Agenda – Health and Social Care Committee

Meeting Venue:	For further information contact:
Hybrid – Committee room 5 Tŷ Hywel and video conference via Zoom	Helen Finlayson
	Committee Clerk
Meeting date: 24 March 2022	0300 200 6565
Meeting time: 09.00	SeneddHealth@senedd.wales

Private pre-meeting (09.00–09.30)

1   Introductions, apologies, substitutions and declarations of interest

(09.30)

2   Hospital discharge and its impact on patient flow through hospitals: evidence session with the Minister and Deputy Minister for Health and Social Services

(09.30–10.45)   (Pages 1 – 37)

Eluned Morgan MS, Minister for Health and Social Services

Julie Morgan MS, Deputy Minister for Social Services

Albert Heaney, Chief Social Care Officer for Wales – Welsh Government

Nick Wood, Deputy Chief Executive NHS Wales – Welsh Government

Research brief

Paper 1 – Welsh Government

3   Motion under Standing Order 17.42 (ix) to resolve to exclude the public from items 4, 8, 9, and 10 of today's meeting

(10.45)

Senedd Cymru
Welsh Parliament

4   Hospital discharge and its impact on patient flow through hospitals: consideration of evidence
(10.45–11.00)

Break (11.00–11.10)

5   Mental health inequalities: evidence session with Centre for Mental Health and Mental Health Foundation
(11.10–12.10)   (Pages 38 – 69)
Andy Bell, Deputy Chief Executive – Centre for Mental Health
Dr Antonis Kousoulis, Director for England and Wales – Mental Health Foundation

Research brief
Paper 2 – Centre for Mental Health
Paper 3 – Mental Health Foundation

Lunch (12.10 – 13.00)

6   Mental health inequalities: evidence session with the Children's Commissioner for Wales and the Older People's Commissioner for Wales
(13.00–14.00)   (Pages 70 – 97)
Professor Sally Holland, Children's Commissioner for Wales
Kirrin Spiby-Davidson, Policy Adviser, Children's Commissioner for Wales
Heléna Herklots, Older People's Commissioner for Wales

Paper 4 – Children's Commissioner for Wales
Paper 5 – Older People's Commissioner for Wales

7 Paper(s) to note

(14.00)

7.1 Letter from Chair, Petitions Committee to the Chair regarding petition P-06-1241 Welsh Government to meet with a wider audience of unpaid carers

7.2 Welsh Government response to Committee's report on the Welsh Government draft budget 2022-23

8 Mental health inequalities: consideration of evidence

(14.00-14.15)

[Consultation responses](#)

Paper 6 – Engagement findings

Paper 7 – Next steps for the inquiry

9 Forward work programme

(14.15 – 14.30)

Paper 8 – forward work programme

10 Impact of the waiting times backlog on people in Wales who are waiting for diagnosis or treatment: consideration of draft report

(14.30 – 15.15)

Paper 9 – draft report

11 Women and girls' health: consideration of letter

(15.15-15.30)

Please note the draft letter will be published and circulated as a supplementary pack on Monday

Agenda Item 2

Document is Restricted

Health & Social Care Committee

Welsh Government evidence paper:
Hospital discharge and its impact on patient flow through hospitals
March 2022

1. Introduction

The Welsh Government welcomes the inquiry into hospital discharge and its impact on patient flow through hospitals. The Covid-19 pandemic has put extreme pressure on all parts of the health and social care system. These pressures and long-standing capacity issues, in part due to many years of UK Government austerity, have led to sustained issues with hospital discharge and patient flow. These issues are not unique to Wales and have been seen in other parts of the UK.

The Covid-19 pandemic has re-emphasised the need for effective discharge and flow through hospitals, but it has also placed enormous strain on the health and social care sectors for myriad reasons, not least due to depleted workforce and re-distributed/withdrawn services and packages of care to enable prioritisation and meet demand.

Hospital flow is not just about the point of discharge and there are multiple facets to smooth operational delivery and positive patient experience and outcomes. Effective partnership working and integration between health and social care coupled with a person-centred approach to care are essential to ensure timely transfers of care and positive outcomes for individuals. Our focus is on a whole system response.

2. Background

Discharge Guidance
At the start of the pandemic we introduced new discharge guidance:
https://gov.wales/hospital-discharge-service-requirements-covid-19.
This is based on the Home First ethos and the Discharge to Recover then Assess (D2RA) pathways.

The "home first" and D2RA approach is based on evidence of better outcomes for people who transfer as soon as possible to their usual residence or other suitable care setting for rehabilitation or reablement prior to assessments for longer term care. Early in the Covid-19 pandemic, we introduced guidance which embeds this approach and the NHS Delivery Unit is working nationally to support implementation.

We have kept the discharge guidance under review in light of emerging scientific evidence, for example in relation to testing and isolation requirements from transfers from hospital to care homes and other care settings.

We have continued with the suspension of the Choice Accommodation Guidance (relating to hospital discharges), recognising the additional pressures that waiting for selected care homes can place on health boards during such a difficult time.

In practice, people still have a choice of care home, but may need to move to an interim placement first. This is set out in the discharge guidance. We will look to develop new Choice of Accommodation Guidance as we continue to recover from the pandemic.

The Six Goals of Urgent and Emergency Care
The Home First and D2RA approach is in line with the Six Goals for Urgent and Emergency Care. These goals set out our expectations for health, social care, independent and third sector partners for the delivery of the right care, in the right place, first time.

Of the Six goals for urgent and emergency care, goals five and six align with and seek to deliver the national discharge guidance

An additional £25m recurring national funding will support Health Boards and NHS Trusts to deliver the 'six goals' for urgent and emergency care. The goals are:
- Goal 1 - Coordination, planning and support for people at greater risk of needing urgent or emergency care
- Goal 2 - Signposting to the right place, first time
- Goal 3 - Access to clinically safe alternatives to hospital admission
- Goal 4 - Rapid response in a physical or mental health crisis
- Goal 5 - Optimal hospital care following admission
- Goal 6 - Home-first approach and reduce risk of readmission

As part of the Six Goals for Urgent and Emergency Care programme, specifically with regard to goals five and six, we have commissioned the development of an Optimal Hospital Care and Home First Programme. This aims to enable optimal discharge practice and delivery of Home First principles to better manage people in the community, release hospital capacity and reduce risk of admission.

Alongside this direct support to urgent and emergency care services, the national communications campaign Help Us, Help You seeks to support people to access services in the optimal place by considering how and when they access care. Ensuring that patients access the right service first time is key to improving outcomes and this includes a focus on alternatives to hospital admission where clinically safe. Accessing alternatives to hospital admission is beneficial to the individual and the health system in reducing pressure, but also requires access to social care and/or third sector support for some people.

Modelling and Monitoring
In addition there is a monthly Health & Social Care Capacity: Modelling and Monitoring Group - a joint initiative, led by the NHS Wales Delivery Unit (DU) and the Welsh Government, in collaboration with health and social care partners across Wales.

The M&M group builds on the joint intelligence gathering undertaken as part of the national Covid-19 response, and undertakes the following:

1. Whole system modelling of the health and social care capacity[1] required to meet the needs of:
   o People discharged from hospital following Covid-19 infection, on a Discharge to Recover then Assess (D2RA) Pathway;
   o People who have not been hospitalised with Covid-19 and will need support in their community to recover from the illness or the effects of shielding/self-isolation;
   o People who may be affected by future potential surges of Covid-19; and
   o Other system pressures (e.g. winter).

2. Monitoring the responses to the identified capacity requirements and adapting in the light of emerging evidence. To do this the group draws on information and data sources including:
   o National health and social care data sets;
   o Discharge data established to support the Covid-19 Discharge Arrangements (Wales);
   o The findings of the national Rehabilitation Workstream;
   o Audit and reports commissioned from other national sources and workstreams.

3.   <u>Scale of the situation</u>

Findings from the latest Health & Social Care Capacity: Modelling and Monitoring Group suggest:
- Sustained pressure on intermediate and social care services, expected to continue to grow over the next few months.
- Lack of capacity in reablement services is leading to significant delays in hospital discharge.
- Some of these delays contribute to sustained high pressure on domiciliary care.
- Delayed discharge data continues to demonstrate over 1000 delayed discharges from hospital and from D2RA pathways into the next stage of care.
- Concerns remain regarding the use of interim placements, without therapeutic input, to address the immediate and critical challenge of hospital flow.

The Goal 6: Home First workstream will co-ordinate work to scope how interim placements are being defined, used and funded across Wales, with a view to developing a framework to safely support and monitor interim placements in line with D2RA principles.

<u>Delayed discharge data</u>

At the start of the COVID-19 pandemic, the Welsh Government suspended delayed transfers of care (DTOC) reporting requirements, along with many other datasets, to allow partners to focus on the emergency response. We introduced new discharge

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[1] For the purpose of this Workstream 'whole system' is used in the context found for example, on page 10 of 'A Healthier Wales' https://gov.wales/sites/default/files/publications/2019-10/a-healthier-wales-action-plan.pdf. 'A single whole system approach in which services delivered by different providers are co-ordinated seamlessly for and around the individual.'

guidance, including the D2RA approach to improve patient flow and support better outcomes. We have been working with the NHS Delivery Unit to collect weekly delayed discharge data as management information to support these arrangements. This data is shared with partners to support effective planning of services and a summary of the data is published each month. We are working towards a more formal data collection and publication in future, in line with the programme of work to deliver Goal 6 of the six goals of urgent and emergency care

Latest delayed discharge figures (published 17 February 2022)

Date	People awaiting transfer from hospital to recovery pathways (D2RA)	People awaiting transfer out of recovery pathways (D2RA) and on to longer-term care	People awaiting transfer from hospital to longer-term care, bypassing recovery pathways (D2RA)	Total Delays
31/12/2021	399	510	172	1,081

Recent management information suggests similar numbers of delays since the end of December.

Categories of delays
1. People awaiting transfer from hospital to recovery pathways (D2RA)
This would include people in a hospital bed, clinically ready for discharge, waiting for transfer to another more appropriate setting for a period of rehabilitation / reablement, followed by assessment for longer-term care.

2. People awaiting transfer out of recovery pathways (D2RA) and on to longer-term care
This would include people who have completed a period of rehabilitation / reablement and been assessed for longer term care needs. This could include delays from a person's own home, from a community hospital or from other step-down settings. Most of these delays would be awaiting a package or care or care home placement.

3. People awaiting transfer from hospital to longer-term care, bypassing recovery pathways (D2RA)
This would include people waiting in a hospital bed for transfer to longer term care, mostly packages of home care or care home placements. Discharges should only bypass the recovery pathways in exceptional circumstances. For example, end-of-life care or where the person has existing long-term complex needs and a re-start of a care package or placement is needed.

Reasons behind delays
There are a number of reasons behind these delays, and co-dependent issues, including:
- sufficiency of preventative services
- discharge planning from the point of admission

- effective implementation of D2RA, to maximise people's independence and reduce longer term care needs
- processes to support timely discharge, such as medication and transport
- availability of post-discharge support including rehabilitation, reablement, social care
- availability of suitable packages of domiciliary care or care home placements with suitable space, equipment and staff to meet people's needs, for example, some care home bed vacancies are not necessarily suitable to meet a person's specific needs, e.g. Elderly Mentally Infirm (EMI) nursing
- Covid-19 pressures such as testing, isolation, closed care homes due to Covid-19, staffing issues due staff being infected or isolating

4. <u>Impacts of the delays (on individuals and services)</u>

Nick Wood, Deputy Chief Executive NHS Wales wrote to Jeremy Griffiths, Director, NHS Delivery Unit on 20 January in relation to significant challenges in the Unscheduled care system, driven in part by an increase in Delayed transfers of care and a fall in regular discharges from hospital beds. The Delivery Unit is undertaking work to support organisations with a day of care audit. This work is being aligned with further national work following a national risk summit meeting of health and social care leaders to focus on re-setting the system to reduce risk and improve outcomes. Support for implementation of the national policy for hospital discharge is a fundamental component of this work.

The five themes from recent Discharge to Recover then Assess returns and recent day of care audit work were:
1. Waiting for internal health assessments;
2. Waiting for reablement or home-based intermediate care;
3. Waiting for restart of domiciliary package of care;
4. Waiting for social care assessment;
5. Acute treatment not complete.

This is a cyclical issue as the challenges in the community health and social care sector in terms of workforce and service capacity result in delay for some people awaiting discharge, and also limit available resource for people who may be able to return home from an urgent/ emergency hospital attendance with the right support.

<u>Waiting times</u>
Delayed discharges impact on patient flow through hospitals, put pressure on acute hospital beds and can exacerbate pressures in A&E departments.

Health board's infrastructure is also a key factor impacting upon planned care delivery. National guidance provided during the pandemic clearly indicated the importance of protecting patients from the risk of Covid-19 transmission and dividing the estate based on risk of transmission. Some health boards struggled where unscheduled care, urgent and planned care are all delivered on one site. This is particularly relevant with the constraints caused by delayed transfers of care where reduced flow of patients out of hospital, particularly into nursing or residential homes because of restrictions in

place due to the pandemic, reduces the flexible use of beds and adds pressure on the estate.

Health board estates will need to be used differently in order to respond to the waiting list challenges. More one-stop clinics where patients are seen and treated in a single appointment are required.

5. Pressure points

As of 14th February 2020, 19 out of 22 local authorities were reporting amber or red ratings on their regular checkpoint returns on their capacity to provide domiciliary support services (DSS), with 11 of those rating red. The majority of local authorities are also reporting a red or amber rating with regard to their capacity to offer reablement services. These ratings have remained consistent over several months and indicate significant challenge to the timely discharge and flow of patients from hospital to home.

The number of requests for domiciliary care and reablement to local authorities have not increased over the last year. However, there appears to be a deteriorating picture in the local authorities' ability to respond to these requests, suggesting demand is outstripping capacity.

Local authorities present a more mixed response to the question on their ability to provide adult residential care. This has been more of a fluctuating and localised picture, due to the additional factor of restrictions on admissions due to Covid-19 outbreaks. This is relevant to hospital discharge for those for whom a care home is the assessed need. In other instances care capacity impacts discharge plans where care homes are planned as step down beds and/or agreed to in order to prevent delayed discharges due to lack of reablement/ DSS.

Research we commissioned in 2019 found an estimated 6.4% of staff within registered adult social care settings in Wales are non-UK EU nationals. In common with the rest of the UK, the sector in Wales has experienced chronic challenges in recruiting and retaining workers. This has only been exacerbated by the ending of free movement and the pandemic and relates to rates of pay, terms and conditions in comparison with those in health, hospitality and retail. This is in addition to the unprecedented pressures on social care staff throughout the pandemic. Employers and local authorities are reporting burnout and exhaustion.

6. Variation in practices across Wales

The D2RA approach is about effective and timely discharge. The NHS Delivery Unit has been working nationally over the last few years to support implementation. However, there are currently significant pressures on the social care system that are impacting on discharge processes.
The D2RA approach and revised data collection has helped to move the conversation away from unhelpful narratives we have experienced in the past and that the focus must be on strong and integrated partnerships and joint solutions. However, implementation of D2RA varies across Wales.

The NHS Delivery Unit is leading work to support and monitor implementation of D2RA. It has co-produced 5 Key Measures for D2RA implementation with regional partnership boards in order to ensure that they added value for operational and strategic planning as well as providing a mechanism by which implementation could be monitored. The Key Measures are listed in the table below:

Measure	Intended outcome
Number of people transferred on to each D2RA Pathway	Increase
% of those transfers that took place within 48 hours of the decision being made (that they were ready for transfer from hospital to this pathway for supported recovery and assessment)	100%
% people transferred to a D2RA Pathway with a co-produced recovery plan in place	100%
% people transferred out of the D2RA Pathway to their usual place of residence	Increase
% people readmitted to hospital within 28 days	Reduce (to around 5%)

Over the last year, the NHS DU has highlighted the following points:
- Regions in Wales do not "know their numbers" – many areas have been unable to submit data for full pathways and/or measures;
- Areas in Wales do not know what the outcomes are for patients – there have been particular challenges around understanding readmission rates and the percentage of people who return home;
- Data collection is largely a manual process that relies on individual staff members trawling and collating data in addition to their substantive posts.

However, despite this, a clear improvement in both the ability to gather and analyse data and the implementation of D2RA has largely been observed; with some areas dedicating resource to improving data collection and integrity with obvious and immediate positive impact.

Overall, we can see a steady upwards trajectory for the numbers of people across Wales being supported by D2RA each month. In January 2021, this figure sat at around 1800 people, peaked at close to 2700 over the summer, and steadied out at over 2000 from the winter. This figure is also an under-representation as many areas are unable to record patients transferring into pathway 0 (transfer home with only third sector support needed) for example.

While the measures suggest that our use of pathway 3 (bed-based intermediate care), is higher than reasonably anticipated, our home-based pathways 1 and 2 do tend to be more heavily used suggesting that the cultural shift towards "home first" is slowly gaining traction.
We can also see an overall upwards trajectory in the percentage of people transferred within 48 hours, with the average starting at around 12%, peaking at 30% during the summer and stabilising around 25%.

The percentage of people transferred with a co-produced recovery plan in place has improved overall, rising from an average of 3% to an average of just over 20%. Some areas have seen a consistent improvement from 0% to 100%, which has been very encouraging. Overall, transfers to pathway 3 are the least likely to be in possession of a co-produced recovery plan, which is concerning given that a robust handover of goals and outcomes is one of the biggest predictors of people returning safely and confidently to their own home.

The percentage of people transferred out of D2RA to their usual residence is one of our best measurements, with early recording only able to establish that around 38% of people on average transferred home across 5 regions of Wales that have been able to capture this data, compared to over 60% now. It is likely that this figure is lower than actual activity for pathway 0-2.
Overall, readmission rates are not reliable across Wales due to difficulties capturing this cohort.

Examples of best practice in Wales and other parts of UK

We have issued national hospital discharge service requirements for health, social care, third and independent sector partners.

The SAFER guidance provides good practice to promote safe and timely discharge, improve patient flow and prevent unnecessary waiting for patients
SAFER comprises the following five principles:
- Senior review: all patients are to have a senior review before midday.
- All patients and their families will be involved in setting an Expected Discharge Date. Flow of patients will commence at the earliest opportunity from assessment units to inpatient wards.
- Early discharge: More than 33% of patients will be discharged from inpatient wards before midday on their day of discharge.
- Review: a systematic multi-disciplinary team review, is undertaken, including patients and their families, for those with extended lengths of stay (>6 days) with a clear 'home first' mind-set.

The SAFER concept is proven to have benefit for individuals and the wider hospital system. Where implemented effectively by well-led teams and communicated clearly to staff enabling them to fully understand all elements, hospitals have seen real benefits to patient outcomes and staff satisfaction. Hospital crowding reduces, Emergency Departments decongest, mortality falls, harm is reduced and staff feel less pressured.

Regional Integration and Funding

Integrated hospital to home services have been supported through both the Integrated Care Fund and the Transformation Fund. These projects have been invaluable during the Covid-19 response and have enabled quicker discharge from hospital to free up much needed capacity as well as preventing admissions by enabling care closer to home.

In 2021/22 £6m of the Transformation Fund was dedicated to the scaling of hospital to home models at a regional level to help embed a national model of working. The funding has been used to support the sustainable scaling of D2RA Pathways with a view to ensuring there is a regional approach to delivering the agreed D2RA model.

