# KENT COUNTY COUNCIL

## SELECT COMMITTEE - LONELINESS AND SOCIAL ISOLATION

MINUTES of a meeting of the Select Committee - Loneliness and Social Isolation held in the Swale 1 - Sessions House on Monday, 17 September 2018.

PRESENT: Mr K Pugh (Chairman), Mr M A C Balfour, Mrs P M Beresford, Mr D L Brazier, Ms K Constantine, Ms S Hamilton, Mr A R Hills, Mrs L Hurst and Ida Linfield

ALSO PRESENT:

IN ATTENDANCE: Mr G Romagnuolo (Research Officer - Overview and Scrutiny), Miss E West (Democratic Services Officer), Mr A Tait (Democratic Services Officer) and Ms D Fitch (Democratic Services Manager (Council))

### UNRESTRICTED ITEMS

**5. Mr Graham Gibbens (Cabinet Member for Adult Social Care and Public Health), Ms Diane Marsh and Mrs Clair Bell (Deputy Cabinet Members for Adult Social Care and Public Health)**
*(Item 1)*

The Chairman welcomed the guests to the Committee and reminded the Committee of the Terms of Reference. A short introduction was given by Members and officers.

**Q – Please introduce yourself and provide an overview of the roles and responsibilities that your post involves.**

Mr Gibbens introduced himself as the Cabinet Member for Adult Social Care and Health. He said that the purpose of Adult Social Care was to support people (adults, young people and carers) who needed help with daily living to enable them to live as independently as possible in a place of their choice. He discussed the four key areas of Adult Social Care which were Older People and Physical Disability, Mental Health, Learning Disability and Disabled Children. Adult Social Care and Health provided social work, personal care, protection or social support services to children or adults in need or at risk or adults with needs arising from illness, disability, old age or poverty. He said that approximately £400m out of the £958m overall budget for Kent County Council each year was spent on Adult Social Care and was the largest individual budget within Kent County Council.

**Q – Is there a mechanism in place within the Adult Social Care and Public Health services which locate individuals who have become unwell through loneliness and are failing to obtain services that they need because of social isolation?**

Mr Gibbens said that one of the challenges that Adult Social Care and Health experienced was around exploring ways in which an increasing older population could be supported. He said that individuals aged 55+ contributed to the majority of Kent's population, although many individuals that used Kent's Adult Social Care and Health services were aged 80+ which meant that people were able to live independently for longer, this was with the help of Kent County Council's services and many other supportive voluntary organisations. He said that he had always sought to support voluntary organisations such as Age UK and said there were many similar organisations which existed around Kent which carried out work for older people. He said that many voluntary organisations also supported carers who were caring for an individual with a long-term illness such as dementia who felt very isolated and lonely, the work that Kent undertook in supporting carers was direct work with the NHS and Clinical Commissioning Groups. He said that supporting carers during times of need was a very important part of Adult Social Care and Public Health's activities. He said that organisations such as Age UK and The Over 60's Community Service in Canterbury had been very effective in providing support to people and many of these organisations provided meals too, to reduce social isolation and loneliness which gave individuals the chance to sit with other people to eat and interact with them. He said that the spectrum of Age UK organisations around Kent undertook lots of work to ensure that older people were connected to their local community to prevent loneliness and social isolation. He said that he felt that the Adult Social Care and Public Health services provided by Kent County Council were good and supported voluntary organisations through financially challenging times. He said that many voluntary organisations provided Befriending services which were a vital function and many people in Kent relied on them. Befriending services provided friendly conversation and companionship on a regular basis over a long period of time. The service also provided an older person with a link to the outside world and acted as a gateway for other services and valuable support. He said that there were always challenges relating to individuals who were living in socially isolating situations and that social isolation and loneliness was a national issue. He said that physical and face-to-face contact with people was important and whilst improving technology was useful in many ways, it often lead to the loss of physical contact.

**Q – Do Kent County Council currently offer a strategy for Social Isolation and Loneliness?**

Mr Gibbens said that he had always supported the establishment of the Social Isolation Select Committee and had worked hard to ensure that more work was undertaken for individuals who were experiencing loneliness and social isolation. He said that if a person was lonely, they were unhappy, and if a person was increasingly isolated, it could bring more health conditions. He said that commissioning through voluntary organisations such as Age UK and Canterbury's Over 60's Service proved that there was a Social Isolation and Loneliness strategy.

