Agenda – Health, Social Care and Sport Committee

Meeting Venue:
Committee Room 3 – Senedd
Meeting date: Thursday, 15 June 2017
Member's pre-meeting: 09.15
Meeting time: 09.30

For further information contact:
Sian Thomas
Committee Clerk
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Informal pre-meeting (09.15 – 09.30)

1 Introductions, apologies, substitutions and declarations of interest

2 Inquiry into loneliness and isolation – evidence session 5 – Royal College of Psychiatrists

(09.30 – 10.15) (Pages 1 – 27)

Dr Victor Aziz, Royal College of Psychiatrists

Break (10.15 – 10.20)

3 Inquiry into loneliness and isolation – evidence session 6 – Welsh NHS Confederation

(10.20 – 11.05) (Pages 28 – 34)

Julie Denley, Interim Director, Mental Health and Learning Disabilities, Hywel Dda University Health Board
Liz Carroll, Head of Nursing, Mental Health and Learning Disabilities, Hywel Dda University Health Board
Cheryl Williams, Cardiff & Vale Local Public Health Team, Cardiff and Vale University Health Board
Tanya Strange, Divisional Nurse, Primary Care & Networks, Aneurin Bevan University Health Board

Break (11.05 - 11.15)

4 Inquiry into loneliness and isolation - evidence session 7 - Welsh Local Government Association (WLGA) and Association of Directors of Social Services (ADSS)

(11.15 - 12.00) (Pages 35 - 40)

Stewart Blythe, WLGA
Dave Street, President, ADSS Cymru

Lunch break (12.00 - 12.45)

5 Inquiry into loneliness and isolation - evidence session 8 - British Red Cross in Wales

(12.45 - 13.15) (Pages 41 - 46)

Chris Hopkins, Wales Director, British Red Cross
Dave Worrall, Programme Manager, British Red Cross
Paul Gerrard, Group Policy Director, The Co-op

Break (13.15 - 13.20)

6 Inquiry into loneliness and isolation - evidence session 9 - Glamorgan Voluntary Services (GVS)

(13.20 - 13.50) (Pages 47 - 50)

Rachel Connor, CEO, GVS
Linda Pritchard, Health and Social Care Facilitator, GVS

Break (13.50 - 13.55)

7 Inquiry into loneliness and isolation - evidence session 10 - Men's Sheds Cymru

(13.55 - 14.25)

Rhodri Walters, Men Sheds Cymru

8 Paper(s) to note

Inquiry into winter preparedness 2016/17 - correspondence from the Royal College of Emergency Medicine

(Page 51)

Inquiry into winter preparedness 2016/17 - correspondence from the Royal College of Physicians

(Pages 52 - 66)

Inquiry into primary care - additional information from Aneurin Bevan Local Health Board regarding Cluster Development Monies

(Pages 67 - 70)

Inquiry into winter preparedness 2016/17 - letter to the Cabinet Secretary for Health, Well-being and Sport

(Pages 71 - 72)

Inquiry into primary care - additional information from Abertawe Bro Morgannwg University Health Board regarding Cluster Development Monies

(Pages 73 - 76)

9 Motion under Standing Order 17.42 to resolve to exclude the public from the remainder of the meeting

10 Inquiry into loneliness and isolation - consideration of evidence

(14.25 - 14.40)

Agenda Item 2

Document is Restricted

Royal College of Psychiatrists
Consultation Response

DATE: **10 March 2017**

RESPONSE OF: **THE ROYAL COLLEGE OF PSYCHIATRISTS in WALES**

RESPONSE TO: **HSCS Committee, Isolation and Loneliness**

The Royal College of Psychiatrists is the professional medical body responsible for supporting psychiatrists throughout their careers, from training through to retirement, and in setting and raising standards of psychiatry in the United Kingdom.

The College aims to improve the outcomes of people with mental illness, and the mental health of individuals, their families and communities. In order to achieve this, the College sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; works with and advocates for patients, carers and their organisations. Nationally and internationally, the College has a vital role in representing the expertise of the psychiatric profession to governments and other agencies.

RCPsych in Wales is an arm of the Central College, representing over 550 Consultant and Trainee Psychiatrists working in Wales.