This additional support has enabled services to be provided seven days a week to establish what community support can be provided to expedite a safe discharge from hospital. Through the use of "What Matters" conversations, patients are provided with tailored information, advice and support that meets their wellbeing needs, promotes independent living, and supports safe timely discharge whilst also reducing the risk of readmissions.

At the end of March 2022 the current Integrated Care Fund and the Transformation Fund will come to an end. To facilitate the greater integration of health and social care and support the whole system approach Welsh Government have announced a new five year Health & Social Care Regional Integration Fund (RIF) which will commence on 1 April 2022 with an annual investment of £144m.

The fund will build on the successes of the ICF and TF, learn from experiences to date, and continue to drive the integration and transformation of health and social care. All activity funded by the RIF must directly support development and delivery of national models of integrated care including home from hospital services and community based preventative and complex care services. The fund will have a strong focus on prevention and early intervention. This new fund will continue to be administered through regional partnership boards to ensure an integrated cross sector approach.

To share best practice across Wales a Home from Hospital Community of Practice was created. Four meetings were held in 2020 and 2021 to highlight examples of integrated services, promote shared learning, develop networks and problem solve resulting in the publication of 'Delivering Home First - Hospital to Home Community of Practice: key learning and practice examples' in May 2021. This document includes case studies from across the UK as well as each region in Wales.
Delivering Home First (gov.wales)

The Community of Practice will re-convene at the end of March 2022 to test the Discharge to Recover then Assess (D2RA) e-learning resource that has been created, establish future topics for shared learning, develop further materials and provide a continuous learning and sharing environment across the regions and for those working or involved with the ethos of 'Home First.' This activity will continue throughout the lifetime of the new Regional Integration Fund.

7. **Support needed for people and services**

Support for unpaid carers
Several local authorities in recent months have faced severe pressures on their social care workforce and publicly requested support from families and friends to support individuals, including around discharge from hospital. Where this involves meeting assessed, eligible needs, direct payments can support and enable that care

or alternatively be used to purchase equipment or other items to support timely discharge from hospital.

Similarly, to assist unpaid carers as part of that process the Welsh Government has changed the focus of the annual £1m carers' funding to local health boards and their third sector carers' partnerships. From 2022-23 projects in receipt of this funding will transition, or develop new projects which focus support for unpaid carers assisting with the hospital discharge of those they care for.

Unpaid carers are also a priority group within the new Regional Investment Fund (RIF) which commences from April. The guidance for the new RIF with regard to unpaid carers has been revised to learn lessons from the Integrated Care Fund. The RIF funding allocation for carers' projects should therefore be more directly focused on services for carers as the primary beneficiaries.

Housing adaptations

Although housing adaptations are not a major cause of delayed discharges, there is a rising demand for adaptations to make homes a safe environment for maintaining independence and the provision of care and reablement services.

Public services invest around £60 million each year in adaptations to over 30,000 homes. The ageing demographic is an underlying pressure.

The Welsh Government currently invests £17.66 million in grants to local authorities, housing associations and Care & Repair agencies, rising to £19.5 million in 2022-23. Most of the remainder is Disabled Facilities Grants funded by local authorities from their general capital fund.

The majority of immediate works required to facilitate hospital discharge are small but speed of completion is essential. The Rapid Response Adaptations Programme was created to meet this need and is within the remit of Care & Repair agencies.

Care & Repair agencies are core funded by the Welsh Government. They received £4.3 million revenue in 2021-22, rising to £4.8m in 2022-23. They also receive capital funding to cover the costs of rapid adaptations, £1.6 million in 2021-22, rising to £3m in 2022-23.

The additional revenue funding provides Care & Repair agencies with the capacity to deal with more complex discharge cases i.e. those where preparatory works need to be undertaken before adaptations can be installed safely. This includes, for example, addressing urgent repair and maintenance issues, or tackling issues such as hoarding disorder which create significant health and safety risks. The additional capital funding is a response to the needs of an ageing population, where early, small scale adaptations (typically under £500 in cost) can have a long term preventative impact.

We have also increased local authorities' Enable grant from £4m in 2020-21 to £6m in £2022-23 so that no-one is required to make a financial contribution towards the

most common type of adaptations, such as stair lifts and downstairs wet rooms. This removes a cause of administrative delay and is intended to improve delivery times.

8.   Action to address the issues

Partnership working and new approaches
We are supporting effective partnership working and integration between health and social care to support timely transfers of care and positive outcomes for individuals. The Welsh Government has provided additional funding to regional partnership boards to support improved patient flow and discharge processes, in particular the (D2RA) approach. We have set out this approach in guidance and we are working with the NHS Delivery Unit to support implementation of the D2RA approach, in line with the six goals of emergency care.

We have ensured a focus in winter plans for 2021-22 on partnership working and integration, including the D2RA approach.

The Home from Hospital Community of Practice has supported shared learning and best practice in relation to the Home First principle.

Funding
We have supported innovative approaches to improve discharge and patient flow though the Integrated Care Fund and the Transformation Fund. For example in 2021/22, £6m of the Transformation Fund was dedicated to the scaling of hospital to home models at a regional level to help embed a national model of working.
The funding has been used to support the sustainable scaling of D2RA Pathways with a view to ensuring there is a regional approach to delivering the agreed D2RA model. From April, these funds will be replaced by the Health & Social Care Regional Integration Fund (RIF), with an annual investment of £144m.

An additional £25m recurring national funding will support Health Boards and NHS Trusts to deliver the 'six goals' for urgent and emergency care. This includes goal five: 'optimal hospital care and discharge practice from the point of admission' and goal six: 'home-first approach and reduce the risk of readmission'. Of the Six goals for urgent and emergency care, goals five and six align with and seek to deliver the national discharge guidance.
In addition to this funding, £2.26million was invested in non-urgent patient transport, in an effort to ease pressure on ambulance services and ensure patients can continue having access to planned care.

We invested £48m in September 2021 to support social care recovery in Wales.
A further £9.8million was allocated to regional partnership boards in October 2021, to support delivery against the priorities set out in the winter plan, alongside a further £32.92million for social care pressures.

The new £50m capital fund for social care includes the development of 50 local community hubs and the strengthening of arrangements to support the integration of health and social care and support the residential care estate.

We have provided over £500,000 in 2021/22 to Care and Repair Cymru to deliver the 'Hospital to a Healthier Home' service. This facilitates safer and quicker discharges for vulnerable older patients who may benefit from home adaptations. Ministers acknowledge that the Committee has raised the issue of the continued provision of this service in 2022/23. Officials have conducted discussions with health boards on the matter and a response will be issued.

Public services invest around £60 million each year in housing adaptations to over 30,000 homes. This can help with timely discharges and support people's independence when home. The Welsh Government currently invests £17.66 million in grants to local authorities, housing associations and Care & Repair agencies, rising to £19.5 million in 2022-23. Most of the remainder is Disabled Facilities Grants funded by local authorities from their general capital fund.

Care Action Committee
Over the winter period, the Minister for Health and Social Services chaired the Care Action Committee. This group has been focused on identifying action to ease pressures on our services and is also supported by representation from the NHS, Local Authorities, WLGA, NHS Confederation, ADSSC, Care Forum Wales and the National Provider Forum.

The committee has met on a regular basis to identify immediate issues and agree solutions to prevent further deterioration of the health and social care system flow and to address concerns such as waiting and discharge times. The group provided a vital function over the winter period as we tackled the joint issues brought about by the usual winter pressures and those resulting from Covid-19. Actions initiated by the group are continuing, e.g. establishing an integrated health and social care dataset.

System Reset
The Welsh Government and the NHS Delivery Unit led a National Risk Summit in mid-February, looking at key issues around discharges and patient flow. As a result, a system "reset" was agreed across Health & Social Care, to support flow throughout the system and reduce the number of delayed patients. This will take place from the 2nd March to the 16th March.

This will highlight the importance of the Home First and D2RA approaches and the need to bolster community services in order to proactively pull people into their local area and keep them safe. Learning from the reset will help to inform interventions to support hospital discharges and patient flow in the future, via the six goals programme.

Healthcare workforce
To support workforce challenges, an investment of £262m is being made available next year to support education and training programmes for healthcare professionals in Wales. This represents an increase of 15% compared with 2021-22 and will deliver the highest number of healthcare training opportunities in Wales.
We will maintain and strengthen investment in education and training of healthcare workers, delivering 12,000 more clinical staff by 2024-25.

Social care workforce

Improved recruitment and retention of domiciliary care workers and care home workers remains a priority and we are committed to the Real Living Wage for care workers.

A national advertising recruitment campaign has proceeded from the summer and has received additional funding from Welsh Ministers. In December 2020 and January 2021, there was an increase of c. 180% of people looking at the national WeCare.Wales jobs portal.

The WeCare.Wales campaign, hosted by Social Care Wales, incorporates this recruitment activity and has rolled out 3 day online introductory training to encourage people into social care roles. Five groups were trained in January and February, with 24 people completing the course. A further 12 groups are planned up to the end of June, some focussing on young people.

We have announced an Additional Payment scheme aligned with the Real Living Wage (10 February). This will make a payment of £1498 to social workers who will be receiving the Real Living Wage and their managers. This additional payment, likely to be made in June, is intended to further demonstrate the commitment of Welsh Ministers to further improvements in terms and conditions of social care roles and to enhancing opportunities for career progression.

In addition to the introduction of the Real Living Wage from April this year, we continue to work in social partnership with trade unions and employers through the Social Care Fair Work Forum, which is looking at how to improve working conditions in the sector. Along with other employment terms and conditions, the Forum is looking at employee voice and wider pay and progression in the social care sector. We are taking steps to professionalise the sector and improve career progression opportunities, in an effort to support recruitment and retention of staff.
In 2020 and 2021, social care staff received payments of £500 and £735 in recognition of their tireless commitment through the Covid-19 pandemic.

Rehabilitation
The Welsh Government published a national rehabilitation framework and underpinning population specific guidance in May 2020 to help services better understand the increasing demand for rehabilitation, reablement and recovery throughout health and social care services. Health boards, local authority and third sector partners are using the Framework to plan rehabilitation services to respond to the needs of their populations.

In June 2021, the Welsh Government announced an additional £5million for health boards to develop primary and community services to meet the needs of people with Long COVID and those indirectly affected by the pandemic, including those whose planned care is delayed.

Rebalancing care and support
The Welsh Government is taking forward a programme of work in response to the Rebalancing Care and Support White Paper consultation, which will support long term improvements in commissioning and joint working between health and social care. This will be important for improving discharge practices and patient flow.

In line with our Programme for Government, we are committed to introduce a strategic National Framework for care and support. The Framework will set standards for commissioning practice, reduce complexity and rebalance commissioning to focus on quality and outcomes. What matters to people will be at the heart of the Framework.

We will also be strengthening joint working via regional partnership boards, in relation to:

- governance and scrutiny;
- planning and performance;
- engagement and voice;
- integrated service delivery; and
- rebalancing the social care market

Agenda Item 5

Document is Restricted

Centre for Mental Health

Mental health inequalities: evidence to the Welsh Parliament health and social care committee

February 2022

Summary

Inequalities in mental health are stark and deeply entrenched. Our chances of having good or poor mental health are influenced from before birth and throughout life by our environments and experiences.

Groups of people who face a higher risk of poor mental health include those living in poverty, women, racialised communities, people with long-term physical illnesses, disabled and neurodiverse people, and LGBTQ+ people.

Mental health inequalities are caused by economic and social inequalities and injustices. Major risk factors for poor mental health include:

- Poverty and financial inequality
- Violence, abuse and bullying
- Racism and discrimination
- Isolation and loneliness.

Unequal access to mental health support is not simply about whether services are available and accessible. It is also about whether those services are relevant, trusted, safe and (where necessary) adapted to people's needs.

A whole system approach is needed to address both the causes and the consequences of mental health inequalities, including:

- A 'mental health in all policies' approach that ensures all government decisions and actions are taken with mental health in mind
- A commitment to reducing financial inequality and poverty
- Tackling racism and ending racial injustice
- Investing in communities to promote and support good mental health
- Developing and implementing strategies to secure equality of access, experience and outcomes from mental health services at all levels and for all age groups.

Introduction

Centre for Mental Health is an independent organisation dedicated to eradicating inequalities in mental health. We work across the UK to address the causes of mental health inequalities and to spur action that reduces them.

We are pleased to provide evidence for the Committee's inquiry. While we do not have evidence specific to Wales from our work to date, our submission draws on UK wide and

international evidence about mental health inequalities: what causes them, what perpetuates them, and what can be done to reduce them.

Responses to the Committee's questions

Which groups of people are disproportionately affected by poor mental health in Wales?

Mental health inequalities are stark and often deeply entrenched. Groups of people who face significantly higher than average levels of poor mental health – but poorer access to effective support – include (but are not limited to):

People living in poverty: children from the most deprived 20% of households in the UK are four times more likely to have a serious mental health difficulty by the age of 11 as those from the wealthiest 20% (Morrison Gutman et al, 2015). Referrals to Improving Access to Psychological Therapies (IAPT) services in England are progressively higher for each decile of deprivation; but completion and recovery rates follow the opposite pattern (Health Foundation, 2020).

Girls and women: women face higher levels of mental ill health than men, with the gap especially pronounced among young women between 16 and 24 (NHS Digital, 2016). There is also evidence of a growing gap between girls and boys of secondary school age

Racialised communities: people from some racialised communities are more likely to be diagnosed with a severe mental illness (especially psychosis). People from racialised communities are less likely to be referred for mental health support by their GP but more likely to come into contact with services through the police, four times as likely as white people to be sectioned under the Mental Health Act, and ten times more likely be given a community treatment order after they leave hospital (NHS Digital, 2021).

LGBTQ+ people: data from the Millennium Cohort Study shows that lesbian, gay and bisexual adolescents are five times more likely to be depressed and almost six times more likely to have self-harmed in the past year compared to heterosexual teens (Amos et al, 2019). Trans young people also have very high levels of depression and anxiety, with more than half having considered suicide within a year of being surveyed (Bachmann and Gooch, 2018).

People with long-term physical conditions: having a long-term physical illness is associated with a doubling of the risk of depression; for people with multiple long-term conditions the risk is greater still. People with long-term conditions have told us that emotional support is often absent in the care they receive for their physical illness, and when they do get mental health support it's often poorly adapted to their needs (National Voices and Centre for Mental Health, 2021)

Disabled and neurodiverse people: children with a learning disability are three to four times more likely than average to have a mental health difficulty (Lavis et al, 2019). Rates of poor mental health are higher than average for autistic children and adults. Many find that mental health services (especially those using psychological interventions that are typically developed for neurotypical people) are poorly adapted to meet their needs (Harper et al, 2019).

For many people, multiple layers of identity means they face higher risks of poor mental health across many of these groups.

What factors contribute to worse mental health within these groups?

Our mental health is determined by our experiences and environments. These create risk and protective factors for mental health: protective factors are things that make it more likely we will enjoy good mental health, while risk factors do the opposite.

People from the groups listed above are more likely to face higher risks and to enjoy fewer protective factors. The balance between the two

There is compelling evidence that **poverty and economic inequality** are major risk factors in themselves. Economic insecurity is a major cause of stress and distress. Studies have shown that moving people out of poverty improves mental health, and vice versa (Ridley, 2020). Reductions in the value of social security benefits or in eligibility have consistently been found to cause increases in levels of depression (Bell, 2020). And societies with higher levels of economic inequality have higher overall levels of poor mental health (Patel et al, 2018).

Violence, abuse and bullying are also major risk factors for poor mental health, whether they take the form of significant traumatic events or ongoing maltreatment. Domestic violence and abuse have been shown to be a major contributor to poor mental health among women (Scott & McManus, 2016). In schools, racist and homophobic bullying may contribute to higher levels of poor mental health among LGBTQ+ and racialised communities (Statham et al., 2012). There is evidence that LGBTQ+ inclusive education reduces the incidence of homophobic bullying (Proulx et al., 2019). Bullying in workplaces has also been noted as a risk factor for poor mental health in adult life (Fitzpatrick and Thorne, 2019).

Racism and discrimination are toxic to mental health for people from racialised and marginalised communities. Racist abuse and injustice have been shown to 'erode' mental health: and because racism is systemic, it's experienced in all aspects of people's lives with a cumulative effect during a person's lifetime and in families and communities across generations (Khan et al., 2017).

Isolation and loneliness are risk factors to mental health. This has been noted to be a potential risk factor for disabled and neurodiverse children, young carers, and children and young people living in remote rural areas (who may, for example, go to school far from home and thus lack opportunities to socialise with their peers) (Allwood, 2020).

For the groups identified, what are the barriers to accessing mental health services? How effectively can existing services meet their needs, and how could their experience of using mental health services be improved?

The barriers to accessing mental health support are multiple and complex. Access to mental health support requires it to be:

Available (close to home): proximity is important to encourage help-seeking (at least when it comes to face-to-face services). Locating support in familiar, trusted locations (eg GP surgeries, schools, youth centres) can make it more attractive and less clinical. This is especially important for groups of people who cannot travel easily (eg children and young people, older and disabled people, those relying on public transport). Locating services close to home is especially challenging in rural and coastal areas, though it can also be a significant barrier for young people in urban areas where travel outside their locality may be unsafe.

Timely: knowing that support will be available quickly makes a big difference to people's confidence in seeking help. Long waiting times both prolong distress and deter help-seeking. There is currently wide variation in waiting times for mental health support: some services available quickly (for example those subject to nationally mandated targets) and others with long waits or high service thresholds (that mean people's difficulties escalate to become more serious before an offer of help is made).

Well-communicated: services need to be proactive in encouraging help-seeking and making themselves readily available, warm and welcoming. This is important for all communities and age groups, but has been noted to be especially important to young people, who are more likely to find formal and clinical feeling services offputting.

Non-stigmatising: while the stigma of poor mental health is gradually reducing, it is still a factor that can make services less accessible. Services can feel less stigmatising through the locations they use (if they are familiar and safe) and their language (avoiding overly clinical terminology).

Relevant: services need to be able to demonstrate that they will meet people's needs and understand their lives and their challenges. If people don't believe that mental health services will be helpful, they may not see any benefit in taking the risk. Some innovative services prioritise engagement with young people by offering help with money, housing or legal difficulties first.

Trustworthy: for some marginalised and racialised communities, mental health services are not trusted. Many fear that seeking help for their mental health will result in the use of coercion: being locked up and restrained. Marginalised young people express fears that health professionals are no different to the police and they won't be safe if they engage. Mental health services need to be actively anti-racist – taking proactive steps to combat and reverse ingrained patterns of oppression and injustice towards racialised communities.

Adapted: for some groups of people, adaptations and adjustments are needed to make mental health support relevant and accessible. This includes many neurodiverse and disabled people (for example from the deaf community) as well as those requiring language interpretation. Being trauma-informed can also help to make services more accessible and safe to people who have experienced traumatic events including gender-based and racial violence.

What further action is needed, by whom/where, to improve mental health and outcomes for the groups of people identified and reduce mental health inequalities in Wales?

A whole system approach is needed to address both the causes and the consequences of mental health inequalities (Commission for Equality in Mental Health, 2020). For any government and wider society to tackle mental health inequalities, important steps include:

A **'mental health in all policies'** approach that ensures all government decisions and actions are taken with mental health in mind: seeking to benefit (and not to harm) mental health, with a clear commitment to reduce mental health inequalities. In education, for example, this would include adopting inclusive education practices and trauma-informed behaviour policies as part of a 'whole school approach' to mental health. Similar gains can be made across all government departments and policies, from combating the climate crisis to preventing homelessness and creating safer and more cohesive communities.