**Q – How can Kent County Council work towards recommending the best prevention strategy?**

Mr Gibbens said that the work that had been carried out with carers organisations was very important and upfront. He said that Adult Social Care and Public Health were working towards ensuring that a strategy was in place to ensure that carers were still able to carry out their role of caring whilst still being able to have a life of their own. He said that Public Health in Kent had undertaken much work for socially isolated people by organising group outings and health walks which had encouraged many older people to talk to one another whilst keeping fit and healthy. He talked about the Public Health budget and said that Kent County Council's Public Health services' aim was to significantly reduce health inequalities in Kent.

**Q – What work are Kent County Council undertaking to identify older people who feel lonely and socially isolated?**

Mr Gibbens said that identifying lonely and socially isolated individuals was difficult if they did not admit that they were feeling lonely and socially isolated. Therefore, Kent County Council were dependent on working with groups and voluntary organisations to share responsibilities. He said that Adult Social Care strived to connect with as many Age UK's and homeless charities such as Porchlight around Kent as possible to allow sight into the different types of work that each organisation was undertaking to identify lonely elderly people and to ensure that support was being put into place for these individuals.

**Q – Are we, as a Council, able to help individuals that are referred to local Health Centres by GP's who have deteriorating health due to loneliness and social isolation?**

Mr Gibbens said that Kent County Council were undertaking work to ensure that the close-working relationship between health and social care improved as it was vital and a key concept of local care. He said that the separation of health and social care was an issue nationally. He referred to the integrated health and social care system in Canterbury, New Zealand and how services were delivered. He said that the Sustainability and Transformation Plan had identified the need for stronger and more local care. He said that Kent County Council chaired the Local Care Implementation Board with the view to integrate health and social care.

**Q – Since Kent County Council have experienced austerity and budget cuts, what services with Adult Social Care and Health have been stopped?**

Mr Gibbens said that recent years had proved challenging for Adult Social Care nationally. He said that as Cabinet Member for Adult Social Care, he had worked hard to identify voluntary organisations in Kent and had worked with Transformation teams which had been a significant part of Kent's social care strategy which set out how Kent could deliver services to residents more efficiently. He said that he was keen to work with Age UK to see how ideas and initiative could be shared and to see how more could be done to support Kent's residents without increasing their budget. He referred to Kent County Council's 'Live Well' Mental Health strategy and said that Adult Social Care were accessing

more mental health clients through organisations such as Porchlight. He said that although there were significant challenges across Kent in relation to loneliness and social isolation, through streamlining services, Kent could provide an effective, reasonable service to adults in Kent. He said that more people would be accessing Kent's services due to the increasing population and people living longer and said that Kent should work together to be able to deliver services.

**Q – How are we managing STP's against a decreasing resource?**

Mr Gibbens said that more money had been allocated to Health services and reminded Members of the Committee that it was for local members to account through Committees such as Health Overview and Scrutiny Committee to ensure that the budget was being used in the most appropriate way.

**Q – How can we ensure that individuals who are socially isolated engage with Kent County Council and other service providers and ask for the help?**

Ms Marsh talked about the 'Here for you, how did we do?' Local Account for Kent County Council Adult Social Care which described the achievements, improvements and challenges over the past year and set out Kent County Council's vision for the future. She said that it was important that Adult Social Care and Health tried to reach out to the lonely and socially isolated individuals that the Council were not aware of. She said that in relation to accessing services, social prescription was very important, Kent County Council needed to ensure that staff were signposting individuals when recognising that they were socially isolated or experiencing loneliness. Ms Marsh talked about a personal experience and said that she had previously worked in a very deprived area in Northfleet and had launched a coffee morning, and the only person that attended the coffee morning was an individual that was starving hungry, suffered with mental health issues and had broken the connection with the 'outside world'. The individual's housing benefits had been stopped and he did not have access to a phone, and therefore when the borough council had attempted to call him to help, he could not answer. She said that she believed the system had failed the individual as he needed someone to have a face-to-face conversation with him and physical interaction. She talked about how local supermarkets had opened special café's which offered individual's the opportunity to talk to new people and there was also a 'quiet hour' for elderly people. She reiterated the importance of recognising that the services that Adult Social Care and Health within Kent County Council provided would help future generations as well as the current.

**Q – In relation to GP's, how actively are we in social prescribing to try and engage GP's?**

Mr Gibbens said that Kent County Council were encouraging work with GP's to connect with older people as much as possible. Mrs Bell said that many people that are experiencing social isolation and loneliness don't feel that they need to visit a doctor as they are fit and healthy individuals.