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Health, Social Care and Sports Committee Inquiry into Loneliness and Isolation

1. The Royal College of Psychiatrists in Wales is pleased to respond to the Committee's inquiry into Isolation and Loneliness. Loneliness can occur at any time in our lives, regardless of how many people are around us. It is an unwelcome feeling of a lack of, or loss of, companionship. Loneliness is more common amongst older people and more common again for the very elderly (age 80+) so the Committee is correct to focus its inquiry on the elderly. However, it should also be noted that loneliness and isolation can affect people at other life stages and situations. Loneliness can be a contributing factor to a range of mental health conditions including depression and can be a risk of suicide.

2. Loneliness and isolation are two very separate things. 'Loneliness' is the overwhelming sense of being on one's own. It is associated with unpleasant emotional distress that arises when we feel estranged from or rejected by others, or a lack of emotional intimacy and interaction with society. This may lead to frustration, unhappiness and sometimes depression. 'Isolation' is the removal or absence of physical and social relationships and contacts. Some people express loneliness even when they are not isolated. This can be because the relationships they have with the people they see do not provide the emotional support that they need. Other people may have only a few contacts but are not lonely.

3. Loneliness is subjective because experiences are very personal and differ from individual to individual. There are different types of loneliness such as emotional loneliness and social loneliness. Emotional loneliness is the absence of a significant other who you are emotionally attached to and social loneliness is the lack of a wider social network of friends.

4. The characteristics and the physical and mental health of the individual tend to influence whether an individual is likely to become lonely or not and their response to it. Expectations and attitudes are crucially important. People who expect to be surrounded by emotionally supportive family and friends and then do not receive this support are likely to report that they are lonely.

The evidence for the scale and causes of the problems of isolation and loneliness including factors such as housing, transport, community facilities, health and wellbeing services

5. A number of research studies conducted at different times suggest 5% to 16% of the older population is lonely. The probable estimate is that about 10% of the general population aged over 65 in the UK is lonely and this figure is even higher in those aged 80+. It is difficult to say if the proportion is increasing but we know that the numbers are as our elderly population continues to grow. It is also important to bear in mind that the percentage of older women living alone exceeds that of men in each age group and women become progressively more likely than men to live alone with age.

6. The number of isolated older people at risk of loneliness is likely to be much larger. 12% of older people say they feel trapped in their homes and 6% report that they leave their homes once a week.

7. There are a variety of causes of loneliness including social isolation, the loss of a loved one, physical disability or poor health, low self-esteem, and depression. It is important that there are many risk factors including:

    - Poorly managed transitions tend to occur in older people and can trigger loneliness;

    - Gay men and lesbians are at greater risk of becoming lonely and isolated as they are more likely to live alone and have less contact with family;

    - Ethnic minority older people have higher rates of loneliness than for the rest of the population;

    - Poor health reduced mobility cognitive and sensory impairment including dual sensory impairment increase the older person's chance of being lonely;

    - Depression could have a negative impact negatively affecting people's perception of the social resources available to them;

    - Geography also has an influence if they are in deprived urban areas or in area in which crime is an issue.

The impact of loneliness and isolation on older people in terms of physical and mental health and wellbeing, including whether they disproportionately affect certain groups such as those with dementia

8. Loneliness is not only caused by poor mental and physical health; the reverse is often true where loneliness can have an adverse effect on a person's psychological and physical state of being. Loneliness has been shown to cause increased risk of heart disease (raised blood pressure), disruptive sleep, which is associated with daytime fatigue making a person more prone to viruses and infections. Lonely people can be less attentive to what other people are saying and this can have a negative impact on relationships and this reduction in social engagement will negatively impact on mood and cognition.

9. Our main concern is the mental health need brought about by loneliness and the difficulty in treating those who are isolated. Loneliness is one of the three main factors leading to depression (including poverty and bereavement). Depression impacts greatly on a person's wellbeing and quality of life. It is common amongst older people and the prevalence of depressive symptoms increase with age (Singh, A). Depression affects

8 – 12% of the general population but this is much higher in the elderly population at 20%.

10. Depression is not an inevitability of old age. Those that 'age well' are often those with religious beliefs, good social relationships, perceived good health, and socioeconomic status.