A commitment to **reducing financial inequality and poverty**: this can include measures to boost pay (for example adopting the Real Living Wage in all public sector organisations and their contractors), to increase the value of social security benefits, and to ensure people are able to get benefits they are entitled to (eg through widening access to high quality money and welfare advice).

Tackling racism and **ending racial injustice**: recognising that racism is a public health hazard and taking action to ensure that racial injustices are tackled robustly. This may include addressing discriminatory policies and practices in education, policing, immigration and other areas of public policy as well as within the health and care system.

Investing in communities: mental health is made in communities and community organisations can play an important part in creating the conditions for promoting good mental health, especially among groups that are poorly served by mainstream services. They need sufficient and sustainable funding (charitable as well as statutory) to be able to fulfil their potential, and especially to be able to advocate for change and challenge established power structures and systems.

Develop and implement strategies to secure equality of **access, experience and outcomes from mental health services** at all levels and for all age groups. NHS England's *Advancing Mental Health Equalities* strategy seeks to take a systematic approach to reducing inequalities in services. This includes action to ensure the mental health workforce is more representative of the communities it serves as well as having the necessary competencies. And it sets out to improve data and transparency about how well services are reducing inequalities. Reforms of the Mental Health Act will also play an important part in addressing some of the inequalities in the use of coercion, but will not by themselves be enough to shift the dial.

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Mental Health Foundation

Submission of evidence to the Health and Social Care Committee Inquiry into Mental Health Inequalities in Wales

Who we are

The vision of the Mental Health Foundation is good mental health for all. We work to prevent mental health problems, to drive change towards a mentally healthy society for all, and to support communities, families and individuals to live mentally healthier lives, with a particular focus on those at greatest risk. The Foundation is the home of Mental Health Awareness Week.

About our response

Thank you for the opportunity to provide written evidence to the Health and Social Care Committee Inquiry into Mental Health Inequalities – we look forward to providing oral evidence to your inquiry on the 24th March 2022.

The Mental Health Foundation (MHF) defines prevention as: taking action to increase the protective factors for good mental health and reduce the risk of experiencing poor mental health.[1] We focus on those at highest risk of mental health problems because of their greater exposure and vulnerability to unfavourable social, economic, and environmental circumstances. Our submission includes evidence from our *Coronavirus: Mental Health in the Pandemic* Study, a UK-wide study that we carried out with the Universities of Swansea, Cambridge, De Montfort, Strathclyde and Queen's, Belfast, where we undertook regular repeated surveys of large representative adult samples across the UK, backed up by parallel in-depth qualitative research. Our evidence also draws on from our 2020 report on mental health inequalities[2] and evidence reviewed for our Manifesto for the Senedd Elections 2021,[3] which included Wales-only data.

1. **Which groups of people are disproportionately affected by poor mental health in Wales? What factors contribute to worse mental health within these groups?**

Poverty: Wales has the highest poverty rate amongst the four nations, with almost 1 in 4 (23%) people living in poverty.[4] Wales has lower pay for people in every sector than in the rest of the UK.[5] Debt and financial difficulties can lead to mental health problems, and the more debt people have, the more likely they are to have mental health problems overall.[6] Poverty can also create other disparities in education, employment and housing. Poverty and debt are often closely tied to

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[1] Mental Health Foundation (2020) The Mental Health Foundation Strategy 2020-2025
[2] Mental Health Foundation (2020) Tackling Social Inequalities to Reduce Mental Health Problems
[3] Mental Health Foundation (2021) Making Prevention Happen: Manifesto for the Welsh Government Elections 2021
[4] Joseph Rowntree Foundation (2022) UK Poverty 2022: The essential guide to understanding poverty in the UK | JRF
[5] Joseph Rowntree Foundation (2020) Poverty in Wales 2020 | JRF
[6] Mental Health Foundation (2020) Tackling Social Inequalities to Reduce Mental Health Problems

educational attainment[7] and employment opportunities in later life. Having lower educational attainment has been associated with mental health problems in adulthood.[8] Lack of access to employment, or good quality employment, can decrease quality of life, social status and self-esteem, which in turn has been associated with mental health problems.[9]

Living in poverty also influences the quality of people's housing and lack of adequate housing is a risk factor for mental health problems. In contrast, transitioning from homelessness to housing, or experiencing housing improvements, has been shown to improve mental health.[10]

We welcome the announcement of the recent Basic Income Pilot for care leavers in Wales and see this as an important step towards a Universal Basic Income that would benefit other groups experiencing poverty. We look forward to working with Welsh Government as the pilot develops.

Adverse Childhood Experiences: Traumatic experiences include interpersonal trauma such as bullying, abuse and domestic violence and childhood traumas such as abuse, neglect, abandonment and family separation. Trauma can also include community trauma such as bullying, gang culture and war[11] and less understood social traumas such as marginalisation, racism and the legacy of violence against entire groups, such as genocide.[12] Whilst we do not know yet how many people are affected by trauma as a result of the pandemic, we know that large numbers of the population have been , exposed to traumatic experiences and put at risk. For example, there is evidence of increases in domestic violence during the pandemic[13] and increases in calls to the NSPCC Child Protection Helpline.[14]

There is a rapidly growing awareness of Adverse Childhood Experiences (or ACEs) and longitudinal studies and a body of wide body of literature seeking to understand the impacts of ACEs[15][16]. We welcome the increased emphasis on ACEs and trauma informed approaches in Wales, including: the focus on ACEs by the Future Generations Commissioner, the establishment of ACE Aware Wales, the emphasis on using trauma-informed approaches in the new statutory guidance for schools on a 'whole school approach' and the new mental health support package for all health and care workers. **We would like Trauma Informed Services to be expanded across all public services in Wales - such**

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[7] Joseph Rowntree Foundation Experiences of poverty and educational disadvantage (summary) (jrf.org.uk)
[8] Mental Health Foundation (2020) Tackling Social Inequalities to Reduce Mental Health Problems
[9] Ibid
[10] Ibid
[11] Van der Kolk, B.A. (2005) Developmental trauma disorder: towards a rational diagnosis for chronically traumatized children, Psychiatric Annals, Vol. 35 No. 5, pp. 401-8 In Sweeney, A., Clement, S., Filson, B., Kennedy, A., (2016) "Trauma-informed mental healthcare in the UK: what is it and how can we further its development?" Mental Health Review Journal, Vol. 21 Issue: 3, pp.174-192
[12] Blanch, A., Filson, B., Penney, D. and Cave, C. (2012), Engaging Women in Trauma-informed Peer Support: A Guidebook, National Center for Trauma-Informed Care, Rockville, MD in Sweeney,A., Clement, S., Filson, B.,Kennedy, A., (2016) "Trauma-informed mental healthcare in the UK: what is it and how can we further its development?" Mental Health Review Journal, Vol. 21 Issue: 3, pp.174-192
[13] Refuge (23 March 2021) A Year of Lockdown: refuge releases new figures showing dramatic increase in activity
[14] NSPCC (4th April 2021) Calls to the NSPCC helpline surge during the pandemic | NSPCC
[15] Bellis MA, Hughes K, Leckenby N, Harcastle KA, Perkins C, Lowey H (2015) Measuring mortality and the burden of adult disease associated with adverse childhood experiences in England: a national survey. J Public Health (Oxf).2015;37:445–54.
[16] Hughes K, Bellis MA, Hardcastle KA,Sethi D, Butchart A, Mikton C, Jones L,Dunne MP (2017) The impact of multiple adverse childhood experiences on health: a systematic review and meta-analysis. Lancet Public Health. 2017;2:e356NP–66

a model has been developed in Scotland.[17] Listening, empathetic services that place the person at their centre should become the norm for all public services, education settings, workplaces, health and social care services, emergency services and criminal justice. This requires appropriate training about trauma and its impact for the professionals working in these services.

Rurality: Around 1 in 3 people in Wales live in an area classed as rural (compared to 1 in 5 in England).[18] There are fewer employment opportunities and mental health support for people living in rural areas. Those requiring specialist services (for example, mothers requiring specialist perinatal mental health support [19]and the deaf community in Wales[20] often have to travel great distances for support - thus taking them away from their families and their communities. Rural communities also experience the outward migration of young people who often seek education and employment opportunities in more urban areas; this, in turn, impacts on the availability of mental health support and opportunities for young people locally. Additionally, the population of rural Wales tends to be older on average, meaning that rural health and social care services are dealing with comparatively higher levels of chronic diseases and age-related disability[21] which can also increase the risk of developing mental health problems.[22]

In our report, in partnership with Public Health Wales, 'Supporting Farming Communities in Times of Uncertainty', we worked with stakeholders (including farmers) and considered key challenges for farming communities in Wales, including the uncertainty and viability of farming post-Brexit. Solutions focused on the need for: better awareness of the support available; improving digital literacy amongst farming communities, working across organisations to recognise stress and anxiety, and for farmer-led, peer-to-peer solutions.[23] Similar solutions apply to fishing communities in Wales, as signalled in our report 'Building resilience in the fishing sector in Wales.[24]'

We agree with the recommendations put forward by the Parliamentary Review of Health and Social Care in Wales in 2018 that Welsh Government needs to develop an overall strategy for enhancing care for rural communities. Welsh Government should prioritise rural mental health and assess, identify and increase the availability of mental health and well-being support across Wales. This should include the mobilisation of local resources, improved digital literacy and digital support, and peer-to peer solutions[25]. Solutions can be framed on a public health model of: (i) Preventing uncertainty and the challenges from adversity; (ii) Protecting against the potential impact of those challenges on mental health and well-being; (iii) Promoting mental health and well-being amongst rural communities to support resilience.

Older people: Wales has a large and growing older people's population: by 2030, it is projected that there will be just over 1 million older people in Wales, which is 33% (nearly one third) of the total population.[26] Older people in Wales are a group experiencing significant inequalities including:

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[17] NHS Education for Scotland
[18] Wales Centre for Health (2007) A Profile of Rural Health in Wales
[19] Maternal Mental Health Alliance (2020) Map of Specialist Community Mental Health Teams
[20] Swansea University (June 2021) Deaf People Wales: hidden inequality
[21] Wales Centre for Health (2007) A Profile of Rural Health in Wales
[22] Mental Health Foundation (2020) Tackling Social Inequalities to Reduce Mental Health Problems
[23] Mental Health Foundation and Public Health Wales (2019) Supporting Farming Communities in Times of Uncertainty
[24] Mental Health Foundation (2020) Building Resilience in the Fishing Sector in Wales
[25] Mental Health Foundation (2021) Making Prevention Happen: Manifesto for the Welsh Government Elections 2021
[26] Office for National Statistics (2019), Population projections for local authorities: Table 2, 9 April 2019.

disability and long-term conditions, digital literacy and exclusion, ageism, access, age-related poverty, loneliness and isolation, experiences of bereavement, and other types of loss and grief. [27] The evaluation of our Standing Together Cymru programme found that access to peer support reduced isolation and loneliness and improved the wellbeing of older people in extra housing schemes in Wales.[28]

Welsh Government's last Delivery Plan for the strategy *Together for Mental Health* is 'all age,' however it does not identify or address older people's specific mental health and well-being needs. Rather, it addresses older people's needs 'universally' and we are concerned that without any support directed at older people, which considering their particular needs, their mental health and well-being will be marginalised. **We are asking for the next Mental Health Strategy in Wales (due in 2022) to include a more 'proportionate' and specific understanding of how older people's mental health and well-being needs will be met through a life-course inequalities plan.**

Ethnic minority communities: There are an estimated 169,400 people from ethnic minority communities living in Wales.[29] These groups are more likely to have higher rates of in-work poverty and child poverty. Research conducted by Cardiff University found that Covid-19 has exacerbated mental health difficulties in ethnic minority communities in Wales. During the pandemic and associated lockdowns, individuals from ethnic minority backgrounds in Wales reported on average more than 4.1 problems associated with mental distress, while White British people reported 2.7, a difference of 55% in relative terms.[30] Being a victim of racism has also been associated with mental health problems.[31] The emotional and psychological effects of racism have been described as consistent with traumatic stress, and the negative effects are cumulative.[32]

Refugees and asylum seekers are more likely to experience mental health problems than the general population. Their increased vulnerability to mental health problems is linked to pre-migration experiences, such as war trauma, and post-migration conditions, such as separation from family, difficulties with asylum procedures, poor housing, homelessness, poverty[33] and discrimination[34]. Our 'Perthyn' (Belonging) project in Wales initially brought women who were seeking sanctuary together to address issues that impacted on their emotional well-being following their transition to Wales from their home country. Now the project has partnered with City of Sanctuary whose aim is to make cities a welcome place for all and seeks to empower men and women - **Wales has also been made a Nation of Sanctuary.** It is yet unclear what the impact of the conflict in Ukraine will be in terms of a new influx of refugees in Europe, but Wales has been a leader in offering support, and the potential economic implications of this conflict need to be taken into account.

We are members of Welsh Government's Task and Finish groups working towards a cross sector and interdisciplinary approach to addressing the inequalities experienced by ethnic minority communities and refugees and asylum seekers in Wales – it's crucial that the findings and learning

[27] Mental Health Foundation and Independent Age. The Mental Health Experiences of Older People During the Pandemic. (2021); Older People's Commissioner for Wales. Taking Action Against Ageism: information and advice for older people. (2019); Seifert, A., Cotten, S. R. & Xie, B. A Double Burden of Exclusion? Digital and Social Exclusion of Older Adults in Times of COVID-19. J. Gerontol. B. Psychol. Sci. Soc. Sci. 76, e99–e103 (2021)
[28] Mental Health Foundation (2022) Standing Together Cymru
[29] Diverse Cymru (2020) Race – the facts
[30] Cardiff University Briefing Paper (July 2021) Covid 19 in Wales: the mental health and well-being impact
[31] Mental Health Foundation (2020) Tackling Social Inequalities to Reduce Mental Health Problems
[32] Ibid
[33] Ibid
[34] The Migration Observatory (Jan2020) Migrants and Discrimination in the UK

from these groups feed into the next Mental Health Strategy in Wales. It's important that the strategy takes a proportionate approach, respecting the – sometimes substantial – cultural and discriminatory experiences of specific ethnic minority sub-populations.

Young adults: Young adults are at especially high risk of experiencing a mental health problem, and three-quarters of mental health problems arise before the age of 24.[35] Care leavers are particularly at risk[36]. Research conducted by the Foundation as part of our *: Mental Health in the Pandemic* study has consistently found that young adults (18-24) were more likely to report stress arising from the pandemic than the population as a whole.[37] Cardiff University used Wales-only data and also found that young adults (aged 16-24) in Wales experienced the largest deterioration in their mental health as a result of COVID-19.[38] Young people have experienced loss of opportunities in education and career development and financial hardship as well as isolation and loneliness as a result of the pandemic.[39]

Women: Women are more likely to experience common mental health problems than men. They are more likely to be responsible for child and elder care, they make up the majority of frontline health and care staff and are overrepresented in low paid and insecure work. Women are much more likely to be affected by domestic violence and abuse and all of these risks have been increased by the pandemic during lockdowns. [40] [41]

Our manifesto for the Senedd Elections called for a new national, cross-government Prevention Strategy that tackles inequalities in Wales when the current mental health strategy finishes in 2022. Young people, especially those transitioning to adulthood, and the inequalities experienced by women, must be fully considered as part of the new strategy.

2. **For the groups identified, what are the barriers to accessing mental health services? How effectively can existing services meet their needs, and how could their experience of using mental health services be improved?**

As a prevention charity, we believe that the inequalities we've identified and seek to address cannot be resolved within mental health services alone – action must be taken to address the social determinants of mental health, in the spaces where people are born, raised, live and work (e.g. in families, communities, schools and workplaces).[42] This should include supporting those at greatest risk such as those living in emergency accommodation, in women's refuges and transitional accommodation or services for those seeking sanctuary.

In our Inequalities report,[43] we recommended that in order to reduce the prevalence of mental health problems, action is required that directly addresses these factors across three different levels:

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[35] Mental Health Foundation (July 2020) Coronavirus: The divergence of mental health experiences during the pandemic | Mental Health Foundation

[36] Mental Health Foundation (2020) Tackling Social Inequalities to Reduce Mental Health Problems

[37] Mental Health Foundation (July 2020) Coronavirus: The divergence of mental health experiences during the pandemic | Mental Health Foundation

[38] Cardiff University Briefing Paper (July 2021) Covid 19 in Wales: the mental health and well-being impact

[39] Mental Health Foundation (July 2020) Coronavirus: The divergence of mental health experiences during the pandemic | Mental Health Foundation

[40] Ibid

[41] Chwarae Teg (2020) Women and Covid 19

[42] Mental Health Foundation (2020) Tackling Social Inequalities to Reduce Mental Health Problems

[43] Ibid

i. **Structural measures** - actions to change the social and economic influences that can lead to mental health problems. For example, reducing income inequality, poverty, unemployment, domestic violence, discrimination and homelessness.

ii. **Measures to strengthen community assets** – including activities to increase social connectedness, improve community environments, foster participation in community decision-making, and increase awareness of both risk factors and community resources to support mental health and wellbeing.

iii. **Measures at the individual level** – this includes educating people about how to look after their own mental health, peer support, and showing people how they can contribute to the mental health of their communities and families.

To maximise impact and address the interrelationship between these factors, concurrent action should be taken across each of these three levels.

With regard to mental health services, action is required **primarily at a local, community level** as well as a national and individual level and we recommend the following to address inequalities:

I. **Culturally appropriate mental health services for ethnic minority communities and those seeing sanctuary:** Research outlines the barriers to accessing services for ethnic minority communities, including discrimination,[44] higher rates of detention under the Mental Health Act,[45] racialised stereotyping of mental distress, cultural and language barriers, lower levels of access to talking therapies and lower satisfaction with care and support.[46] **We recommend continued investment and support for Diverse Cymru's Cultural Competency Toolkit,[47] and their more recent certification scheme, to support mental health services in Wales to become culturally competent.**

II. **Improving access to specialist services via public transport in Wales:** Service planning is undertaken according to population sizes, meaning that people living in rural areas in Wales often have to travel long distances to access services – this is even more so for specialist services such as deaf services, specialist perinatal services and eating disorder clinics, when people often have no option but to leave their families and communities to receive the care they need. Whilst it isn't possible to keep everyone in their local area or community due to the specialist nature of some services, **investing in improvements to public transport and working with national organisations such as the Community Transport Association (CTA) is imperative for people to be able to connect to services in rural areas. Priority should be given to those in financial hardship, those with disability and access issues and those unable to access private transport.**

III. **Digital literacy and digital exclusion:** Some populations (for example older people and those for whom English isn't their first language) have reduced access to digital mental health support such as 'Tier 0' approaches like Silver Cloud or online/ telephone peer support groups. **Populations that aren't able to access digital mental health support should be given training and support to use them or the option of alternatives such as face to face or phone support if this is their preference.**

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[44] Mental Health Foundation (4 October 2021) Stigma and discrimination | Mental Health Foundation
[45] Confluence Partnerships (February 2014) Ethnic Inequalities in Mental Health: Promoting Lasting Positive Change. London: Lankelly Chase Foundation, Mind and The Afiya Trust and Centre for Mental Health
[46] Diverse Cymru (2016) Cultural Competency Toolkit
[47] Ibid

IV.   **Support in the Welsh language:** 29.1% of the Welsh population aged three and over were able to speak Welsh in 2021[48] and enabling access to mental health support, particularly talking therapies, in your mother tongue is vitally important to improved mental wellbeing. Whilst mental health services are legally obliged to offer services through the Welsh language, in reality, the current crises in the NHS have meant that there are recruitment and retention issues across all services, both English- and Welsh-speaking. **As part of the review of the mental health workforce, attention should be paid to the need to retain and recruit talking therapists who speak Welsh, especially for Welsh-speaking areas such as Ceredigion and North Wales.**

3.   **To what extent does Welsh Government policy recognise and address the mental health needs of these groups? Where are the policy gaps?**

Welsh Government policy has recognised the mental health needs of some of these groups to an extent, but it could go much further. Improvements include: 1. *Together for Children and Young People,* with its emphasis on prevention, early intervention and joint working between health, education and social care 2. The recent focus on the needs of ethnic minority groups and those seeking asylum through the Task and Finish groups – both of which are working towards a cross sector and interdisciplinary approach to addressing the inequalities experienced 3. Increased emphasis on ACEs and trauma-informed care in Wales and 4. The recent announcement of the Basic Income Pilot for carers.

