anything that we are thinking about in relation to health inequalities and the wider health and justice portfolio. There are many opportunities to join some of that up with the prison needs assessment.

Richard Meade: The point about intersectionality is really important. Carers are more likely to be women, in poverty and older; they are less likely to be in work. That all combines to contribute to the poorer health outcomes that they face when compared with non-carers.

We need to take a systematic approach to how we address that because, if we fix one bit of it, the rest will not just fall into place; we need to look at the whole system. That includes everything from the health and social care system to transport, the environment and access to services—I mentioned digital exclusion earlier. We need to take a public health approach when we are talking about how to tackle the needs of unpaid carers, but I do not see the possibility of that on the horizon at the moment. I really hope that, as a consequence of this inquiry, some of those issues are addressed and that pressure is put on Government and others to take a systematic public health approach in doing so.

Karen Lewis: In relation to people coming through the rent deposit scheme, as I said earlier, the issue is often just poverty. I say "just"—I mean that they are in poverty but they do not have other complex needs, so they may not have other agency involvement. Therefore, I see very limited evidence of health and care services taking a trauma-informed approach.

Many people—certainly those I talk to—go through services without any assessment of the traumatic impact on their health of their situation and experiences. I am not aware that people are asked about that or that that is investigated. I think that trauma exists within people, and services can assist people, but we are not really digging down to take a trauma-informed approach to those things—I have certainly not observed that in housing services.

11:15

Dr Wright: There does not seem to be a trauma-informed approach in social security. Rather than taking intersectionality into account or taking a person-centred approach, the UK-based system seems to be driving trauma and reinforcing disadvantages and structural inequalities. Therefore, it would be a fantastic improvement if trauma was taken into account and people were treated in a genuinely person-centred way. The DWP suggests that people's back-to-work plans and claimant commitments are individually tailored, but, in practice, according to the people we have spoken to, all that means is that people might have a reduction in the number of hours that they are expected to spend looking for work or an adjustment will be made to their conditionality. The approach is not genuinely person centred in relation to health or social care.

Worse than that, the system directly invalidates physical and mental health problems, because it takes too long to assess people's health and disregards medical evidence—the medication that people must take, the opinions of specialists and GPs—because that in no way informs how they are treated, given that they are pushed towards work until they have a work capability assessment. Even after a work capability assessment, many people are not eligible because, particularly in relation to mental health, they cannot score enough points for that to make any difference to what is expected of them. Therefore, a trauma-informed approach would be a fantastic improvement.

Carol Mochan (South Scotland) (Lab): Many points have been well made today, and a lot of my questions have been answered. I take the points about lobbying and ensuring that we get the system change across the UK that is desperately needed. In the meantime, what can we in the Scottish Parliament do in terms of our responsibilities? It has been suggested that we can maximise the benefits that are available to us here, and that we can look at making system change in Scotland. I am interested to hear from witnesses about carers in particular. We want people to know that they are entitled to benefits, healthcare and access the systems that are in place. How can we best do that with the powers that we have?

Richard Meade: You are right. As I mentioned, although it is welcome, the carers allowance supplement could definitely be higher. There is a cost of living crisis. The Scottish Government set a precedent during the pandemic when it doubled carers allowance supplement on at least two occasions, I think. We would certainly like to see that again this winter to support people with the cost of living. We know that energy bills will go up again. At the moment, there is a consultation on the proposals for the Scottish carers assistance benefit, and Scotland has a really good opportunity to create a far better, far fairer and much more supportive carers benefit, and we would urge the Government to consider doing that.

Ensuring that people are aware of what they are entitled to is a huge issue. As I mentioned before, lots of carers do not recognise themselves as carers or are not identified as such. We have done research that suggests that it can take carers up to two years to realise that they are in a caring role. In that time, they could have been getting support—social security support or support from social care services, such as short breaks and respite. Therefore, we must do more to raise the visibility of unpaid care and caring roles. We must also do more across all our health and social care systems to proactively identify carers, approach them and then support them so that they realise what support they are entitled to and should be getting to help them in their caring roles.

Carol Mochan: Do the witnesses have any thoughts on how we can ensure that the system understands that people are entitled to that healthcare?

Toni Groundwater: I will follow on the points that Richard Meade has highlighted. The majority of people whom Families Outside supports are women, who are often supporting a son or partner in prison. There could be more wraparound support in prisons and the justice arena to ensure that carers are identified and have access to the appropriate support.

Carol Mochan: That is lovely. Thank you.