**Q – What impact does technology have on socially isolated individuals?**

Mrs Bell said there was a lot of scope for Kent in relation to technology to positive effect. She said that telecommunication and internet for connecting people was very important and could be very powerful if used in an appropriate way. She said that although there were many concerns in relation to social media and fast-changing technology, there was scope to encourage individuals to use technology through voluntary groups, and as generations changed, more and more people used social media, phones and computers. She said that there was still much work to be undertaken in relation to technology and opening eyes to possibilities such as creating a WhatsApp group to bring individuals closer. She said that individuals needed to seek ways in which to become more connected within their communities as Kent County Council could not reach everybody.

**Q – Are there any other issues, in relation to the review, that you wish to raise with the Committee?**

Mr Gibbens discussed the importance of the Social Isolation Select Committee and the importance of addressing the issue of Loneliness and Social Isolation in Kent. He said that although the Social Isolation Select Committee focused on individuals aged 60-65, Kent County Council acknowledged that loneliness did exist outside of that age group, for example, students, male suicide and working age adults with disabilities. Diane said that more intergenerational work needed to be done in the area of Social Isolation and Loneliness.

**6. Katie Stewart (Director of Environment, Planning and Enforcement) & Stephanie Holt-Castle (Head of Countryside, Leisure and Sport)**
*(Item 2)*

(1) Katie Stewart (Director of Environment, Planning and Enforcement (EPE)) explained that the EPE Division had a net budget of £14m and was responsible for the provision of 19 services including Strategic Planning, Flood Risk, Ecology, Environment, the Energy and Low Emissions Strategy, Planning Applications, Public Protection (i.e. Trading Standards Community Safety, etc) and Green Infrastructure such as Country Parks and Public Rights of Way.

(2) Katie Stewart continued by saying that a vital component of the Division's and Directorate's work was the goal of creating a place which provided access for all to Kent's Landscapes and Environments. When asked what from GET's perspective were the main causes of social isolation and/or loneliness in the elderly, Katie Stewart described how poor health was a major contributor leading to social isolation where people missed out on the County's social networks and physical activity opportunities and also prevented them accessing community assets such as Libraries, Public Footpaths and Country Parks. More more widely across GET, it was also through the planning of GET services such as Libraries, Trading Standards, Sport, and Planning.

(3) Stephanie Holt-Castle (Head of Countryside, Leisure and Sport) explained that a crucial part of her role as GET's public health subject matter expert was to ensure that community assets were available, physically accessible and welcoming to a range of demographics, including older residents and those less

physically able. This was achieved by practical measures such as the provision of a sufficient number of toilets, shelters, seating and signage to supplement the creation of health walks and ranger-led walks. The latter included the creation of easy, half-mile walks and trails.

(4) Katie Stewart then explained that Community Wardens also played a key role in connecting people, particularly those who were socially isolated to such green spaces as well as social networks. Meanwhile, the Countryside Partnerships ran community volunteering conservation projects that connected communities to the parks and green spaces across the county.

(5) In response to a question from Mr Balfour as to whether there was empirical evidence of the work in the Division in supporting wellbeing and overcoming social isolation, Stephanie Holt-Castle said that the Kent Wildlife Trust calculated that each pound spent on green space reaped £3.75 in health benefits. There was a range of Social Return on Investment data that the Directorate captured, as well as some clinical data, but the challenge for the GET Directorate was to gather sufficient clinical data to demonstrate to public health, health and social care providers that the rewards of its endeavours were significant in preventing ill health. This could only be achieved by working hand-in-hand with health commissioners. Stephanie Holt-Castle emphasised the evidence paradox that a lack of good data about the benefits of prevention became a reason not to invest in capturing the data that could demonstrate this. Many 'place based' services were wholly or largely discretionary in nature, and did not have sufficient budget to capture clinical evidence of impact, whether short or long term.