Salient policy gaps include: 1. Rural mental health - both policy and information and support on rural mental health and the inward/outward migration of people in rural areas that impacts on mental health and well-being support in rural areas is out of date. 2. Women's mental health and well-being - consideration of the gendered impacts of mental health and well-being beyond domestic violence and women prisons is needed, to include caring responsibilities and low paid and insecure work 3. Older people's mental health and well-being support. The recently published Older People's Strategy, *Age Friendly Wales* must work in alignment with the new Mental Health Strategy which, in turn, should address older people's mental health according to the principles of 'proportionate universalism' (see below).

As a prevention organisation, we have called for a new cross-government Prevention Strategy that tackles all inequalities through 'proportionate universalism'. A proportionate universalism approach balances universal actions (for everyone) with targeted actions (for specific groups) and allocates resources according to levels of need. Under this approach, action should be taken for everyone, but the scale and intensity of interventions should be proportionate to the level of disadvantage experienced.[49]

4.   **What further action is needed, by whom/where, to improve mental health and outcomes for the groups of people identified and reduce mental health inequalities in Wales?**

The Wellbeing of Future Generations Act (Wales) 2015 requires all public bodies to work towards well-being goals and think about the long-term implications of decisions through sustainable development principles and working together to prevent persistent problems such as poverty, inequalities and climate change. Public Services Boards (PSBs) oversee the work locally of producing wellbeing assessments, which looks at evidence covering the economic, social, environmental and cultural well-being of an area and produce a well-being plan to improve attainment of these goals. Every year, Ministers review milestones and the 46 national indicators to monitor progress.

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[48] ONS (6 October 2020) Welsh language data from the annual population survey July 2019-June 2020

The inception of this important legislation came midway through the previous, 10-year cross-government mental health strategy. **We therefore see the new strategy as being an important opportunity to bring together the Future Generations legislation and the mental health strategy within government to address and reduce inequalities in Wales, and thereby improve population mental health.**

For further information please contact:
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Ymateb i Ymgynghoriad / Consultation Response

Date / Dyddiad: **23rd February 2022**

Subject / Pwnc: **Senedd Health and Social Care Committee Inquiry into mental health inequalities**

Background information about the Children's Commissioner for Wales

The Children's Commissioner for Wales' principal aim is to safeguard and promote the rights and welfare of children. In exercising their functions, the Commissioner must have regard to the United Nations Convention on the Rights of the Child (UNCRC). The Commissioner's remit covers all areas of the devolved powers of the Senedd that affect children's rights and welfare.

The UNCRC is an international human rights treaty that applies to all children and young people up to the age of 18. The Welsh Government has adopted the UNCRC as the basis of all policy making for children and young people and the Rights of Children and Young Persons (Wales) Measure 2011 places a duty on Welsh Ministers, in exercising their functions, to have 'due regard' to the UNCRC.

This response is not confidential.

Introduction

Under the United Nations Convention on the Rights of the Child (UNCRC), *all* children have human rights to which they are entitled. These rights equally apply to all children aged 0-18 without discrimination of any kind.

Rights under the UNCRC include the right for every child to enjoy the 'highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health'[1]. Children also have the right to physical and psychological recovery and social reintegration if they have suffered trauma, in an environment which fosters the health, self-respect and dignity of the child (article 39); to be protected from all forms of discrimination (article 2); and for institutions of the State to act in their best interests (article 3). It is clear that, in Wales, some children do not have access to their human rights in the same way as others, and access to mental health care is a key inequity.

We do not always have the data available to us here in Wales which would assist us in establishing exactly where inequalities lie. As highlighted in my joint report with the other UK children's commissioners to the United Nations Committee for the Rights of the Child, published in December 2020[2], there is neither joined-up nor disaggregated data for expenditure on children's mental health services beyond specialist services. We do not have publically available data on interventions or treatment. While I recognise the balance that must be struck so that professionals' time is not disproportionately taken up by reporting statistics, Wales would benefit from a more comprehensive understanding of the landscape. It should also be noted that there are big overlaps between mental health, neurodiversity and learning disabilities in terms of young people with learning disabilities or neuro-developmental conditions having a higher than average likelihood of experiencing mental health challenges. We also have very little reliable data directly from services in these areas.

The data that are available to us through other sources, though, suggests a number of key indicators which mean that children are less likely to be able to enjoy their right to the best possible standard of care for their mental health. I outline some of these in this response, alongside those identified through the work of my office.

Part of the response to try to level the playing field has to be, in my opinion, work towards a No Wrong Door[3] approach. We have highlighted practice examples of taking a child-centred, early intervention approach, such as the SPACE-Wellbeing panels in Gwent[4]. The principle of these is that individual children's circumstances are taken into consideration by various agencies who can offer rapid support together, *in one place*, rather than multiple referrals being made to different services with varying waiting lists. Child-centred, timely, early intervention approaches are, by their nature, a tool for tackling inequalities because they utilise the resources of various agencies and bring wraparound support directly

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[1]   https://www.unicef.org.uk/what-we-do/un-convention-child-rights/
[2]   https://www.childcomwales.org.uk/wp-content/uploads/2020/12/UN-report-2020-examination-.pdf
[3] https://www.childcomwales.org.uk/publications/no-wrong-door-bringing-services-together-to-meet-childrens-needs/; https://www.childcomwales.org.uk/wp-content/uploads/2022/02/No-Wrong-Door-Report-February-2022.pdf
[4] https://www.childcomwales.org.uk/faqs/case-study-gwent-space-wellbeing/

to the individual needs of the child and their family. This prevents families being told that they have been knocking on the wrong door for help, or that their problems do not 'fit' with referral criteria.

Question 1: Which groups of people are disproportionately affected by poor mental health in Wales? What factors contribute to worse mental health within these groups?

The following is not intended to be an exhaustive list of which groups of children and young people are disproportionately affected by mental health, and the disparities in accessing mental health support. This response is based in large part on two sources of evidence. Firstly, my office's large-scale surveys of children and young people in Wales carried out in 2020 and 2021. Secondly, evidence from my office's core work in both supporting children and their families with their individual circumstances if they feel they have been treated unfairly through our Investigations and Advice team[5]; and through our policy influencing and project work.

Coronavirus and Me **surveys: disabled children; children identifying as an ethnic minority; and secondary school aged children.**

In May 2020, my office surveyed nearly 24,000 children and young people on their experiences during the initial lockdown period. We then repeated the exercise in a further period of strict lockdown in January 2021; this time hearing from nearly 20,000 children and young people.

We asked children and young people how they had been feeling during the lockdown periods, and gave options including levels of happiness, safety, loneliness, and how worried they felt. We also asked children whether they needed extra help during lockdown, and if they were confident knowing where to go for support with their mental health and wellbeing.

Our results from both surveys showed that disabled children and young people, and children and young people who self-identified as a Black, Asian or minority ethnic group, were statistically significantly more likely to report negative feelings across several indicators.

In January 2021[6], we found that disabled children and young people, compared to non-disabled children and young people, were:

- More likely to feel sad, unsafe and lonely
- More likely to say they need extra help, and want support to make them feel happy and well
- Less likely to know where to get help if they need support to feel happy and well.

[5]   https://www.childcomwales.org.uk/about-us/investigation-advice/
[6] https://www.childcomwales.org.uk/wp-content/uploads/2021/02/CoronavirusAndMe_Jan21_ENG_110221_FINAL.pdf

We found that children and young people identifying as a Black, Asian or minority ethnic group, compared to white Welsh or British respondents were:

- More likely to feel lonely, unsafe, sad and worried.
- More likely to say they need extra help, and more likely to say they need more help to feel safe at home
- 7-11 year olds were more likely to say they need extra help to feel happy and well.

While the results were not all the same as May 2020, several of the results from January 2021 were very similar in terms of divergence from the non-disabled population in the case of disabled children; and divergence from white Welsh or British respondents in the case of respondents identifying as from Black, Asian and minority ethnic groups.

Those aged 15-18 were more likely to report negative emotions than younger children, as demonstrated by the following two graphs taken from our *Coronavirus and Me 2* report. This pattern of increasingly negative wellbeing indicators as children get older is reflected in the School Health Research Network's National Report 2019/20[7], which used a measure of psychological attributes through the Strengths and Difficulties Questionnaire (SDQ).

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[7] https://www.shrn.org.uk/national-data/

Figure 4: the percentage of young people who feel happy and safe 'most of the time'

Figure showing two lines across ages 7 yrs old to 18 yrs old.

% Who feel safe 'most of the time' (blue line): 89%, 87%, 86%, 85%, 83%, 77%, 74%, 71%, 71%, 64%, 62%, 57%

% Who feel happy 'most of the time' (pink line): 60%, 61%, 57%, 57%, 61%, 53%, 47%, 39%, 34%, 28%, 21%, 23%
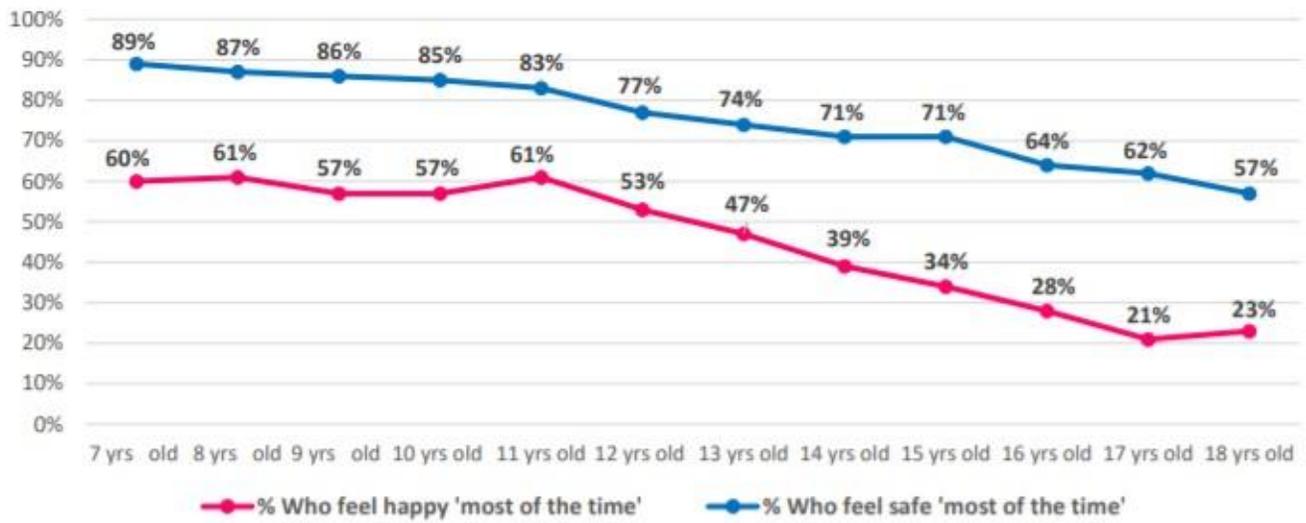
Figure 5: the percentage of young people who feel worried, sad and lonely 'most of the time'

Figure showing three lines across ages 7 yrs old to 18 yrs old.

% Who feel worried 'most of the time' (green line): 10%, 11%, 12%, 12%, 11%, 13%, 15%, 18%, 22%, 25%, 30%, 30%

% Who feel sad 'most of the time' (purple line): 8%, 7%, 9%, 8%, 9%, 13%, 16%, 23%, 24%, 29%, 32%, 33%

% Who feel lonely 'most of the time' (pink line): 13%, 11%, 13%, 15%, 17%, 20%, 24%, 28%, 30%, 36%, 40%, 34%
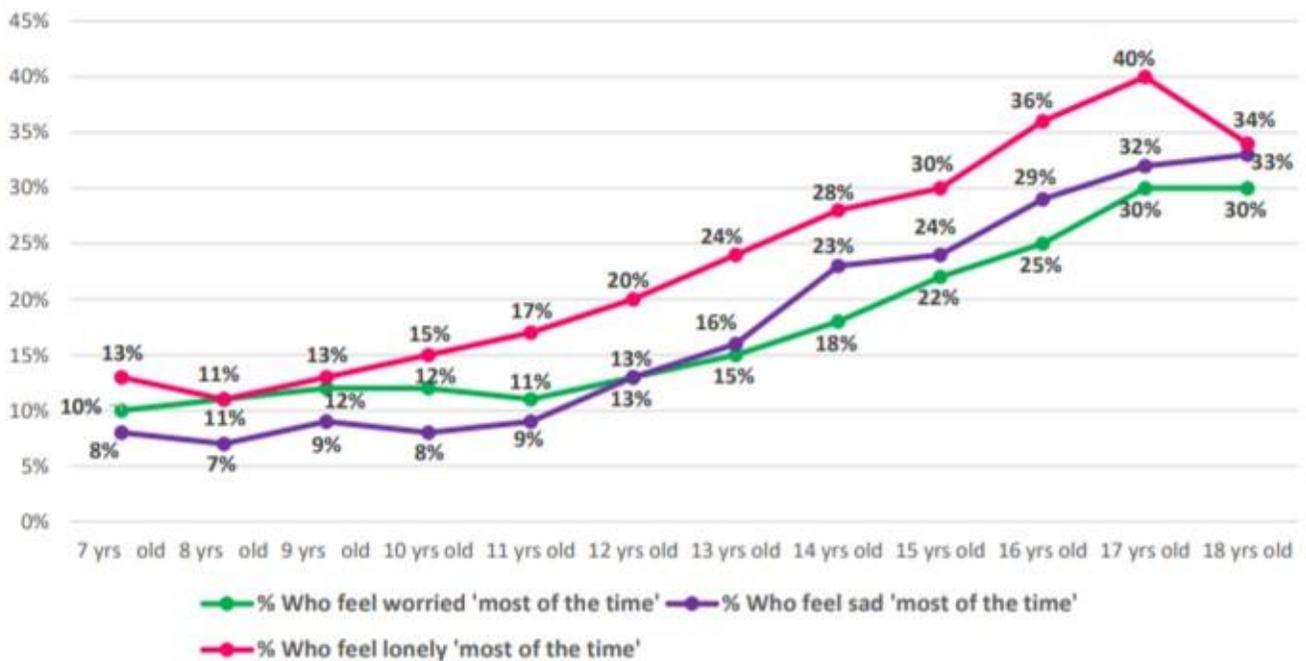
It is important to say here that neither survey asked children and young people to identify themselves by defined categories other than age, gender, ethnicity and disability. We did not ask, for example, for information which would give any indication of family affluence / socioeconomic status. This was because the surveys were being completed at home, during periods of lockdown, and children would not have

had the support of teachers to complete the survey. We therefore had to limit the number of questions asked.

Income inequality

While our surveys did not ask respondents for information which would allow us to make any comment on how income inequality affects mental health and wellbeing, the link between family income and prevalence of poor mental health is well documented. As an example, the Millennium Cohort study has shown children from the lowest income families are four times more likely to have serious mental health difficulties by age 11 than those from the highest income families[8].

The School Health Research Network's analysis of their data from a 2021 Health and Wellbeing survey of primary school aged children[9] shows that children in year 6 who had a low family affluence score were more likely to report higher behavioural and emotional difficulties scores. 10% more children from the low affluence cohort met the threshold for elevated or clinically significant behavioural difficulties than children from the medium family affluence cohort.

Neurodiversity and mental health

Figures show that children with diagnosed neurodevelopmental conditions face an often unmet clinical need for support for their mental health and wellbeing needs[10]. Our experience through our Investigation and Advice service is that there is also a high level of need for mental health services from those awaiting an assessment for a neurodevelopmental condition, or for whom their neurodiverse traits do not meet the criteria to qualify as a neurodevelopmental condition to access clinical support.

Early intervention and whole-family support

We know that 50% of mental health problems are established by age 14[11], and recent research has shown around 1 in 12 year 6 students in Wales score above the threshold for potentially clinically significant emotional difficulties and behavioural difficulties[12]. And yet the support available to children and their families before their teenage years in particular varies across Wales. We know that some families are more likely to need support for a child's mental health. As the Nuffield Trust put it:

> *there are significant inequalities in mental health disorders among young children, with disorders more prevalent among young children of families with poor parental mental health, lower incomes, and in receipt of benefits.[13]*

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[8]   https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/newcentury.pdf
[9]   https://www.shrn.org.uk/national-data/
[10] https://www.frontiersin.org/articles/10.3389/fpsyt.2021.649399/full
[11]   https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-15.pdf
[12] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8550448/
[13]   https://www.nuffieldfoundation.org/wp-content/uploads/2021/12/Are-young-children-healthier-than-two-decades-ago-Nuffield-Foundation.pdf

We should be doing all we can to support children and their families as early as possible, particularly

those families with known risk factors.

Two health board areas have dedicated infant mental health teams (Aneurin Bevan UHB and Cardiff and Vale UHB), including the recent encouraging development of the Gwent Parent-Infant Mental Health Service (G-PIMHS)[14]

School absence / exclusion

In 2018-19, our Investigation and Advice team experienced an increase in contacts from families of children aged 8 and under who were not able to access their human right to an education under the UNCRC. These children were at risk of exclusion or being taught in isolation from their peers. Some were receiving no education at all.

Our *Building Blocks* report[15] highlighted that when children were taken out of the classroom setting there was a lack of support for their mental health and wellbeing, and that far too often they were placed in unsuitable and isolating alternative settings, or excluded completely. The experience of excluding children from their peers can of course be traumatic in and of itself. We were told about incidents including children being kept in isolation all day with two adults in the room with them.

Recent research evidences that those with diagnosed neurodevelopmental or mental disorders, or with a record of self-harm, are more likely to be absent or excluded from school. This research also demonstrates the impact of absence or exclusion from school on current or future poor mental health[16].

The pandemic has of course further affected school absenteeism. Despite Welsh Government policy placing less emphasis on fines in the pandemic period, we have received anecdotal accounts of some local authorities taking action by threatening fines on the family, without taking the time to try to fully understand and support the family's individual needs. The increased non-attendance of pupils can lead to some experiencing a phobia of going to school as they have spent so long away from the school environment.