The impact of loneliness and isolation on the use of public services, particularly health and social care

11. Loneliness and isolation can result in a deterioration of physical and mental health. This is noticeable in the elderly where levels of loneliness are particularly high and where age plays a natural part on a person's physical health. However, isolation and loneliness can affect all ages and the signs and symptoms may not be easily identifiable in younger people as they are often in natural social networks such as schools or in employment. Completed and attempted suicides in middle-aged men have increased significantly in recent years and reported incidence of self-harm in the younger population have also increased significantly. Although these rises are due to a number of factors including loneliness and social isolation, we do know that people are not receiving the help that they need either because they are less likely to seek help or because they are unable to access basic services.

Suicide

12. Suicide can occur at any age. In the UK, the risk is highest amongst men aged 35-55 and then amongst people over 75. Worldwide, the over 75's are the group with the highest suicide rates yet suicide prevention initiatives often overlook this group. Loneliness can be a significant contributing factor. *Talk to Me 2,* the suicide and self-harm strategy for Wales sets out a number of measures to combat loneliness. We would advise considering that *Talk to Me 2* could be strengthened by emphasising the need for local ownership of implementation. In other evidence, Samaritans Cymru recommend loneliness mapping as a strategy to identify men at risk. We feel that this may merit further investigation.

Alcohol

13. The very psychosocial factors linked to loneliness amongst older people (including bereavement, retirement, boredom, isolation, homelessness and depression) are all associated with higher rates of alcohol use. Because of physiological changes associated with ageing, older people are at increased risk of adverse physical effects of substance misuse, even at relatively modest levels of intake. Psychiatric comorbidities of substance misuse are sadly common in older people including intoxication and delirium, withdrawal syndromes, anxiety, depression and cognitive changes/dementia but this problem often is ignored or left unnoticed.

14. The overall figure of elderly people being treated for substance misuse problems is rising, including for addiction to alcohol. Because there are no services available in Wales to deal with the specific needs of this age group, the numbers of people being seen by CDATs may be tip of the iceberg. This is very worrying. We are not aware of the scale of the problem so it is likely that a large group of elderly people's needs are not being met and that their conditions are worsening. We know that how the body reacts to alcohol changes as you get older. Older people who consume too much alcohol are at greater risk than the general population, primarily due to risks associated with old age, such as frailty, cognitive impairment, and co morbidities. The interaction alcohol can have with some prescribed medication is also cause for concern.

Ways of addressing problems of loneliness and isolation in older people including interventions to specifically address the problems and other projects with wider aims. Evidence for what works and the outcomes for older people in terms of health and wellbeing

15. Loneliness is a sign that something needs to change, so it is important that the person plans ahead so that they are active and busy. There are simple steps that an individual can take to combat loneliness, such as getting involved in social activities, discovering a hobby, helping others who are lonely, keeping active – or if this is not possible, stimulate the brain and imagination by reading and writing.

16. There are however fundamental issues that are much more difficult for individuals to overcome. The poor provision of public transport links particularly in rural areas result in people being isolated. Many elderly people stay at home because there are no or very few public toilets. We know that the Public Health Wales Bill once passed will address the issue of public toilets and we believe that the provision of Health Impact Assessments is a good lever to ensure that any decisions being made about transport and regeneration takes into account it's on the health of elderly people. We had called specifically for the reintroduction of this provision in the Bill when it was introduced at the last Assembly.

17. Organisations like Age Connects Wales, Age Cymru and many others, who deliver essential befriending services that so many older people rely on. It is vital that the third sector is fully engaged and supported to provide their expertise and knowledge, particularly as they have become a lifeline to many people.

18. Older people who are socially disconnected and feel lonely rate their physical health lower than that of others so are more likely to visit their GP to make use of their services. One study suggested that loneliness is a predictive use of Accident and Emergency services independent of chronic illness. There is an opportunity for those working in primary care and emergency departments to spot signs of loneliness and be able to provide signposting to relevant services.