(6) The Officers were asked what KCC should invest in if it were given a blank cheque. Katie Stewart agreed that there was a need for such investment in order to enable the Division to pilot its work against clinical evidence criteria. Stephanie Holt-Castle replied by informing the Select Committee of a draft report being prepared by Public Health, Social Care and GET which was proposing a joined up approach across the three Directorates to engaging with 13 communities in Kent with the highest health inequalities. The three Directorates were sharing their own practices in order to identify the most effective way to work together. It had already become clear that there was no single solution. Such an approach should inform KCC how to invest for the short and long term prevention of social isolation and loneliness in the elderly*. Katie Stewart agreed to provide a copy of the draft report to the Select Committee.*

(7) Katie Stewart warned that there was an incorrect public (and health commissioner) assumption that the provision and maintenance of many of the assets which EPE and GET managed such as Country Parks and Public Rights of Way were free. Country Parks were currently almost 80% self-funding, but ultimately a number of the services still required public funding, albeit with budgets that were much smaller than those of other parts of KCC. If services which were academically and commonly recognised as providing the much lauded preventative 'offer' essential to achieve a step change improvement in England's long term health outcomes, then the demise of such services had to be avoided.

(8) In response to a question about the role of green spaces, Katie Stewart went on to say that the Kent and Medway Growth and Infrastructure Framework had mapped the green spaces such as country parks, AONBs and other green assets across Kent. It also clarified that green space was more than simply a desirable extra that was “nice to have.” The District and Borough Councils were under intense pressure to provide housing, so it was encouraging that many had adopted the Kent Environmental Strategy with the aim of ensuring that housing development did not compromise their environmental aspirations.

(9) Katie Stewart replied to a question by saying that Community Wardens were mainly at Grades KR6 and KR7 within the Kent Scheme (between £19.8k and 24.7k per annum rising to some £30k in overall costs.) Volunteers cost about £12k per annum in the first year, reducing thereafter once the training had been completed. Parish Councils did not have sufficient finances, so GET part-funded them. However, Katie Stewart did commit to confirming these costs in order to double check the estimates she had provided. *Katie Stewart has since confirmed that a Community Warden costs £28k a year with on costs, and that a volunteer warden costs £800 to 1,000 in the first year with an annual cost of £400 to 500 in future years.*

(10) In response to a reference to flood wardens and the link to volunteer support wardens, Katie Stewart said that work was being undertaken to connect and co-ordinate the work of the Community Wardens across the County with flood wardens in order to keep both sets of volunteers more engaged and to maximise the value of their efforts across a community. This had been identified by the Kent Resilience Forum as a priority if communities were to become more resilient at a time when resources were becoming increasingly scarce.

(11) Stephanie Holt-Castle underlined the need for the role and potential of the GET Directorate to be fully recognised both politically and across all Directorates in respect of GET’s very real ability to impact on the social isolation and wider public health agenda. She said that the health remit must not be confined to those who worked for Social Care and Public Health. The draft report referred to earlier aimed to complement the STP process. It was essential to make a conscious effort to stop working in silos, if the ‘step change’ in prevention described by the Marmot Health Inequalities Review, the Care Act and the NHS Five Year Forward View was ever to be achieved.

(12) Katie Stewart said that the GET Directorate was very well placed to contribute to any strategy for overcoming loneliness and social isolation because it touched the lives of all residents, literally from birth to death. It provided many services that everyone knew about (from pot hole repairs to Libraries) and was therefore in a unique position to connect with people whether KCC corporately knew about them or not.

(13) Stephanie Holt-Castle said that the GET Directorate was working on a number of studies with the 5 East Kent Districts to identify and improve the community assets to deal with social issues such as smoking and obesity. An

example of this was Social Prescription where GPs referred patients to non-clinical services such as groups who organised walks in Country Parks.

(14) Committee Members variously commented that there were a number of activities such as archaeology, equestrianism and even darts that could benefit from the Social Prescription approach. Volunteering itself was an activity that prevented social isolation. It was also considered to be important to offer as wide a range of activities as possible in order to reach people regardless of personality, social background or any other disadvantaged circumstance.

(15) When asked how GET could embed consideration of social isolation and loneliness in the elderly, Stephanie Holt-Castle noted that Equality Impact Assessments already captured both the intention to not disadvantage older age groups with policies/programmes/projects and a Business as Usual culture, but also identified the opportunities to improve the lives of older residents. This could fairly easily be supplemented through GET's internal communication channels by shaping and delivering a 'hearts and minds' awareness-raising campaign so that all GET staff understood social isolation and loneliness in the elderly in Kent.