Indications so far this year are that absenteeism is high – 2.9% of pupils have already missed more than 8 weeks of school. Prior to the pandemic between 4 and 5% were persistently absent — more than one child in every classroom. This tends to be older children.

Our Coronavirus and Me surveys showed a wide range of reactions from children in relation to their views of school and school work during lockdown. While there was a strong element of children and young people being desperate to be back in school for both socialisation and learning, some were happier out of school because of their neurodiverse needs or bullying, or both. Some enjoyed the freedom to direct

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[14]   https://abuhb.nhs.wales/hospitals/a-z-of-services/gwent-parent-infant-mental-health-service-g-pimhs/
[15]   https://www.childcomwales.org.uk/wp-content/uploads/2020/12/Building-Blocks-Report_E.pdf
[16]   https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(21)00367-9/fulltext#seccestitle160

their own learning. Many older young people reported that they had lost motivation with their school work.

The response to these inequalities requires social care, youth work, health care and education to work together to regain children and families' confidence in returning to school. Welsh Government have provided money for extra resource to tackle this specific issue, but a shortage of staff right across our public sector can mean that even with generous funding it can be difficult to deploy more staff to do the kind of individualised support that is the best way to tackle this.

Some examples of local responses to this situation include having multi-disciplinary panels (such as Gwent's SPACE- Wellbeing panels) to discuss the needs of the child and family and develop a broad support package, youth workers engaging with the young person to encourage them back into school or more pastoral staff within schools. There is also a need to provide better alternatives to the standard full school timetable and classroom setting

Gender identity

We know from contact from families and in conversations with commissioning bodies that young people wishing to access support and/or treatment from gender identity services face a very long wait, with very little support available in the meantime. There are some local support groups available across Wales, but it really is a postcode lottery. The impact of a long wait for treatment can have a detrimental impact on mental health.

In my response to the Welsh Government consultation on the LGBTQ+ Action Plan, I welcomed the intention to review the Gender Identity pathway for children and young people in Wales following the review by NHS England.

An independent review has been commissioned by NHS England to make recommendations on the services provided to children and young people who are exploring their gender identity or experiencing gender incongruence. The current extremely long wait for assessment and treatment must be reviewed.

In that response, I also welcomed the plan for guidance on trans inclusion in schools. There is a clear lack of guidance currently for schools who want to do their best to protect the human rights of all their students.

Care experienced children and young people

Care experienced children and young people are likely to have histories of adverse childhood experiences which can result in poorer mental health and lower wellbeing, reporting lower life satisfaction[17].

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[17] https://shrn.org.uk/wp-content/uploads/2017/03/Long_LAC_English.pdf

Care experienced children and young people are not currently receiving the service they should under the corporate parenting principle. Professionals report to us that local authorities are often buying in private therapy because of difficulties accessing NHS mental health services. Some regions in Wales are developing a dedicated service for supporting care experienced children's mental health, such as Gwent.

We also hear from professionals who tell us that the process of transition to adult services has led to some care leavers being unable to access the therapeutic care they were receiving previously.

Question 2: For the groups identified, what are the barriers to accessing mental health services? How effectively can existing services meet their needs, and how could their experience of using mental health services be improved?

The long wait to get help

For too many children and young people, the experience of trying to access mental health support involves waiting for a very long time for an appointment, or going to an appointment only to be told they can't be helped by that service and either told they don't meet the criteria and offered no support or referred on somewhere else. All the while, for many children and young people, no practical support is offered while they wait. This can particularly be the case for those trying to access particular support services alongside mental health support, such as neurodevelopmental services or gender identity services.

The most recent publicly available figures (December 2021) on waiting times for a first specialist CAMHS appointment[18] show a worsening situation over recent months, with just 22.1% of children being seen within the 4 week waiting time target. The figures vary between health board areas. While five of the seven health board areas report over 80% of referrals receiving a first appointment within the target time of 4 weeks; in Swansea Bay (service provided by Cwm Taf Morgannwg UHB), just 2.3% of children referred, and in Cardiff and Vale just 3.5% of children referred, are seen within the target time. This is in contrast to the situation before the pandemic, when good progress was being made on waiting times in most areas.

In part, the large difference can be explained by some health board areas having a Single Point of Access system where potential referrals are discussed and often referrers are signposted to other services or immediate advice is given. This means that the numbers referred in to specialist CAMHS directly are lower than they were, where other services or supports may actually be more appropriate. But it is undeniable that there is clearly an unacceptably long wait for assessment and treatment for large numbers of children in Wales

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[18] https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Mental-Health/specialist-child-and-adolescent-mental-health-services-scamhs/first-appointment-waiting-times/percentageofscamhspatientpathwayswaitingforafirstappointment-by-month-groupedweeks

As highlighted by my office in recent months, children far too often also do not have a suitable place to go when they are experiencing a mental health crisis[19]. I have called for 'sanctuaries' or safe spaces to be created for children and young people when they are experiencing a mental health crisis. I am pleased to say that some regions of Wales have plans in place to develop such spaces and I look forward to these initiatives developing at pace. The following are case studies taken from my *Making Wales a No Wrong Door Nation[20]* report:

*In **Cardiff and the Vale of Glamorgan** there are plans for a new 'safe space' open access model for children and young people in severe distress, to avoid the need for hospital admission. This new provision would provide a suitable child-friendly environment staffed by multi-disciplinary professionals, to respond to the needs of young people without them needing to waiting in A&E or be placed in an inappropriate setting. There will be a clear pathway set out for accessing this provision. There will be further discussion and planning to ensure this model is right and has all of the necessary connections to wrap around the young person and offer the right support at the right time from the right person. While this model is developing, there is temporary accommodation provision for under 18s on wards , until the new safe space is operational and embedded. Cardiff & Vale UHB will also be extending the operating hours of the Crisis Team to 24/7 by March 2022.*

*In **North Wales** there are plans for a new 'safe space' drop in centre in Wrexham for children aged 13-18 to receive support for an urgent mental health or emotional wellbeing issue. The centre will be led by CAMHS regional clinical lead, coordinated by health and Wrexham Local Authority. The project hopes to expand further to include third sector organisations. It will be open in the evenings, nights and weekends.*

The project aims to prevent or reduce deterioration in a young person's emotional, behavioural or wellbeing state which may otherwise result in an application of section 136 of the Mental Health Act ('being sectioned'), calls to emergency services, or admission into hospital or presentation at an emergently department. There will be a three-month trial in the coming months.

Neurodiversity and mental health

As highlighted in my recent report, *Making Wales a No Wrong Door Nation[21]*, children awaiting assessment for neurodevelopmental conditions face an extremely long wait (typically several years) and in the meantime their mental health and wellbeing can dramatically deteriorate, without appropriate support being offered. Those with concurrent neurodevelopmental conditions and mental health conditions (which is common) receive a very disjointed service because of the fact they require input from separated services.

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[19] https://www.childcomwales.org.uk/2021/10/no-suitable-places-for-young-people-in-mental-health-crisis-warns-childrens-commissioner/

[20]   https://www.childcomwales.org.uk/wp-content/uploads/2022/02/No-Wrong-Door-Report-February-2022.pdf
[21]   https://www.childcomwales.org.uk/wp-content/uploads/2022/02/No-Wrong-Door-Report-February-2022.pdf

Below I outline some themes summarising issues regularly brought to my office, and some case studies

of individuals supported through our Investigations and Advice service.

Too often we hear from families where there are examples of:

- Miscommunication between agencies
- A lack of clarity over responsibility between primary and secondary or specialist CAMHS
- Families finding themselves in the position of awaiting an assessment from the neurodevelopmental team (NDT) which then prevents access to other services. This is despite the fact that the current average wait for a neurodevelopmental assessment is upwards of 2 years
- Confusion over where referrals can come from
- A lack of support while awaiting assessments, despite behaviour often described as dangerous to self and others

The following case study examples were brought to the attention of my office last autumn:

1) 15 year old

- Young person has been involved in services for 2 years and has not had an ASD assessment over this time. The referral response has always been that the young person doesn't meet the criteria
- They have just been accepted to the pathway and are on the 2 years-plus waiting list. The young person's mother asked for referral to primary CAMHS as she believes the young person has an eating disorder. Primary CAMHS told the family won't see her and that they should be seen by specialist CAMHS (sCAMHS)
- sCAMHS did a telephone assessment, then after 2 face to face assessments said the young person needs to be under primary CAMHS because they have an eating disorder.
- Young person not accessing any support in the meantime and is currently awaiting an appointment with primary CAMHS.

2) 12 year old

- Child who has been home schooled since February 2020
- October 2020 - Child is on the NDT pathway and has suicidal thoughts — been told waiting list is in excess of 19 months and appointments cannot be expedited
- Community Pediatrician won't accept a referral as waiting for an NDT appointment
- March 2021 - parents started to pay for child to see a consultant psychologist at a cost of £90 per session, who recommends medication. GP can't prescribe and child not seeing anyone in CAMHS so it can't be prescribed through them
- Reports high levels of anxiety and severe depression
- August 2021- Community Paediatrician wrote to GP advising as child is on the NDT waiting list the community Pediatrician won't see them — family will have to wait for NDT appointment as Community Pediatrician 'does not cover mental health'
- September 2021 – letter sent offering CAMHS appointment in December

3) 16 year old

- Young person who has not been in school for 2 years has been seen by CAMHS. We were told that the CAMHS nurse strongly believes that the YP has ASD and to date the mother's request for a referral has been denied.
- We were told the school have refused to make the referral stating that this young person has not been in school for 2 years, and they won't refer them to the educational psychologist who the ALNCO says is the only person that can make the referral
- GP has also stated that they cannot make a referral as it needs to come from the school
- We are concerned that this is contrary to NICE guidance, and indeed the Health Board's own public facing website which states that referrals should come from the professional who knows the young person best.

My report *Making Wales a No Wrong Door Nation* makes a recommendation to Welsh Government that they should support and deliver the joined up approach to neurodevelopmental services which recognises the full spectrum of neurodiversity, as developed by T4CYP.

The report highlights good practice case studies throughout, and there are encouraging examples we can draw on.

For example, Denbighshire CAMHS appear to have an encouraging sounding model where joint CAMHS / ND consultations can be offered through CHOICE appointments. They told us that parental consultation appointments can happen immediately, without having to wait for a diagnosis. Under their previous system they would have just been on the ND waiting list.

In Aneurin Bevan UHB, neurodevelopmental services have been streamlined into the SPACE-Wellbeing panels process to make sure the panel approach also considers neurodevelopmental needs.

But it is clear to me that neurodevelopmental services require a significant cultural change — they need to provide for both children and their families awaiting assessment, and for those who have been told they do not meet the criteria to be supported. Neurodevelopmental services need to broaden out to include support for neurodiverse children when they are suffering extreme emotional distress.

Transitions to adult mental health services

The transition from child to adult mental health services is an area where children and families often find themselves caught up in a lack of foresight for planning such a transition, and disputes between agencies over responsibility. We hear from young people, their families and professionals that they face a 'cliff

edge' on reaching the age to transition to adult services whereby their nature of the service they receive changes dramatically — often meaning less direct contact with professionals for example. For children with other health and or social care needs as well as mental health needs in particular, the transition experience can be extremely difficult and distressing.

New Welsh Government guidance for Health Boards on the wider transitions landscape in health[22] is very welcome, and includes new roles created specifically to manage the caseload of young people who need support to move into adult services, and a named worker who coordinates individual support with that transition for the young person. There are also new Transition and Handover Plans designed to improve children's direct involvement in their transition. These changes should help to better manage children and young people's transitions within health. It is vital, though, that health professionals work in harmony with other agencies involved in children's care in order for transition to be a success.

Question 3: *To what extent does Welsh Government policy recognise and address the mental health needs of these groups? Where are the policy gaps?*

NEST / NYTH Framework

We welcome the work which has been undertaken by the Together for Children and Young People programme, and in particular their development of the NEST / NYTH framework. This framework will support Regional Partnership Boards and individual partners to create their local whole system approach to bringing services together for children and young people's mental health and wellbeing.

The key principles of this framework include a No Wrong Door approach, and we believe this framework reflects our priorities for creating a service which designs services to wrap around children and young people's needs, rather than expecting children and young people to fit into existing services.

Part of this framework includes improving the support given to children and young people who are neurodiverse and need support with their mental health. We are pleased that the Welsh Government has commissioned a review of the demand and capacity of neurodevelopmental services, which should assist in getting a clearer picture of the data, and the options available for improving the current system.

While this framework is very welcome, there are several important elements which are needed to ensure its success. These are detailed in my report, *Making Wales a No Wrong Door Nation*.

ICF and Transformation funding has been made available to RPBs for projects to support children and young people's mental health and wellbeing, including specific funding for Regional Partnership Boards to create new safe accommodation for children with complex needs. This provision would support those young people who don't currently 'fit' into the system we have in place because they have multiple needs

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22   https://gov.wales/transition-and-handover-childrens-adult-health-services

beyond a mental health or social care intervention. I am pleased to say that most Boards now have plans for this accommodation, with new beds beginning to be made available this year.

A whole-school approach

There is a need to invest in preventative and early intervention in schools and communities, especially where there is more deprivation. As highlighted by my office's *Building* Blocks report, schools must also do more to create a supportive environment around children to avoid them being taken out of the classroom setting away from their peers.

The Welsh Government's whole school approach guidance[23] is welcome. It is clear that some schools will have already been on this journey and will take to the requirements of the guidance well, while others will struggle because they are further behind on the journey. A supportive mechanism which provides bespoke support to individual schools will be vital in implementing this guidance. I urge the Government to invest in replicating individual schemes which have been proven to provide support to pupils across schools where they don't yet exist. This would include examples such as nurture units — spaces made available to children who need a safe and supportive place to go during the school day.

The new curriculum of course also supports the whole school approach guidance through the health and wellbeing area of learning and expertise.

Question 4: What further action is needed, by whom/where, to improve mental health and outcomes for the groups of people identified and reduce mental health inequalities in Wales?

Overall, there is a lot of good will to address these issues, and there are green shoots across Wales, which I highlight here and in more detail within my *Making Wales a No Wrong Door Nation* report.

Clearly, mental health services in Wales are hampered by workforce issues which are common across the UK. However, there are examples within Wales of good practice that can be promoted and replicated throughout Wales. Single Point of Access approaches are a major step forward and can mean services come to the child together rather than expecting the child and their family to find which individual services are right for them. This approach to bringing support to the child can be embedded through whole school approaches within schools. All of these approaches are likely to support children and young people from groups that are likely to face more barriers than others to accessing support, including a lack of confidence and resources on the part of parents and carers to persist in seeking help through a complex system.

I believe that Welsh Government could provide a stronger role in ensuring good practice which maximises resources to provide a wraparound No Wrong Door approach to their young population (like the SPACE-

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[23]   https://gov.wales/framework-embedding-whole-school-approach-emotional-and-mental-wellbeing

Wellbeing panels in Gwent) is rolled out across the country. There will of course be regional variance in

how these initiatives are delivered, but I am convinced that we have the ideas and examples of delivery in pockets of Wales that could be scaled up to serve our children and young people equitably. We have the NEST / NYTH framework which can help us to achieve this, but it will require a huge effort of collaboration between services to achieve its ambitions.

Submitted by:

Professor Sally Holland

Children's Commissioner for Wales

Comisiynydd Pobl Hŷn Cymru
Older People's Commissioner for Wales

Mental Health Inequalities
Health and Social Care Committee

February 2022

Introduction

The Older People's Commissioner for Wales welcomes the opportunity to respond to the Health and Social Care Committee's inquiry into mental health inequalities.

Maintaining good mental health and being able to receive support for mental health issues in later life are essential parts of ageing well. Older people have been at the highest risk during the Covid-19 pandemic, and subject to its most stringent restrictions. This has exacerbated long-standing inequalities in older people's mental health. Older people should be seen as a vital part of society in recovery planning and should be able to have more opportunities to participate in and contribute to our economy and our communities as we build back better. This will mean redressing those inequalities.

It is crucial that the diversity of older people is reflected in policy and practice, in particular, those who have faced life-long discrimination and inequalities, which includes LGBTQ+, Black Asian and Minority Ethnic, disabled and socio-economic disadvantaged older people. Reflecting the diversity of all older people and older people's needs, especially where discrimination and inequality has been experienced across a lifetime, is essential and we must ensure that policy and practice moves away from treating older people as a homogenous group.

Mental health issues range in duration and severity, from life-long conditions to those which have developed more recently, and from mild illnesses which can be addressed in the community to severe conditions which need specialist treatment. This response addresses functional mental health needs, but these may exist alongside organic disease of the brain and be obscured by it. This can lead to under-diagnosis of, e.g., anxiety and depression, in people living with dementia.

For further information, please contact:
Valerie Billingham, Health and Care Lead

1. **Which groups of people are disproportionately affected by poor mental health in Wales? What factors contribute to worse mental health within these groups?**

<u>Older people</u>

Many older people have long-standing and under-served mental health needs[1] which are now being exacerbated by the Covid-19 pandemic.[2] Life events that lead to serious mental health issues have been felt by older people in particular: bereavement, illness, stress from caring, and trauma. The rising cost of living and spiralling fuel costs are adding to long-standing financial pressures felt by older people, causing anxiety and leading to difficult and dangerous decisions about heating or eating. The direct harms experienced by an individual have knock-on effects on the mental health of their families and other people close to them, many of whom are older people themselves.

The Covid-19 pandemic has created unprecedented levels of harm and need for health, care and support services in Wales. The Welsh Government recognises that long-term effects of the disease, economic impact, the loss of usual societal participation and loss of family and friends, and the impact on the health and social care workforce are likely to increase the demand for rehabilitation, probably for many years,[3] while the Royal College of Psychiatrists has predicted a tsunami of mental illness.[4]

In telephone survey of 500 older people conducted for the Commissioner in 2021, 17% of those surveyed said they had needed mental health support in the previous 12 months, but only 12% had sought it. The latest available data from the Welsh Health Survey in 2015 highlighted the low level of take up of mental health services by older people compared with the general population.[5] The National Survey for Wales, which replaced the Welsh Health Survey, does not include equivalent data.

The Commissioner is particularly concerned about the mental health of older people who are: socially isolated or shielded in their own homes; awaiting paused NHS care; living in care homes; unpaid carers, and at risk of or experiencing abuse.

The biggest increase in the suicide rate in 2018 was among males aged 75 years and over, when compared to all other age groups, 32% higher than in 2017.[6] Similarly, across April – July 2020 in England and Wales, suicide rates in females aged 75 and over saw an increase.[7] The Office for National Statistics highlighted that in 2019, suicide rates 'tend to increase in the oldest age groups for both males and females' with contributing factors including 'psychiatric illness, deterioration of physical health and functioning, and social factors.'[8] In 2020, ONS saw a statistically significantly lower suicide rate across the whole population than the 2019 rate, and males and females aged 45 to 49 years had the highest age-specific suicide rate. The decrease is likely to be driven by two factors; a decrease in male suicides at the start of the Covid-19 pandemic, and delays in death registrations because of the pandemic.[9]

People socially isolated or shielded in their own homes

From the Commissioner's engagement and direct contact with older people, the Commissioner has heard that older people were missing their families more later in the pandemic than they had at the beginning; that winter, a hard time of year for many older people,[10] had been made even harder; that people felt cut off and lonely; that some were too scared or lacked the confidence to go back out into their communities, and that people could not see an end to the pandemic in sight.