19. There are ways of addressing problems of loneliness and isolation in older people. Below are a number of examples.

- Understanding the nature of the person's loneliness and developing a personalised response and supporting them to access appropriate services is key.
- Develop services to support them to maintain existing relationships.
- Develop new connections and change their thinking about their social connections with a menu of such approaches.
- Group based services are generally better.
- Concentrate on existing clear and positive relationships. Having friends is more important than frequency of seeing them.
- Support older people to sustain these relationships and build up a reserve of social support and psychological support resources to compensate when they are unable to do things.
- Identifying people at risk of loneliness can be difficult (not all are socially isolated and there is the social stigma associated with loneliness) but targeting those disproportionately affected by loneliness – lower socio-economic groups, the widowed, the physically isolated, people who have recently stopped driving, those with sensory impairment and the very old – has proven most effective.
- Support older people through difficult transitions such as bereavement.
- Transport and urban planning which will affect the person's ability to participate socially.
- Interventions not specifically targeted at combating isolation and loneliness can still have a tangible positive effect on people who are lonely.
- Intergenerational contact is probably more effective in combating loneliness than contact with one's own age group.
- Interventions to elevate loneliness can be signposting service or providing individual support for the individual such as befriending, mentoring, buddying, way-finders.
- Group interventions such as day centres, social groups, community arts, local history groups, health promotion , walking groups, healthy eating groups and volunteering work, possibly more use of technology.

Professor Keith Lloyd
Chair, RCPsych in Wales

Dr Victor Aziz
Chair, Old Age Faculty, RCPsych in Wales

Cynulliad Iechyd, Gofal Cymdeithasol a Chwaraeon
Health, Social Care and Sport Committee
HSCS(5)-18-17 Papur 2 / Paper 2

Introduction

1. We welcome the opportunity to contribute to the Health, Social Care and Sport Committee Inquiry into loneliness and isolation. The Welsh NHS Confederation represents the seven Health Boards and three NHS Trusts in Wales. The Welsh NHS Confederation supports our members to improve health and well-being by working with them to deliver high standards of care for patients and best value for taxpayers' money. We act as a driving force for positive change through strong representation and our policy, influencing and engagement work.

	The Welsh NHS Confederation response to the Health, Social Care and Sport Committee inquiry into loneliness and isolation.
Contact	Nesta Lloyd – Jones, Policy and Public Affairs Manager, the Welsh NHS Confederation. [redacted] Tel: [redacted]
Date:	9 March 2017

Overview

2. Loneliness and isolation is a significant and growing issue amongst our population. A number of Health Board's population needs assessment have highlighted tackling social isolation and loneliness across their populations, but particularly for older people, as a key priority. Its impacts are devastating and costly, with comparable health impacts to smoking and obesity.

3. Loneliness and isolation appear to increase with age, and among those with long-term health problems. The causes of loneliness are not just physical isolation and lack of companionship, but also sometimes the lack of a useful role in society. There are many different factors that affect loneliness and isolation, including health, mobility, housing, transport and income and the NHS is working collaboratively with a range of statutory and voluntary sector partners to address these factors.

4. The effects of social and emotional loneliness on physical and mental health and well-being are extensive. Evidence suggests that loneliness is associated with increased risk of dying, sleep problems, abnormal stress response, high blood pressure, poor quality of life, frailty, increased risk of heart attack and stroke, depression and increased risk of dementia.

5. Tackling loneliness and isolation is inherently preventative in terms of delaying or avoiding the need for more intensive support. Loneliness is 'amenable' to a number of effective interventions, particularly befriending. Practical, flexible and low-level assistance is often most effective and individually tailored solutions can yield the best results. Effective action to combat loneliness is best delivered in partnership and it is believed that many GP consultations may have loneliness at the root of the problem.[i] However many health and well-being services do not tend to identify those who may be at risk of loneliness and social isolation because they are not asking people if they are lonely. However, as our response will highlight, the NHS across Wales has introduced a number of initiatives and projects to combat loneliness and isolation, including the "Ffrind i mi/ Friend of mine" initiative in Aneurin Bevan University Health Board (UHB).

Terms of Reference

The evidence for the scale and causes of the problems of isolation and loneliness, including factors such as housing, transport, community facilities, health and wellbeing services;

6. It is important to recognise that although loneliness and isolation are two different concepts, they both relate to people's sense of connection with others. As Age UK state "*Isolation refers to separation from social or familial contact, community involvement, or access to services. Loneliness, by contrast, can be understood as an individual's personal, subjective sense of lacking these things to the extent that they are wanted or needed*."[ii] We recognise that it is possible to be isolated without being lonely, and to be lonely without being isolated. The issues of isolation and loneliness can affect people at any age and is a significant and growing issue.