**7. Multi-Disciplinary Group**
*(Item 3)*

***Richard Munn*** *(North Kent and Swale Service Manager – KCC),* ***Jenny Walsh,*** *CED – Red Zebra),* ***Fiona Keyte*** *– Social Prescribing Manager – Red Zebra),* ***Melinda May****, Newly Qualified Social Worker – KCC),* ***Debbie Williams*** *(Case officer Adult Social care – KCC),* ***Kerrie Lane*** *(Senior Occupational Therapist – KCHFT),* ***Cathy Bellman*** *(Local Care Lead – K&M STP) and* ***James Shaw-Cotterill*** *(Project Manager – K&M STP) attended for this item.*

(1) The Chairman welcomed members of the Multi-Disciplinary Team to the meeting and invited them to introduce themselves, explain their role and answer questions from Members.

(2) Richard Munn explained that his areas of responsibility included managing and promoting the supporting independence teams which included Occupational Therapists and other staff who carried out assessments to promote independence. They also carried out supporting independence reviews and responded to urgent changes in need.

(3) Jenny Walsh stated that Red Zebra received referrals from GPs and also self-referrals – they saw 50 new clients a month. The Red Zebra team visited people in their home and, rather than focusing on what was wrong they discussed with the client – "what was strong" – a large percentage of referrals related to loneliness.

(4) Fiona Keyte informed the Committee that the Red Zebra social prescribing team consisted of 3 part time and 1 full time worker. Their aim was to help people to help themselves. They promoted a database called "Connect Well Kent" – which listed local services and activities which could be matched to the

individual's interests. This database could be accessed by individuals as well as the prescribing team.

(5) In relation to a question on referrals, it was explained that there was a weekly Multi-Disciplinary Team meeting, which considered referrals from GPs, health professionals, self-referrals and referrals from neighbours or other members of the community. Red Zebra's services were promoted by GPs and various other methods including talks to community groups. People requiring support were visited in their own homes or in a community setting, wherever the referred person preferred. They might be lonely and want to get out into the community, so they would help them to access the database and see what there was that they were interested in. Most people wanted social activities but there was also a need to provide assistance with housing or welfare needs, including referring them to services for advice/support. It was about the community assisting in providing support and signposting to what was available in people's local area. An example was given of a client who had been widowed and was socially isolated. He was referred to Red Zebra and visited in his home, he wanted to meet people in the community and enjoyed reading and chatting, he went along to Talk Time events and made friends, this gave him the confidence to try other activities.

(6) Another example given was a lady who lived in Kent but worked in London and had no family or friends in her local area. She was due to retire and was concerned that she would be lonely. She had lots of energy and wanted to give something back to the local community. Red Zebra referred her to the local volunteering bureaux so that she had something in place when she retired.

(7) Melinda May explained that she was a newly qualified social worker who saw people in the community and assessed their current needs.

(8) In response to a question it was confirmed that Red Zebra has been established from a pilot in 2016 and each year the number of referrals had increased, from 176 in the first year, to 600 in the second year and in the current year they were on track to deal with over a thousand referrals.

(9) Debbie Williams explained that as a case officer her role was to go out and assess people with the aim of enabling them to remain in their own home. She used Red Zebra for ideas about community activities, as one method of addressing a client's needs. She also met with colleagues from other agencies to share ideas regarding support that could be provided. She confirmed that referrals came from many sources such as GPs, self-referral, referrals from family or friends or others in the community.

(10) In response to a question on the value of heritage, arts and music related activities and whether these were the most popular activities for older people. It was confirmed that the most popular activity was attending a lunch club, there were waiting lists in some areas as this and other activities were run by smaller organisations. It was confirmed that there were organisations who did not have funding to deal with increased demand. One of the most popular

requests was a befriending group which where they exist had a long waiting list – so funding bids were being drafted.

(11) It was confirmed that there was a difference between what people wanted and what was available. Some activities were, free, some were low cost and some were market rate. Art and exercise classes were expensive, but attempts were being made to plug gaps in activities and support.

(12) Kerrie Lane stated that Occupational Therapists saw clients in their own homes to assess needs for adaptations to keep them in their own homes. Occupational Therapists liaised closely with colleagues and had a multi-disciplinary team approach and could refer if there was an issue with social exclusion.

(13) In response to a question it was confirmed that as part of integrated discharge support was given for up to 6 weeks, as it was a short-term service, other support could be identified if needed for longer.

(14) Cathy Bellman explained that in relation to primary community services over the past few years the way services had been commissioned had created barriers leading to a negative impact on communicating and sharing information between organisations. Organisations were not talking to each other for fear of information being used to the detriment of any possible tender bids. The STP were trying to address this and to get statutory organisations to use their workforce in an efficient way. A game changer was recognising the value in the voluntary sector. There was growing demand but not growing funding so there was a need for organisations to work together e.g. GPs working together (for populations of 30,000-50,000) and services developed around the practices to build a community of health and social care workers. She had been talking to people who ran clubs and if evidence of demand was provided to clubs they would be able to address that need. Investment in community services was important.