Loneliness was also a strong theme in the Commissioner's Winter Stories[11] report of older people's lived experiences over the 2020-21 winter, and in data from a mental health and wellbeing telephone poll of 500 people over 60 carried out in 2021 on behalf of the Commissioner. Of those surveyed, 13% identified "lonely" as one of their three predominant feelings, and it was the fourth most popular word people used to describe themselves. The Winter Stories research highlighted the lack of intimacy, exacerbated by winter, the need for face-to-face contact with relatives and friends, a huge reduction in older people's sense of purpose and a loss of communication and social skills.

The poll also found that older people were seeking ways of making themselves feel better which were not necessarily healthy: for example, 25% of poll participants said drinking alcohol made them feel better.

People awaiting paused care

The Commissioner has received testimony of the impact of paused care on older people, both directly and indirectly through the emotional and practical impact of harm which has happened to a loved one. For example, disabled older people unable to access physiotherapy have spoken of becoming immobilised physically and robbed of mental well-being. An older woman whose son had died in his 40s due to paused cancer treatment said her life would never be the same again.

Paused care has been particularly challenging for people living with dementia who need treatment for other conditions. Limited communication from hospitals throughout the pandemic and not knowing how long someone has to wait for treatment have led to high levels of anxiety and put a strain on family relationships.

People living in care homes

The Commissioner's "Care Home Voices" report[12] and the evidence of inquirers to the Commissioner's Advice and Assistance team show that isolation from loved ones was particularly acute for older people living in care homes and their relatives, many of whom are themselves older people.

Unpaid carers

The number of unpaid carers in Wales increased by 196,000 in 2020,[13] as planned packages of care could no longer be provided, or people were unwilling to take the risk of allowing care workers into their homes. For some older unpaid carers and those caring for

people living with dementia the combination of the closure of respite facilities such as day centres, combined with lockdown restrictions, has pushed them towards breaking point. The Commissioner is very concerned about the further impact on carers of recent Health Boards calls for families to provide more care at home to expedite hospital discharge.

People experiencing abuse

Thousands of older people in Wales are experiencing mental and physical abuse. During the pandemic and its restrictions on everyday life, the opportunities to identify older people at risk of or experiencing abuse have reduced. At the same time, the restrictions may have exacerbated existing abusive situations or led to new ones. Older people may have experienced abuse over many years and may be living with long-term trauma.

Financial crime attempts on older people are increasing, adding to older people's fears. When an individual succumbs to a scam it can be devastating, not only because of the financial loss but because of the stigma and the sense of guilt that can accompany it. Polling conducted for the Commissioner's State of the Nation report found that 75% of older people in Wales were aware of attempts to trick them into parting with money or personal information, and 64% of older people reported that these attempts have increased since the start of the pandemic.[14]

2. **For the groups identified, what are the barriers to accessing mental health services? How effectively can existing services meet their needs, and how could their experience of using mental health services be improved?**

Language and stigma

The language of public discourse about mental health can often be unfamiliar and stigmatising to older generations, who have not grown up with phrases like "mental health issues" and do not connect phrases like this with their own mental and emotional states, or experience shame and guilt in relation to them. These feelings may be compounded by long-term discrimination and inequalities within minority population groups. If we are to ensure that mental health services and support are accessible to older people, then work needs to be done on communication and language around services, to check that they are inclusive for older people.

Ageism and age discrimination

The Royal College of Psychiatrists' Suffering in Silence report highlights discrimination, infringement of human rights, unmet need and neglect of older people in mental health services in the UK.[15] According to the report, deep-rooted cultural attitudes to ageing are particularly evident in mental health; in the past 10 years the position of older people in mental healthcare has fallen behind that of younger adults, and services for older adults have been excluded from investment and have seen reduced resources in some areas.

Throughout its report, the Royal College of Psychiatrists provides examples of what constitutes age discrimination within a service, which can be summarised as:

Direct discrimination

- Preconceptions, for example depression is an inevitable consequence of ageing
- Requirement to transfer services at a certain age, resulting in disadvantage and loss of relationships
- Inequitable distribution of resources, including through perceptions, for example that diverting more resources to younger people is more cost-effective; over-emphasis on Quality-Adjusted Life Years (QALYs); long-term underfunding and falling investment
- Denial of access to younger people's services that could meet older people's needs, e.g.: crisis resolution; home treatment; talking therapies, due to preconceptions that: older people are unsuited to the service; physical and social issues should take priority.

Indirect discrimination:

- Failure to recognise changing need
- People of all ages receiving the same services regardless of specific needs.

Digital exclusion

The increasing use of digital technology has accelerated during the Covid-19 pandemic, with remote consultations now being delivered by the NHS throughout Wales. Whilst these appointments will be suitable for many people, there is still a significant number of older people who do not have access to the internet or lack the confidence and skills to engage in this way – the latest figures from the National Survey for Wales show that 31% of people over 75 do not have access to the internet at home.[16] Older people have shared concerns with the Commissioner about access to health services as more has gone online.

Whilst moving services online and introducing new ways of interacting with the public can offer potential benefits to those who can access them, it is also important to recognise the risk of excluding those who do not want to, or are unable to, access services in this way, which includes a considerable number of older people.

Where older people can access remote consultations about their mental health, the concern is that an online conversation may make it more difficult for the clinician to pick up as many indications of someone's true state as they would if the consultation were face to face.

3. To what extent does Welsh Government policy recognise and address the mental health needs of these groups? Where are the policy gaps?

<u>Data</u>

The Welsh Government's policy on mental health service provision is influenced by data from the National Survey for Wales, which shows lower levels of self-reporting of mental illness in the older population than in younger generations.[17] However, given older people's own accounts of the direct and indirect harms of the pandemic to their mental health, and given other sources of data which reveal the serious burden of mental illness on the older population in other UK nations, this lower level of self-reporting should not be taken at face value.

In England, the Department of Health and Social Care estimated before the pandemic that 40% of older people in GP clinics have a mental health problem, rising to 50% of older people in general hospitals and 60% of those in care homes.[18] Depression, the most common mental health problem in older people, is estimated to affect 22% of men and 28% of women aged 65 or over and 40% of older people in care homes (Age UK, 2016).[19] The Royal College of Psychiatrists estimated that 85% of older people with depression receive no help at all from the NHS.[20]

Equivalent data do not appear to be available for Wales. The National Survey self-reported data may be influenced by a range of factors including different concepts of mental illness and assumptions about treatment in older generations, persistent stigma, stoicism, fatalism, and a tendency to regard generalised messages and services as being for someone else.

This evidence gap must be addressed to establish a firm evidence base for policy on older people's mental health and services in Wales. The accuracy of older people's self-reporting, whether they are under-reporting and the reasons why, need further investigation. The deficiencies in data collection on mental ill-health in the older population in Wales need to be addressed, and data must be segmented to reflect the diversity of the older population and evolving needs over the long period of time spent in later life.

<u>Policy and strategy</u>

The Welsh Government's Together for Mental Health Delivery Plan 2019-22 includes measures to improve the access, quality and range of psychological therapies for older adults, including: introducing a psychological therapies infrastructure in Wales to support service improvement, workforce development and strengthen governance; commissioning the development of an evidence based All Wales Traumatic Stress Quality Improvement Initiative, and scoping the potential to expand the Health for Health Professionals (HHP) Wales Service to both NHS dentists and paramedics. It also sets out measures to increase older adults' access to crisis and out of hours care, including: implementing the National Crisis Concordat Action Plan; completing a rapid urgent mental health access and conveyance review; investment to support health boards to extend and standardise the

delivery of crisis and out of hours services to provide 24/7 access, and supporting a range of pilots to inform evidence based practice .

However, some of the initiatives in the plan could not be expected to produce results on the ground for some time. The redeployment of mental health clinicians to support the NHS workforce during the pandemic, and the low uptake of mental health services by older people are also concerning. It would be helpful to see evidence of any improvements so far in older people's access to psychological therapies.

The Together for Mental Health ten-year strategy is due to be reviewed and refreshed in 2022. The Welsh Government must take the opportunity of the review to address the availability of appropriate mental health services to meet older people's needs.

Funding

The Welsh Government has announced an additional £50 million for mental health services in Wales in the 2022 Budget. The Commissioner understands that the Budget is, for the first time, a thematic Budget that acknowledges that other Welsh Government departments should also contribute to alleviating pressures on mental health by addressing the wider determinants of health. It would be helpful to have more information about what this means in practice for older people.

Third Sector

The Commissioner has recommended to the Welsh Government that it should build the capacity of local voluntary and community groups to provide, develop and scale up services and activities which improve older people's health and wellbeing and can remedy deconditioning, deterioration in mental health, and isolation and loneliness.

It is essential that the Welsh Government works with the public and third sectors to ensure that the right support is in place at community level to address older people's mental health needs, which may have changed significantly during the pandemic. Examples of such services include: Age Cymru Dyfed's Third Sector Mental Health Services Project, which aims to support those ages 50+ suffering with low to moderate mental ill health and well-being issues who are experiencing loneliness and isolation, as well as their carers; Age Cymru's Friend in Need Telephone Befriending, and a range of physical activity programmes which also benefit mental health.

Following the Commissioner's recommendations, the Welsh Government announced £3.8 million additional investment in third sector early intervention and prevention services for physical and mental health in their Health and Social Care Winter Plan 2021 to 2022.[21] It was good to see evidence of longer-term approaches to voluntary sector funding in the Welsh Government's announcement in December 2021 of an additional £21m over three years for the future of Wales' voluntary sector, on top of the Community Facilities Grant.[22]

4. What further action is needed, by whom/where, to improve mental health and outcomes for the groups of people identified and reduce mental health inequalities in Wales?

Data

Having, robust, accurate and current statistics on mental wellbeing, mental health problems and access to and uptake of mental health services is critical to shaping Welsh Government and NHS policy on mental health services. In Wales, this means radically improving data collection on mental health and older people, at regional and national level.

Determinants of mental health

Very often people have developed mental illness as a result of tangible problems in their lives and need practical support such as a change of housing, financial support or help to return to activities such as volunteering or work. Where it is needed, this help must be available.

Environments which foster social connection and provide somewhere to go, something to do and someone to meet can all contribute to support an individual's mental health and help to combat the loneliness and isolation which contribute to mental illness. The development of 'age-friendly communities' throughout Wales will help to achieve this. The Commissioner is working with local authorities and has established a Community of Practice to support this development and welcomes the commitment of the Welsh Government towards age friendly communities as set out in 'Age Friendly Wales: our Strategy for an Ageing Society'.[23] There is also the opportunity to learn from and link to the work being carried out internationally through the United Nations Decade of Healthy Ageing (2021 – 2030). The areas for action are age friendly environments, combatting ageism, integrated care, and long-term care.[24]

Prevention and early intervention

It is essential that the Welsh Government builds the capacity of local voluntary and community groups to provide, develop and scale up services and activities which improve older people's mental health and wellbeing and remedy deterioration. Community spaces need to be provided where groups can come together to offer mutual support and therapeutic activities, with community connectors ensuring that older people are informed about the opportunities and facilitated to attend and participate.

Community-based services

The Welsh Government should, during its review of the Together for Mental Health 10-year strategy:

- establish the post-pandemic availability of community-based mental health services for older people and their fitness for purpose;
- examine the extent to which ageism and age discrimination are limiting older people's access to appropriate services;

- eliminate ageism and age discrimination in services; and
- ensure appropriate service delivery for older people as they build back better services.

It is positive that Health Education and Improvement Wales (HEIW) and Social Care Wales' (SCW) forthcoming mental health workforce plan will include bringing mental health care closer to home, upskilling the workforce, mental health literacy for everyone, and broadening access to Third Sector mental health services, and that equality and diversity are themes running throughout. The Commissioner's team has raised concerns about ageism and age discrimination to HEIW and SCW and will be looking carefully for evidence that they have been addressed throughout the strategy when it appears.

Outcomes

The Commissioner understands that the Welsh Government is developing an outcomes and measures framework for mental health. The Royal College of Psychiatrists' examples of what constitutes age discrimination within a service provide a useful framework for defining the outcomes for older people which should be formalised in the next iteration of Together for Mental Health, and which should be used to shape service change.

The revised strategy should drive culture change in health and care organisations, so that the people working in them no longer see mental illnesses such as depression as an inevitable consequence of ageing. It should ensure that health and care organisations understand what constitutes direct and indirect age discrimination in mental health services and act to prevent it, and that they do not predicate service plans for the future on the discrimination of the past.

Resources for mental health services should be equitably distributed. Older people should receive the mental health services which are most appropriate to their needs, and mental health service commissioners and providers should recognise that people's needs change and evolve. No-one should be denied access to services which could meet their needs simply on grounds of age, nor be required to transfer from one service to another simply on grounds of age.

The Commissioner's team have discussed this with the Welsh Government officials developing the new outcomes and measures framework.

Conclusion

The Older People's Commissioner for Wales views the revision of the Together for Mental Health strategy as an important opportunity for improving older people's access to mental health services in Wales. The Commissioner strongly advocates that tackling ageism and age discrimination is given high priority within the revised strategy, and that data collection is radically improved to provide an evidence base for policy and service development.

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The Older People's Commissioner for Wales

The Older People's Commissioner for Wales protects and promotes the rights of older people throughout Wales, scrutinising and influencing a wide range of policy and practice to improve their lives. She provides help and support directly to older people through her casework team and works to empower older people and ensure that their voices are heard and acted upon. The Commissioner's role is underpinned by a set of unique legal powers to support her in reviewing the work of public bodies and holding them to account when necessary.

The Commissioner is taking action to end ageism and age discrimination, stop the abuse of older people and enable everyone to age well.

The Commissioner wants a Wales where older people are valued, rights are upheld and no-one is left behind.

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Russell George MS

Chair

Health and Social Care Committee

Tŷ Hywel

Cardiff Bay

CF99 1SN

2 March 2022

Dear Russell

Petition P-06-1241 Welsh Government to meet with a wider audience of unpaid carers

The Petitions Committee considered the above petition at our meeting on 7 February, alongside correspondence from the Deputy Minister for Social Services and the Petitioner.

At the meeting members agreed to write to you in order to highlight the petition and to ask if there will be scope in the future for the petitioner to engage in any inquiries or evidence-gathering sessions on the issue.

Further information about the petition, including related correspondence, is available on our website at: https://business.senedd.wales/ieIssueDetails.aspx?IId=38598&Opt=3.

If you have any queries, please contact the Committee clerking team at the e-mail address below, or on 0300 200 6454.

Yours sincerely

Jack Sargeant MS
Chair

Croesewir gohebiaeth yn Gymraeg neu Saesneg.

We welcome correspondence in Welsh or English.

Senedd Cymru
Welsh Parliament

Agenda Item 7.2

Responses to HSSC Committee on Draft Budget

Recommendation 1. When bringing forward future draft budgets, the Welsh Government should set out who has been consulted or engaged with in the development of the proposals, how this has been done, and what changes have been made as a result.

Response: Accept in principle

There are many well established fora for discussion and engagement with NHS colleagues which all help to inform our policy development, prioritisation process and ultimately budget allocations. These include the NHS Leadership Board, which includes all NHS Wales Chief Executives and also representation from meetings, the Welsh NHS Confederation. I also meet regularly with NHS Chairs.

In terms of mental health and social care, Ministers regularly engage with a wide range of stakeholders, both individually and through representative groups such as:
> ➢ the Welsh Local Government Association's Cabinet Member Networks,
> ➢ the Care Action Committee,
> ➢ the cross-sector Health and Social Care Covid Planning and Response Group, and
> ➢ the Wales Alliance for Mental Health.

The Minister for Finance and Local Government also engages with a range of stakeholders during the development of the budget. Stakeholders highlighted a number of priority areas such as supporting the most vulnerable, including children, younger and older people; and progressing decarbonisation and biodiversity. These have been reflected within our 2022-23 spending plans.

The Budget Improvement Plan (BIP) sets out actions to improve budget and tax processes including actions to continue to refine and improve the transparency of budget information. As part of this work, we will reflect on how we can further improve transparency and publish an appropriate level of detail on the formulation of budget plans.

Recommendation 2. When bringing forward future draft budgets, and providing written evidence to inform Senedd committee scrutiny of the budget proposals, the Welsh Government should provide greater clarity about how each allocation within the budget aligns with Welsh Government priorities, what measurable outcomes each allocation is intended to achieve, and how progress made against such outcomes will be monitored and transparently reported

Response: Accept in principle

The draft budget narrative provides the overall context for the budget and sets out how the allocations align to the Government's priorities for a stronger, fairer and greener Wales. In the detailed evidence to the Committee, we have endeavoured to

demonstrate how the allocations within our portfolio align to these overall priorities, particularly when they are supporting specific Programme for Government commitments.

Inevitably, a significant proportion of new allocations to the Health and Social Services portfolio will be need to support cost and demand growth for NHS Wales, including pay awards for our highly-valued NHS staff, and so it is not always straightforward to align these additional allocations to specific outcome measures. Officials hold NHS Wales organisations to account across a wide range of delivery and outcome measures through regular monthly review meetings and through biannual Joint Executive Team meetings. However, where allocations are being deployed to achieve specific outcomes, we will ensure that the mechanism for monitoring those outcomes is set out clearly in future evidence.

Recommendation 3. The Welsh Government should confirm whether it has had any discussions with health bodies or local authorities about shifting funding from resource to capital in order to fund transformative health and social care capital projects. This should include indication of whether the Welsh Government is willing to consider requests from health boards for funding to be shifted in this way.

Response: Accept

There have been no discussions with NHS organisations about shifting funding from revenue to capital linked to developing combined health and social care capital projects. The provision of £50m in 2022-23 to Social Care is a positive development in this area which will see close involvement of Regional Partnership Boards in identifying priority areas for investment.

Recommendation 4. The Welsh Government should provide an update on e-prescribing. The update should include: details of what needs to be done during each phase of the project, how long each phase is anticipated to take, how the anticipated duration of each phase has been assessed and how deadlines have been set, and what steps are being taken to ensure that e-prescribing is rolled out without delay.

Response: Accept in principle

Welsh Government remains committed to delivering Digital Medicines Transformation (formerly known as ePrescribing) as quickly as possible, within the 3-5 years previously communicated. I will shortly be releasing a written statement setting out a more detailed update, including timelines, on Digital Medicines Transformation. The four workstreams of the portfolio are progressing in parallel, though there are no "phases" in the traditional sense as the application of such waterfall methodologies slows down the delivery of solutions.

By way of a short update ahead of the fuller written statement, tender documents for the procurement framework for a secondary care digital medicines management solution are now live for suppliers to respond to, and we expect the supplier framework to be available for health boards to begin to call-off against by the end of June. Welsh Government are providing funding to health boards and trusts to commence pre-implementation work, including user discovery; this will accelerate the adoption of secondary care platforms by allowing health boards and trusts to bring in dedicated resources to work solely on the implementation of Digital Medicines.

Work is ongoing around the potential implementation of Electronic Prescription Transfer using the existing NHS England technology platform, though this does require work to separate Welsh and English financial systems (for payment of prescription charges by the NHS) and other factors. It also does not facilitate the prescribing activities of non-GP primary care prescribers, and so DHCW are continuing to explore how this can be addressed. The patient app functionality is in the user discovery stage, as the programme explores what functionality users (both clinicians and patients) want from an app; this incorporates the recommendations and findings from the primary care discovery currently being undertaken by the Centre for Digital Public Services through the Digital Services for Public & Patients programme which is delivering the NHS Wales App. The medicines repository work has commenced with consideration of the architectural building blocks; this will be further informed by the open data standards that suppliers on the secondary care framework wish to use, and a confirmation of selection (or otherwise) of the EPT technology platform from England for the primary care workstream.