Evelyn Tweed (Stirling) (SNP): In our evidence, we have heard a lot from people who are worried about the cost of living crisis and how they will pay their bills. It is a case of heating or eating. Obviously, a lot of people have switched off their heating at the moment, but they are worried about winter. Will Rishi Sunak's cost of living payments help? Are people still in for a difficult winter? I put that question to Dr Wright.

Dr Wright: Yes, the cost of living payment will help people, but it will not help them enough, given that the shortfall will be so great. Some people have a history of debt that has built up over time to become enormous. Given the amount of money that people get through benefits and the extent of in-work poverty for people on low wages or who work part time, there is an enormous gap between the amount of money that people need and the amount that they are getting.

On what we can do in Scotland, I support the proposal to double the carers allowance supplement again. Also, there are a couple of ways in which we could maximise take-up. We could do that via targeted adverts. Facebook can be quite effective; its targeted adverts function could be used to target carers and women in the demographic groups that we are most concerned about. Radio adverts, too, could be a good way to get to women in the demographic of people that need the carers allowance supplement.

Toni Groundwater: There is robust evidence of the financial impacts on the family when someone goes to prison. Families Outside is involved in research to get more up-to-date evidence on that. Often, the person who goes to prison is the sole breadwinner for the family.

For families, one of the most important things is to keep connected with the person in prison, and the increased cost of living, including transport costs, makes that increasingly difficult.

There is means-tested help with prison visits that people can access—the scheme sits with the UK Government. There are considerable challenges if a family member who is experiencing in-work poverty cannot access that benefit because they are employed. The scheme does not take account of, for example, how far the family member might live from the prison. The financial issues increase social isolation, and we know about all the impacts of that.

The Convener: Family relationship breakdown could be an impact, which is particularly difficult when someone comes back into the community.

Toni Groundwater: Absolutely.

Richard Meade: On the Chancellor of the Exchequer's announcements, some carers will receive support, if they are pensioners or on means-tested benefits—we have not yet worked out how many will get support—but a number will get no additional support beyond what the rest of the population gets. That gap is exactly why we think that the carers allowance supplement should be doubled again this winter, to ensure that carers are not disproportionately impacted, again, by the cost of living crisis.

The Convener: That brings us back to your earlier comment about the disproportionate impact of the increase in the cost of living, particularly with regard to fuel.

I see that Sandesh Gulhane wants to come in, but first of all I want to pick up on something that Dr Wright said at the very start of the session. I actually wrote it down, and I just want to get a little more information on it and find out whether I heard it right. Dr Wright, when you talked about people being put off from claiming and the disincentives in that regard—we have been hearing about that throughout the morning—and about people who might have mental health problems being treated as fit for work, you said, I think, that they might then turn to "survival crime" and "survival sex". Can you expand on that? Did I hear that right?

Dr Wright: Yes, you heard it right. It is really upsetting.

That was a finding of a big research project that I carried out between 2013 and 2019 on welfare conditionality, in which we looked at the impact of sanctions. We found that a number of things, including not only the sanctions system itself but benefit caps such as the household benefit cap, the two-child limit and the freezing of the value of benefits had combined to put people in extremely difficult financial situations that were much worse than would have been the case before 2010. We interviewed people who had turned to extreme measures because they had no alternative. It was only a very small minority of the 481 people to whom we spoke, but some had been forced to turn to survival crime and, in a couple of situations, survival sex, because they had no money and no way of getting any. They had to take those extreme measures to try to get by, and it is very distressing to find people doing such things in times when they should not be happening.

The Convener: Thank you for the clarification. I guess that, with the cost of living crisis, we might see more of that as people are plunged deeper into poverty.

Sandesh Gulhane has a final question before we wrap up.

Sandesh Gulhane: I want to pick up on the financial impact of going to prison. When someone gets released from prison, do the jobs that they can get pay much less? Indeed, will they struggle to get any job whatsoever?

Toni Groundwater: The struggles that many people with previous convictions face as they try to reintegrate into society and gain meaningful employment are well noted. I would agree that that is an added barrier, but I also go back to my earlier point that issues with meaningful relationships, access to care and so on will all have an impact on health, too. It is a really important issue.

The Convener: I thank all four of you for the time that you have spent with us this morning, and I also extend my thanks to the many people whom you brought to speak to us a couple of weeks ago, some of whom are in the gallery today. It is nice to see them again, and I hope that we will be able to meet them after the meeting.

At our next meeting on 21 June, the committee will continue to take evidence for our inquiry into health inequalities. That concludes the public part of our meeting.

11:28

Meeting continued in private until 11:37.

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