(15) James Shaw - Cotterill confirmed that the STP provided support across Kent and Medway to CCGs and KCC. One of the objectives was care navigation and social prescribing which meant talking to CCGs and Councils about, for example, models of care. He had written a case paper on social prescribing for NHS England, working to reduce the pressure on the health care system, such as primary care. He gave the example of a patient who used to ring his doctor's surgery 4 times a week to speak to the practice. The patient was referred by Red Zebra for befriending and gardening help. The patient's confidence improved, and he began accessing activities in his community, as his social needs were met. Contact with the doctor's surgery reduced to once a week and the calls were more focused and medically based.

(16) James stated that in London a company called I5 Health was supporting CCGs with social prescribing. I5 Health helped to identify patients at GP level, on specific disease registers that would benefit from social prescribing. The tool suggests invitations, cost and savings from social prescribing. This was

a great example of evidence based proactive preventative social prescribing that made a difference to the individual, system and to service costs.

(17) It was suggested that more should be done to market the service available rather than waiting for a referral or self-referral. James explained that the ethos behind the Multi-Disciplinary team meeting was preventative and identifying patients who were at risk or in need.

(18) It was confirmed that Red Zebra and the Multi-Disciplinary team were looking at waiting lists and the capacity issue and presenting this to the CCG, they tried to apply for other funding as well to fill the gap. The example was given of someone who had been referred for debt counselling with their first appointment at the end of December.

(19) Reference was made to the example of the Mental Health contract when over 100 grants to groups were reduced to 4 lots. This led to the risk of people not fitting into the smaller number of specific services. If the Multi-Disciplinary Team and Red Zebra were taken away, the example of other contracted services, showed the risk that this would leave a gap in service provision.

(20) In relation to barriers to accessing support, Cathy stated that there was a need for consistency across the County. The Strategic Commissioning Steering Group were forming and their function would be to look at making strategic decisions around big ticket items; social prescribing being an example of where a strategic approach would give consistency of provision rather than just filling gaps.

(21) In response to a question regarding transport to e.g. lunch clubs – it was confirmed that there were community transport schemes, which used volunteer drivers, for an annual fee and a charge of 45p per mile.

(22) Regarding how much could be done to get the community involved including community wardens and flood wardens, it was important to support the community to support local people and encourage local people to support the community. Community meetings were a forum for raising awareness of social prescribing and led to referrals. Community Wardens and others used the Connect Well Kent database. It was a way of bringing organisations together.

(23) An example was given of the need for social prescribing to mitigate social isolation and to benefit not only the older person but also their wider family who were feeling the stress of supporting a multi-generational family whilst also working.

(24) In response to a question about gender, ethnicity and the impact on social isolation, Richard stated that in East Kent there was a tendency for older women who did not have English as a first language to become isolated. Direct payments were a means for individuals to control how their care needs were met, rather than imposing services, individuals chose who provides their care.

(25) In relation to integrated discharge it was confirmed that neighbours could be involved if the patient agreed and this would be welcome by the services.

(26) The importance of a GP referring patients and their families to social prescribing, illustrated by a specific example was highlighted.

(27) Cathy explained that the essence of the Multi-Disciplinary Team ambition was to get services wrapped around GP practices to identify vulnerable and frail patients who would benefit from support but who might not seek it themselves.

(28) The emphasis should be on doing more to prevent or reduce social isolation and James stated that there were examples of where social prescribing had made a difference which he would supply to the Committee. It was important to be more consistent and proactive across Kent and Medway when it comes to social prescribing. It was important for GPs to be involved and aware of the importance of social prescribing including the positive impact it could have on GP services by freeing up capacity.

(29) A way of doing this could be social prescribing clinics in GP practices to signpost or just to have a cup of tea with a patient and identify ways of mitigating social isolation. There was a tendency for older people who were socially isolated to go to their GP

(30) Another suggestion was to work towards parity of opportunity for social prescribing across Kent. Also, people who were referred to services should have their needs looked at holistically, social care was about more than just making sure that people were fed and kept clean.

(31) The Chairman thanked the members of the Multi-Disciplinary Team for attending and for answering Members questions. He invited them to submit written evidence in support of the Select Committee's work.