Recommendation 5. The Welsh Government should provide further information on how any additional capital funding for health and social care that becomes available in year, for example through Barnett consequentials, will be prioritised. This should include details of what preparatory work is being done to ensure that there is a pipeline of projects that could be progressed without delay.

Response: Accept

NHS organisations have long been in the practice of having capital schemes available at short notice should additional funding become available.

Capital schemes by their very nature can take significant time to thoroughly develop. As a result, there is an on-going pipeline of schemes that NHS organisations are working on. There are inevitable challenges with this due to the complex nature of the works capital funding is sought for. Priority is given to those works linked to ensuring that NHS sites are safe (which include investments in fire prevention and electrical infrastructure). In addition there are schemes linked to Covid recovery (such as those around endoscopy provision) as well as wider service transformation.

The challenges of annualised funding envelopes (i.e. the need to have utilised funding in the year it is available) means that organisations have well developed schemes "on the shelf" as and when any funding becomes available. This has been an effective mechanism for supporting organisations equipment replacement programmes which have shorter delivery lead times.

Recommendation 6. The Welsh Government should provide further information about the impact of reductions in capital funding on decarbonisation in the health and social care sectors, and any implications for the sectors' response to the climate emergency.

Response: Accept

The reduced capital allocation will restrict the opportunities available to the NHS around decarbonisation but, where possible, these will be incorporated into scheme designs so we will continue to make progress against the net zero target. All NHS capital business cases reference available decarbonisation opportunities.

The NHS Wales Decarbonisation Strategic Delivery Plan sets out a target to demonstrate we are well on the way by reducing emissions by 16% by 2025. This will present a challenge and organisations will need to consider a range of initiatives and funding sources to deliver against this.

There remain a number of schemes currently in the capital programme for 2022-23 that will help make progress towards to the decarbonisation targets. These include the solar farm being developed by Hywel Dda University Health Board (alongside the solar farm already supported at Morriston Hospital).

In addition, the provision of additional capital for Social care in 2022-23 will offer new opportunities for organisations towards reducing the sectors carbon footprint.

Recommendation 7. The Welsh Government should provide further assurances about how it will ensure that all health boards in Wales achieve financial sustainability and balance within the 2022-23 to 2024-25 integrated medium term planning cycle

Response: Accept

We have provided NHS organisations with a significant uplift in core funding in 2022-23, equating to 2.8% of core hospital and community budgets. This is in addition to the £170m funding we have confirmed for recovery, £20m for value-based healthcare, and the funding for 2022-23 pay awards which will be issued once these have been confirmed.

The NHS Finance (Wales) Act 2014 established a statutory duty for Health Boards and Trusts to provide an Integrated Medium Term Plan (IMTP). Plans must balance over a rolling three year period in order for them to be recommended for approval by the Minister for Health and Social services. The statutory process was paused in

March 2020 due to the pandemic. The NHS Wales Planning Framework was issued in October 2021, requiring NHS organisations to submit IMTPs on 31st March. This will require NHS organisations to set out their financial plans for the period 2022 to 2025 and effectively reset the planning cycle. Plans will be subject to robust scrutiny by officials and the Finance Delivery Unit (FDU) before recommendations on approval are made to the Minister. The FDU works closely with organisations to test financial assumptions and to understand areas that need to be strengthened. The establishment of the NHS Executive functions will enable and enhance the scrutiny and improvement of financial planning.

Recommendation 8. The Welsh Government should set out how it will work with health boards to reduce their fixed operational costs, including any plans it has to set targets or expectations for fixed cost reduction.

Response: Accept

All NHS organisations are expected to deliver efficiency savings in 2022-23 as a minimum at the level they are achieving in the current financial year. Organisations have access to a significant resource of benchmarking and cost data managed by the Finance Delivery Unit to enable them to compare the efficiency of their services with peer organisations.

Through the NHS Wales Decarbonisation Strategic Delivery Plan, some all-Wales actions are being undertaken to reduce carbon usage and assist with fixed cost reduction. For example, good progress has been made to date across the NHS Estate with the installation of LED lighting. The target as set out in the Strategic Delivery Plan is to fully replace all existing lighting with LED lighting by 2025. Going forward the progress on LED lighting and reporting on other initiatives are being considered for inclusion as part of the annual Estates and Facilities Management System (EFPMS) data collection process operated by NHS Shared Services Partnership – Specialist Estate Services (NWSSP-SES). Decarbonisation strategies will also need to target improvements to building management systems. The Decarbonisation Strategic Delivery Plan sets out that all buildings will have up-to-date, standardised, and effective building management systems (BMS), to optimise the use of energy on sites.

Recommendation 9. The Welsh Government should provide clarity about how the impact of value-based health care, and the focus on service transformation and redesign in the recovery plan, will be assessed to ensure that they are driving new ways of working and new models of service delivery, and

achieving better outcomes and experiences for people who are using health care services.

Response: Accept

We have allocated £20m recurrent funding to support the implementation of value-based healthcare, of which £15m has been allocated to local health boards. The remaining £5m will be deployed during 2022-23 to support the development of value based healthcare action by NHS Trusts and Special Health Authorities, further implementation in Health Boards dependent on the maturity of value based healthcare plans, and the overall system requirements to support value across NHS Wales.

We expect organisations to use this funding to support:

- Making progress with implementing evidenced high value interventions that align to local population need and priorities
- Making significant progress in measuring cost and outcome data to inform future value based health care decision making for priority condition areas
- Ensuring a delivery programme of Patient Reported Outcome Measures (PROM) collection and a mandate to sharing PROM data nationally to inform value based decision making and direct clinical care
- Identifying opportunities to reduce unwarranted variation and activity of limited value, and prioritise standardisation of best practice pathways which support delivering improved outcomes
- Ensuring that changes being implemented are monitored in terms of the improvement in outcomes being delivered and change in how resources are utilised to deliver value.

Organisations are expected to deploy this funding on either the direct implementation of high value interventions in priority clinical areas, or organisational infrastructure to support value based healthcare in line with the requirements above.

In developing plans, organisations are expected to maximise the support of the national infrastructure, which includes the Value in Health Centre, hosted by Cwm Taf Morgannwg University Health Board, the Finance Delivery Unit, as well as the expanding knowledge, evidence base, and products that will support delivery of value based healthcare.

Mechanisms will be put in place by the Value in Health centre, the Finance Delivery Unit, and through regular organisational performance management arrangements to monitor organisations implementation of value-based healthcare approaches in order to measure its impact and support further spread and scale across NHS Wales.

Recommendation 10. The Welsh Government should:

- **Confirm as a matter of urgency whether the COVID-19 statutory sick pay enhancement scheme will be extended beyond March 2022, and whether there is funding available in the 2022-23 draft budget for this purpose.**

- **Consider consolidating the principles of the scheme into the terms and conditions of the social care workforce i.e. an ongoing eligibility for enhanced sick pay for social care workers who are self-isolating or taking sick leave as a result of COVID-19, and who would otherwise receive only Statutory Sick Pay or no income at all.**

Response: Accept in Principle

We have approved the continuation of the Statutory Sick Pay Enhancement Scheme until the end of June 2022. Officials are submitting proposals for the identified £0.5m of the estimated cost of doing so. In the first instance this will be sought from within the MEG by the use of any underspends which may be forthcoming. A transfer from reserves may be needed as part of the in-year supplementary budget process.

The Social Care Fair Work Forum is working in Social Partnership. Members of the Forum come together to determine the priorities and timeframe for progressing the forums work. The Forum is to considering a range of fair work issues and recommendations for the social care sector about improved terms and conditions, which are likely to include sick pay.

Recommendation 11. The Welsh Government should set out the timescales within which it expects the Social Care Fair Work Forum to make urgent recommendations for improving the terms and conditions for social care workers in Wales. This should include recommendations on career progression and broadening eligibility for sick pay for reasons unrelated to COVID-19. It should also confirm whether provision has been included within the draft budget to fund the costs associated with any proposals (including implementation costs).

Response: Accept in principle

The Social Care Fair Work Forum was convened by the Deputy Minister for Health and Social Services in late 2020 and is a Social Partnership Forum Chaired by Professor Rachel Ashworth of Cardiff University. Members of the Forum come together to determine the timetable for progressing its work. The Forum set out its early priorities in a position statement last year. This is published online: Position statement: Social Care Fair Work Forum | GOV.WALES

In the latter part of 2021, the Forum focussed its activity on the provision of advice for Ministers on implementation of the Real Living Wage commitment. It is now returning to the wider priorities set out in the position statement. As part of this work it will be considering what its recommendations to the sector will be and what the expectation is in terms of timescales for progressing that work. Any costs associated

with implementation of the Forum's work, including where these would fall, will need to be considered alongside the development of those recommendations. We will work closely with and as a member of the Forum regarding any potential calls on the SSID budget to support the development work. £60,000 has been allocated to the evaluation of the Real Living Wage commitment for 2022-23 and this will also provide valuable information to support the Forum's future work.

Recommendation 12. The Welsh Government should provide assurance that the funding available for respite care for unpaid carers in Wales is sufficient, including details of any specific financial assessments that have been conducted on the cost of delivering sufficient respite and breaks to the increasing number of unpaid carers in Wales.

Response: Accept in principle

Welsh Government reacted swiftly to the calls for more support at a local level by providing local authorities across Wales with additional total funding of £3m in 2021-22. Each local authority is using their allocation to support more opportunities for carers to access different forms of breaks, as well as more traditional forms such as an overnight sitting service. Indicative funding of £3million is mentioned in Welsh Government draft budget 2022-23 to take forward our Programme for Government commitment to establish a national short breaks scheme for unpaid carers. However this is not the only funding stream that supports respite care.

Local authorities receive substantial financial support from the Welsh Government through the Local Government Revenue Support Grant (RSG). From 2022-23, the RSG will receive an annual uplift of £180million to support the living wage for social care workers and increased demand due to the pandemic. This is provided as hypothecated funding which offers considerable flexibility for authorities to prioritise their services in line with the needs of their communities, including unpaid carers.

In addition, Regional Partnership Boards will be expected to invest a minimum of 5% of the overall Regional Integration Fund investment into direct support for unpaid carers from 2022/23, focusing on integrated delivery of services to meet the health and well-being needs of unpaid carers.

With ever changing numbers of carers and levels of need in our local communities, carrying out a financial assessment of demand for respite and short breaks would be costly, time consuming and could very quickly become out of date. Allowing local authorities and health boards to use the systems they have in place, such as population needs assessments, to monitor and respond to the needs of their local populations provides a more flexible and cost effective way to measure demand for respite care and short break opportunities.

Unpaid carers will want and need different forms of a break to meet their needs, and level of demand will have changed as pandemic restrictions have eased or been reintroduced. There is no one size fits all. Nevertheless, we will continue to work with Ministerial Advisory Forum on Unpaid Carers to deliver a new vision for respite and short breaks in Wales.

Recommendation 13. The Welsh Government should provide further detail on its strategic priorities for prevention and tackling health inequalities, and how allocations in the draft budget for 2022-23 have been targeted and will be monitored to ensure that spending by health boards and other public bodies delivers the required outcomes.

Response: Accept

The causes of health inequalities are extensive, as too are the interventions which are required to tackle them. For this reason, as noted in our initial evidence paper to the Committee and as debated in the Senedd earlier this year, the Welsh Government has worked to hard-wire action to tackle health inequalities across the breadth of the government's work programmes. This is achieved through the Welsh Government's health in all policies approach (supported by health impact assessments), and through the legislative and strategic context created by the well-being goals of the Well-being of Future Generations (Wales) Act 2015.

In the long term, the national indicators (including indicators on healthy life expectancy at birth including the gap between the most and least deprived, adults with two or more healthy lifestyle behaviours, children with two or more healthy lifestyle behaviours, and the mean mental well-being score), will help us understand how successful our polices have been.

In 2021, the Welsh Government laid a number of national milestones before the Senedd to track our progress against the national indicators. This included a national milestone concerning children with two or more healthy behaviours. Work is currently underway to develop national milestones in respect of the other national indicators referenced earlier which will assist in monitoring our progress in tackling health inequalities in Wales.

Within this context, the Welsh Government's revised Programme for Government provides the overarching strategic aim to move to tackle inequality in all its forms and contains significant commitments across all areas of government activity which are designed to tackle health inequalities. In light of the integrated approach we have taken, action on health inequality is a strategic priority across all aspects of

government activity. Within our portfolios, A Healthier Wales confirms the crucial importance of prevention activity and its contribution to tackling health inequalities.

A number of the leading risk factors associated with years of life lived with a disability and years of life lost are attributed to unhealthy lifestyle behaviours such as lack of physical activity, poor diet and smoking. These factors are amenable to change through public health prevention work but we also know that these factors exist on a social gradient, with those in the most deprived areas more likely to be obese or to smoke than those in the least deprived. Consequently, tackling health inequalities through prevention activity in weight management and smoking cessation are strategic priorities for delivery. For this reason, tackling health inequalities is at the core of our proposals to tackle obesity and to help people to stop smoking.

We will provide further detail on our strategic priorities in relation to tackling obesity within the forthcoming Healthy Weight: Healthy Wales Delivery Plan 2022-24 which will be published in March. Furthermore, the consultation on our draft Long Term Tobacco Control Strategy for Wales and its associated Delivery Plan for 2022-24 began in November 2021 and will close on 31 March 2022. Following consideration of consultation responses, we will publish our Tobacco Control Strategy and its action plan later this year.

In the bullet points below, we highlight specific examples of how allocations in the draft budget for 2022-23 deliver against these priorities:

- As discussed briefly at the committee session on 13 January, the Welsh Government has moved to reprioritise the £7.2m annual Prevention and Early Years funding from April 2022. This funding will be used by Directors of Public Health across all health boards and over the next financial year it will be repurposed to support interventions in the obesity and tobacco policy areas to support projects that will directly contribute to the following aims:
    - In conjunction with Public Health Wales, support the rollout of Help me quit in Hospital (the secondary care smoking cessation model) in all local health boards, broadly based on the 'Ottawa' model;
    - To support a reduction in the number of people smoking in pregnancy and support cessation; and
    - To support prevention work in the obesity and overweight space, in line with the Healthy Weight: Healthy Wales strategy and meeting existing population health measures.
  To monitor progress, the Welsh Government has already outlined expectations around certain population health measures as part of the NHS Delivery Framework, which focus on measures around tobacco and obesity.

- Through our Healthy Weight: Healthy Wales strategy we are prioritising how we will enable and help to support positive change. The delivery plan for 2022-24 is being supported by a budget allocation of £13m (£6.63m per annum) and offers direct support to a number of preventative actions that also aim to reduce health inequalities. The funding allocation is set out below:
    - £2.9m Investment per year into the delivery of services with Local Health Boards through our All Wales Weight Management Pathway.

- • £1.2m Investment into systems based approaches, to help support and drive local action and delivery will include working with local communities to co-design and enable local decision making.
- • £0.6m Investment into a Children and Families Pilot taking place in three areas Cardiff, Merthyr Tydfil and Anglesey. A core part of this approach is the implementation of a secondary prevention Home Based Intervention for families of children in the early years from 3 – 7 years of age in line with the foundation phase.
- • £0.6m Investment through Sport Wales to continue delivering an over 60s leisure offer and to invest funding to work with National Governing Bodies to increase opportunities for children and families.
- • £1m investment into the delivery of an All Wales Diabetes Prevention Programme, which is being trialled across all Local Health Boards across Wales.
- • £0.33m to support the development of evaluation, communications and further research. This provides us with the tools to understand whether what is being delivered is appropriate for the population of Wales and whether there is a need to expand or reprioritise areas to meet the needs of the population.

- • The £5.9m Healthy and Active Fund (HAF) available over 4 years (2019-2023) is funding 16 projects aiming to improve mental and physical health by enabling healthy and active lifestyles. Projects funded by the HAF seek to reduce inequalities in outcomes for one or more of the following groups: children and young people; people with disability or long-term illness; people who are economically inactive or who live in areas of deprivation; and older people and those around the age of retirement from work.

In addition to the programmes of work set out above, our Programme for Government also commits the Welsh Government to develop an all-Wales framework to roll out social prescribing. The framework will contribute to facilitating access to prevention services across Wales and work to tackle health inequalities. The framework is currently in development and will be the subject of public consultation in the Spring.

Recommendation 14. The Welsh Government should provide further detail on how specific allocations within the draft budget will contribute to a shift in resources towards primary and community care, and how progress on that shift will be monitored throughout the financial year.

Response: Accept

A Healthier Wales sets a clear vision on health and care services designed to support people to do what matters to them, accessible at or as close to home as possible. No one should access care in a district general hospital unless this is the right place for that individual's needs. To achieve this vision, the whole health and

care system is required to re-balance the focus of leadership and allocation of funding, workforce and other resources away from hospitals and illness towards health and wellbeing in our communities.

As Wales moves from pandemic to endemic, there is a unique opportunity to increase the pace and scale of this system re-balance and end the traditional medical model where hospital-based care attracts the lion's share of resources and attention.

The recent King's Fund paper *'Covid-19 recovery and resilience: what can health and care learn from other disasters?'* states that a successful and sustainable recovery is possible if there is investment in the resilience of communities and community-led approaches.

The Welsh Government has been clear on how it expects this challenge to be picked up at local level through the 2022-25 NHS Planning Framework and Ministerial measures. These Ministerial measures include a category for Care Closer to Home which as the measures evolve together with the Single Outcome Framework being developed will track the improved outcomes for the health and wellbeing of the population of Wales.

Examples of specific allocations in the 2022-23 Budget which support the progressive re-balancing of the health and care system include:

- £170m to recover and reset planned care system across primary, community and secondary care,

- £144.7m five year Regional Integration Fund will launch on 1st April 2022. This fund will drive change and transformation across the health and social care system through the development of at least six new national models of integrated care, two of which are directly centred around community based care: Community based care – prevention and community coordination and Community based care – complex care closer to home

- £60m Digital Policy and the Digital Priorities Investment Fund:

Funded through the Digital Priorities Investment Fund, a number of initiatives are enabling the shift of care away from hospitals.

- Technology Enabled Care Cymru (TEC Cymru), is focussed on the scale and spread of telehealth and telecare (including video consultation) across Wales, across health boards and social care organisations.
- The Welsh Community Care Information System (WCCIS) enables the sharing of care records between health boards and local authorities to provide a richer understanding of the patient/service user through additional data being available to the clinicians or service provider
- The deployment of population health actuarial analysis across Wales will allow more targeted interventions in people's care – helping to understand

how earlier interventions could improve health outcomes, being targeted to patients who would benefit most.

In addition, further investment has been made in primary care contracted services this year to increase prevention:

- *The General Medical Services (GMS) Contract* saw £2m funding made available in year to support additional capacity through the winter period. From April 2022 this will increase to £4m and supports the aim to deliver more care from within the community through an increase in resources.
- The current 3 year agreement *Community Pharmacy Contract Framework* provides an additional £18.3m funding for pharmacies by March 2023, with a clear focus on the provision of a clinical service and move away from a solely dispensing nature of operation.
- In March 2021, the Welsh Government published the *Future Approach for Optometry Services* in Wales. A key priority is the move of the delivery of services from hospitals to primary care to address hospital backlog in patient appointments and delay in follow-up, and to release specialist consultant and GP resource.

Recommendation 15. The Welsh Government should outline its priorities for the £50m additional allocation for mental health, and provide details of how funding will be allocated to health boards and how spending and outcomes will be monitored and reported

Response: Accept

We are working through the detail of the funding allocations but to confirm it will be supporting front line mental health services, alongside areas such as implementation of the Liberty Protection Safeguards, prevention in public health, substance misuse and supporting people to stay in employment where they have mental health / substance misuse issues. The £50m allocated will also make a contribution to support our Programme for Government commitment to prioritise service redesign to improve prevention, tackle stigma and promote an approach to mental health support that ensures people will be directed to the right advice and support at the right time.

Funding directed to mental health services will support both the recovery of services and the priorities laid out in the Together for Mental Health Delivery Plan 2019-2022. However we recognise that Covid19 has had a significant impact on the ability of health boards to recruit to posts that were identified and approved within 2021/22. Whilst we are consulting on our longer term plan for a sustainable mental health workforce, we do need to recognise the challenge for health boards in filling existing vacancies and expanding priority services where recruitment is difficult. Therefore prior to us releasing funds to health boards for 2022/23 we are undertaking an exercise across all health boards to identify any legacy posts / grades that they have not yet recruited to. By working with health boards we will also be able to consider

what further action can be taken nationally to bolster provision in these key areas, whilst allowing time for health boards to recruit to previously approved posts. Following this work we will be in a position to confirm allocations of the additional funding.

Recommendation 16. The Welsh Government should clarify when it plans to publish its "proposals" for women's health. When the proposals are brought forward, the Welsh Government should ensure that they include: □

- **Details about how the proposals reflect women's multi-layered and intersectional identities and characteristics, and how services, interventions and funding will be targeted to take existing health inequalities into account.**

- **Clear and measurable objectives, and details of how progress will be assessed and reported.**

- **Confirmation of the resources available to deliver against the proposals.**

- **Details of the Welsh Government's plans to engage and communicate with women and girls about the proposals.**

Response: Accept

Welsh Government's proposals to support women's health are still at an early stage of development. Initial work has been undertaken with a coalition of women's groups and service users to produce a women's health Quality Statement. The first draft of this document has been received and is being considered by policy officials. The intention is to publish the Quality Statement by May 2022.

Officials attend meetings of the UK Government-led Menopause Task Force and will contribute to actions being driven by that group, which will result in shared best practice to support women experiencing menopause in Wales. The intention is that this will include a new menopause pathway.

Officials have just commenced the development of a women's health plan. The aim of this plan is to help improve health services and outcomes for women and girls in Wales. This plan builds on and complements the concepts for person-centred care set out in *A Healthier Wales* and needs to be seen in that context. As the plan is developed, officials anticipate there will be regular engagement with both clinicians and women's groups to ensure it meets the needs of women and girls. Officials intend to publish the plan in the autumn of 2022.

Recommendation 17. The Welsh Government should provide further information on how it plans to earmark financial support for dementia diagnosis and care.

Response: Accept

In 2021/22 we have allocated an additional £3m for memory assessment services to Regional Partnership Boards to provide additional support for people during the assessment process and following diagnosis. This is in addition to the £9m allocated at the time of the publication of the Dementia Action Plan to develop a joint health and social care approach to dementia support, representing a significant increase in funding directly to support the implementation of the Dementia Action Plan. This is in addition to other funding available for instance through the Regional Investment Fund commencing in 2022/23. We have not allocated any further funding in 2022/23 to directly support the Dementia Action Plan implementation as we are using it as a period to consolidate the use of the additional funding that has been made available from this year. We will be reviewing this in the autumn, with the intention to allocate further funding in this key priority area from 2023/24.

Recommendation 18. The Welsh Government should provide assurances that the draft budget will address both the immediate crisis facing social care in Wales and the longer term challenges. This should include identifying and explaining:

- **Actions that will be taken in the immediate term to address the workforce and other pressures faced by social care providers, and details of any contingency plans that are in place to ensure that people continue to receive the care and support that they need should the pressures faced by the sector worsen.**

Response: Accept

In December, we announced £43m funding to support salary uplifts for social care workers to the Living Wage Foundation's Real Living Wage. The roll-out of this commitment will commence from April 2022 and is for registered workers in care homes and domiciliary care, in both adults and children's services, and for Personal Assistants funded through a Direct Payment. The commitment is a long term commitment which introduces a new baseline for the sector. It is linked to our programme of work aimed at professionalising the sector, improving terms and conditions and making it a more attractive place to work.

On 10 February we announced an additional payment for social care workers aligned with the Real Living Wage. This payment of £1498 will be made to those social care workers who will receive the Real Living Wage plus managers within care homes and domiciliary care. It is estimated the scheme will cost circa £100m. £96m has been budgeted from the HSS MEG for 2021-22 and a further £4.3m has been approved from 2022-23 funding. This additional funding will allow the additional payment to be made to eligible social care workers who have started in the sector from 1 April 2022. We are working with stakeholders currently, but payments are likely to go out in June 2022. The purpose of this scheme is to further underline our commitment to social care workers. This additional payment, coupled with the real living wage, will help us tackle some of the challenges providers are experiencing recruiting and retaining people with the skills needed to undertake these crucial

roles.

We have funded an extensive recruitment campaign from August 2021 that will continue to the end of the financial year. This comprises extensive TV advertising, radio advertising, social media and 'out of home' advertising. This comprises extensive advertising on TV, radio, cinema, along with digital (*YouTube, Facebook, Google) and on buses, trains and at supermarkets.* This has resulted in a 176.5% increase in traffic to the WeCare.Wales national jobs portal, compared to the same period 12 months previously.

Recommendation 19. Actions that will be taken within the duration of this multiyear budget to stabilise the sector, prepare for reforms, and achieve a fair and sustainable balance between funding for health and social care.

Response: Accept

The budget provides a major step up in resources for local authorities; with an additional £180m provided within the Local Government settlement to implement the Real Living Wage for social care workers, and to support the sector's pressures. These allocations reflect our clear choice to invest in the social care workforce, to support those who work so hard on our behalf, to stabilise our care provision, and to better support those with care needs.

In addition, the Health and Social Services MEG will see the creation of a £50m Capital Fund from 2022-23. This will rise to £60m in 2023-24, and £70m in 2024-25. This new Capital Fund will support the development of integrated health and social care hubs across Wales, and the rebalancing of social care through investing in our social care estate. This new funding is in addition to the baseline funding for social care, enabling continued support to activity across the social care sector. This social care allocation will enable the Welsh Government to directly influence the transformation of social care infrastructure in line with aspirations of the Social Services and Well-being (Wales) Act, and 'A Healthier Wales', and is evidence of achieving a fairer and more sustainable balance of funding.

Within the Health and Social Services MEG, from 2022-23 a new £45m Social Care Reform Fund has been created, rising to £55m in 2023-34, and £60m in 2024-25. This Reform Fund will be used to support the reform and delivery of sustainable services across the social care sector, and to deliver the Programme for Government commitments to reform social care and to protect, re-build and develop our services for vulnerable people.

The £144.7m Regional Integration Fund is a combination of several previously separate funding streams. It has taken the learning from both the Integrated Care Fund and the Transformation Fund, building on key successes and making changes where improvement was needed. The key differences for the new Regional Integration Fund include the focus on developing and embedding six national models

of care, a new requirement for match funding to support the mainstreaming of services, dedicated support for Regional Partnership Board infrastructure costs, the development of an outcomes measurement framework from the outset, and a clear exit strategy for the end of the programme. The Regional Integration Fund will be subject to clear and robust monitoring and scrutiny arrangements which are being established to support effective delivery.

Regional Partnership Boards will develop investment plans for the new Capital Fund, alongside their plans for the Regional Integration Fund. This will maximise impact, ensure capital and revenue investment is aligned, and that integrated models of care and delivery can be developed and operationalised.

We need a strong social care sector to overcome both the immediate crisis facing social care in Wales and the longer term challenges, and this Budget is a major step towards a stronger future. "Stronger" and "more sustainable" does not, however, mean staying this same. Our plans for a National Care Service underpin our ambitions for the future of the social care landscape in Wales.

Recommendation 19. The Welsh Government should provide an update on any progress or developments regarding paying for care in Wales, and any assessments of the associated financing implications.

Response: Accept

We have prioritised investment in the social care workforce, rather than reform to the charging regime at this point, because the huge challenges in social care right now are part of the wider labour market crisis which a number of sectors are facing. The immediate priority must be to act to address this.

The UK Government has chosen a different path, favouring charging regime reform in the short-term but our immediate choice to stabilise the sector by supporting the workforce is the right choice for Wales.

However, we have a long term ambition, shared with Plaid Cymru, to create a National Care Service which is free at the point of need and continuing as a public service. An Expert Group is being established to work rapidly to propose practical next steps towards this.

Clearly, providing care free at the point of need will not be without cost; nor can an ambitious agenda such as this be implemented immediately. Our current view is that realising our ambition for "care free at the point of need" will not be fully delivered within this budget period, given the potential complexity of implementation or potential requirements for legislative change. It will be important to look at the practical next steps the Expert Group proposes, including their timescales for delivery and costs, in order to define the associated longer-term budgetary implications.

Recommendation 20. The Welsh Government should explain how the replacement of the integrated care fund and the transformation fund with the health and social care regional integration fund will provide the drive for the rollout of innovation and transformation across health and social care. This should include clarity about how the Welsh Government will ensure that its priorities are reflected in the plans developed by regional partnership boards, how good practice will be rolled out and mainstreamed, and how such plans will be transparently scrutinised and monitored by the Welsh Government.

Response: Accept

The Regional Integration Fund is a key lever to drive change and transformation across the health and social care system. Our aim is that by the end of the five year programme we will have established and mainstreamed at least six new national models of integrated care so that citizens of Wales, where ever they live, can be assured of an effective and seamless service experience in relation to;

- Community based care – prevention and community coordination
- Community based care – complex care closer to home
- Promoting good emotional health and well-being
- Supporting families to stay together safely, and therapeutic support for care experienced children
- Home from hospital services
- Accommodation based solutions

These six national models of integrated care have been identified and prioritised for investment based on experiences and learning from the ICF and TF and through extensive engagement and co-design work with Regional Partnership Boards and key partners. Therefore, all activity funded by the RIF must directly support development and delivery of the six national models of integrated care. RPBs will be required to submit their proposed programmes of work via investment plans, they will have the flexibility to determine which projects and services align to which model of care but essentially all RPBs will need to ensure plans meet Welsh Government priorities by;

- investing in the development and embedding of the six priority models of care.
- demonstrating they are meeting the needs of all the priority population groups within each of the models of care (noting some priority groups will be more relevant than others for each model of care).
- maximising the use of key enablers to ensure their models of care are innovative, integrated and transformative, these include; integrated planning and commissioning, technology and digital solutions, promoting the social value sector, integrated community hubs and workforce development and integration.
- seizing every opportunity to increase the 'active offer' of integrated services through the medium of Welsh across all population groups.

While the RIF will provide opportunity to support the further creation of new models of care, it will also enable the RPBs to mainstream and embed effective models of

delivery tried and tested under the ICF/TF and will also support the strategic alignment and integration of existing services.

The fund architecture for the RIF has been co-designed with Regional Partnership Boards to further encourage the testing, embedding and mainstreaming of national integrated models of care. Alongside long-term funding, matched resources and tapered support is a key feature of the new RIF. Its purpose is to ensure national models of care are embedded and mainstreamed into core service delivery by attracting support from the core budgets of statutory organisations, which themselves have received budgetary uplift through the Welsh Government's recent budget announcement for the next three years.

Learning from the ICF and TF, the RIF required a clear outcomes framework that clearly identifies key outcomes and measures. This framework will enable us to clearly see the changes that are taking place across the system as a result of the RIF investment. We will continue to work with RPBs and delivery partners to shape our outcomes framework, which will have continual review through our Communities of Practice. As a minimum, six Communities of Practice, one for each model of care, will be established to share learning and actively support the development and embedding of these integrated models of care.

A status report will be used to collate a set of agreed data each quarter maintaining the integrity of the reporting and support a successful audit and evaluation process. Welsh Government will meet with RPBs on a quarterly basis to undertake progress meetings, covering finances, key activities, progress and risks. In addition to the reporting requirements, periodic audits will be carried out over the lifetime of the RIF. The aim of the audits is to support the effective mainstreaming of these six models of care and to assess the perceived and/or potential impact of the RIF in long term prevention, integration, collaboration and involvement to help public bodies undertake better planning for the well-being of our population and future generations.

Recommendation 21. The Welsh Government should set out the next steps and associated timescales for the development of the role and operation of regional partnership boards, including how their governance and accountability arrangements will be strengthened and how the Welsh Government will ensure that all regional partnership boards are operating at the level of the most successful ones.

Response: Accept

Wales has been firmly on the journey towards integration since launch of the Social Services and Wellbeing (Wales) Act in 2014 including;

- Regional planning and delivery through seven regional partnership boards (RPBs)
- Regional Population Needs Assessments and Area Plans to ensure planning is joined up and based on clear evidence of need

- Investment in Integrated models of care through the Integrated Care Fund and Transformation Fund (now to be replaced by the Regional Integration Fund).
- The promotion and establishment of pooled funds in relation to commissioning older peoples care homes placements
- The development of WCCIS as a national cross sector digital information tool

The 2021 Rebalancing Care and Support White paper proposed resolving some of the governance and accountability challenges faced by RPBs through making them corporate legal entities. However statutory partners were clear that this was not a necessary or desirable step and so there was agreement to work within existing legislation and structures to strengthen the role of RPBs.

Therefore the rebalancing care and support programme has been established to further strengthen regional partnership boards by clarifying and strengthening five key areas;

- governance and scrutiny,
- planning and performance,
- citizen engagement and voice,
- integrated delivery of services
- rebalancing the market.

Five stakeholder groups are being established to oversee the progress in relation to each of these key areas and it is intended that they will review and strengthen current arrangements culminating in amended Part 9 guidance in mind 2023. Much work is already underway in taking this strengthening work forward.

During this time Welsh Government Officials will continue to work very closely with Regional Partnership Boards to provide ongoing support and challenge on implementation of the Part 9 guidance. Officials meet with RPB leads at least once a month to support sharing of learning across Regions and Ministers will meet with RPB Charis and leads on a quarterly basis to monitor progress and to support the sharing of best practice across Wales.

An Integrated outcomes framework for health and social care is in development to help us measure the impacts of integrated services delivery.

Recommendation 22. The Welsh Government should provide a breakdown of the current and anticipated energy costs for health boards in Wales, and what, in practice, it will mean for health boards and the services they deliver if energy costs and the demand for heating and cooling continue to rise significantly. It should also provide details of any guidance provided to health and social care bodies in respect of energy costs or planning for energy needs.

Response: Accept

NHS Wales has co-ordinated its purchasing of energy since 2015 through an Energy Price Risk Management Group (EPRMG). The Group has both Estates staff with Energy Management responsibilities and finance staff – with representatives from all LHBs and Trusts in NHS Wales. It is also supported by British Gas. During regular meetings, the EPRMG receives a Market Overview session provided by an expert from British Gas who has detailed knowledge of the market conditions and the issues that are influencing prices, both up and down. This briefing is received before the group considers its pricing strategy.

In normal market conditions, the NHS spends approximately £13.5m on natural gas, and £26m on electricity per annum. Given the unprecedented position of the Energy Market over the last 6 months, the EPRMG has been meeting monthly with a full agenda to determine the purchasing of Energy approach for the period ahead. NHS Wales has benefitted substantially from the strategy that had been put in place by the EPRMG. This strategy has protected NHS Wales to a degree from the massive increase in market prices for 2021/22. Given the unprecedented price increase, the group has been reluctant to purchase for many months ahead in order to avoid 'locking in' high prices if the market prices improved, and took the position of monitoring the position on a month by month basis. Given the ongoing volatility in the market, the approach has been to only purchase at these high prices for the month ahead, when there is little or no option to avoid the cost for NHS Wales.

For 2022-23, advanced electricity purchases at low price levels were made previously which will continue the protection for NHS Wales to September 2022. Thereafter, a new contract or an extension will have to be established. If the market price levels remain at a high level, then this may put pressure on NHS budgets later in 2022-23.

For Gas, a new contract was established for April 2022 onwards, and no purchases had been made against this new contract since the market had started increasing when purchases could be considered. The approach considered at recent meetings is to continue the monthly EPRMG meetings and consider the purchases to be made on largely a month by month basis.

There is no reliable advice as to whether the current market conditions and prices levels will continue at current levels for a prolonged period of the year ahead. Cost forecasts have been produced to inform 2022-23 budget setting, based on current market pricing. Current prices are around four times normal levels, and so this could place an added financial risk to NHS Wales if prices at these levels continue during 2022-23. Welsh Government will continue to monitor the impact of this risk on NHS finances during next financial year.

In terms of monitoring NHS Wales energy usage, data is collected annually by NHS Shared Services Partnership-Specialist Estate Services (NWSSP-SES) from all health boards, Velindre University NHS Trust and the Welsh Ambulance Services NHS Trust as part of the Estates Facilities Performance Management System (EFPMS). The data relates to the previous year. A dashboard report is produced and the supplementary data for all organisations is shared for benchmarking purposes.

There are limited changes from year to year unless different energy solutions are introduced recognising that energy costs are currently rising significantly.

The NHS Wales Decarbonisation Strategic Delivery Plan was launched in March 2021. The Strategic Delivery Plan includes 46 initiatives that will help NHS Wales to decarbonise and contribute to the ambition for the public sector to be net zero by 2030. The Plan includes targets for both new and existing buildings.

The initiatives in the plan include low carbon heating, building management systems and increased renewable energy use. A renewable energy example is the Swansea Bay Solar Farm which has been shared by NWSSP-SES, as an example of what could be achieved, with all organisations.

Swansea Bay University Health Board secured land by way of a 26-year lease agreement to develop a 4-megawatt solar farm at Brynwhilach Farm, near Llangyfelach in Swansea. The solar farm comprises 10,000 panels on 14 hectares of land which will provide power to Morriston Hospital via a 3km private wire connection meaning Morriston Hospital will become the first hospital in Wales, and it is believed the UK, to develop its own full-scale solar farm. The solar farm will supply almost a quarter of Morriston Hospital's power, cutting the electricity bill by around £500,000 a year and significantly reducing carbon emissions. At peak production times it could meet the electricity demand for the entire hospital

Recommendation 23. The Welsh Government should explain how the impact of rising energy costs and increased demands for heating and cooling have been taken into account when setting health and social care allocations in the 2022-23 draft budget (and the indicative allocations for 2023-24 and 2024-25).

Response: Accept

The draft budget included a revenue increase of £824m in 2022-23 for the NHS, rising to £1.3bn by 2024-25. This represents a significant recurrent investment in the NHS. We have already allocated an additional £180m to NHS organisations for 2022-23, an increase of 2.8% on core hospital and community budgets, to help them manage these and other demand and cost pressures. NHS organisations are due to submit their integrated medium term plans for 2022-23 to 2024-25 by the end of March, and we will use these plans to assess any risk to managing energy and other pressures with the funding we have made available.

Agenda Item 8

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Agenda Item 9

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Agenda Item 10

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