7. Loneliness should be viewed as a risk factor to an individual's health and well-being. There is a wealth of evidence that indicate the scale and causes of the problems associated with social isolation and loneliness. According to Age Cymru, over 75,000 people aged over 65 in Wales (over 12% of the Welsh population who are over 65 years old) say they are often or always lonely[iii] and 46% say the TV or their pet is their main form of company. 12% of older adults feel trapped in their own home, and 9% feel cut off from society.[iv]

8. A Local Government Association report in England, Combating Loneliness,[v] published in January 2013 lists a number of potential risk factors for loneliness, including:
   - Living alone. More than 75% of women and a third of men over the age of 65 live alone in Wales;[vi]
   - Poor health;
   - Being aged 80+;
   - Loss of friends;
   - Having no access to a car/ never using public transport. In Wales, two-thirds of single pensioners have no car, and so reliable local transport is extremely important as people get older;[vii]
   - Living in rented accommodation;
   - Living on low income or on benefits as main income; and
   - Having no access to a telephone.

9. Other risk factors that been identified include;
   - Single/Divorced/Widowed;
   - Living in a care home;
   - Bereavement;
   - Carer;
   - Retired;
   - Ethnicity (1st generation);
   - Gay/Lesbian;
   - Dementia;
   - Sensory impairment/s;
   - Living in high crime/high deprivation areas;
   - Veterans; ex-service personal have reported that they have issues integrating back into civilian life;
   - Living in sheltered accommodation; and
   - Nursing and residential homes where older people feel they have no sense of purpose.

10. With the population ageing, loneliness is going to become more of a problem over time and all public services will need to identify and support people who are lonely and isolated. At the moment health and well-being services do not tend to identify those who may be at risk of loneliness and social isolation because they are not asking people if they are lonely. However, under the Social Services and Well-being (Wales) Act 2014 Health Boards are now under a duty to carry out population needs assessments and publish them and as a result many have recognised that tackling social isolation and loneliness is a key priority.

The impact of loneliness and isolation on older people in terms of physical and mental health and wellbeing, including whether they disproportionately affect certain groups such as those with dementia;

11. According to the Ageing Well in Wales Programme, loneliness and isolation can have serious impacts upon the health and well-being of older people in Wales.[viii] Loneliness and isolation has links to poor mental and physical health and the adverse effects includes;
    - Increased risk of dying, loneliness increases the likelihood of mortality by 26%;[ix]
    - Sleeping problems;
    - Poor quality of life;
    - Frailty;
    - Increased risk of coronary heart disease and stroke;
    - More prone to depression;
    - Increased risk of dementia;
    - Increases the risk of high blood pressure;
    - Higher risk of the onset of disability;
    - Abnormal stress response;
    - Poor sleep;
    - Cognitive decline; and
    - Increased feelings of fear, abandonment, anxiety, inadequacy, desperation, depression, stress, aggression, suicidal thoughts and vulnerability.

12. Age UK[x] reports that loneliness can be as harmful to our health as smoking 15 cigarettes a day, and people with a high degree of loneliness are twice as likely to develop Alzheimer's as people with a low degree of loneliness. The Alzheimer's Society has identified that loneliness and isolation is a problem for lots of older people, but it is particularly difficult if people are also struggling with dementia. In fact, people with dementia tend to be lonelier than the population as a whole and a survey by the Alzheimer's Society in 2013[xi] found 38% of people with dementia felt lonely. One of the reasons dementia could be compounding loneliness is because people don't remember that someone has been to see them. The nature of dementia makes loneliness worse, rather than loneliness causing dementia, although there is evidence[xii] which suggests that the risk of Alzheimer's disease more than doubles in older people experiencing loneliness.

The impact of loneliness and isolation on the use of public services, particularly health and social care;

13. The impact of loneliness and isolation on the use of public services is not fully understood and service providers do not routinely assess this presently. There needs to be a better understanding across public services on the impact of social isolation and loneliness on an individual's health and well-being. We would recommend that there needs to be a recognised measuring tool to identify those who are, or who are at risk, of loneliness and isolation to better understand the impact of loneliness and isolation on public services.

14. Age UK's evidence review in 2010[xiii] found that lonely people have more likely to use public services, particularly social care and health, than other people. Lonely individuals are more likely to:
    - Visit their GP, have higher use of medication, higher incidence of falls and increased risk factors for long term care;
    - Undergo early entry into residential or nursing care; and
    - Use accident and emergency services independent of chronic illness.

15. Discussions with primary care teams, including doctors, nurses, ward staff, pharmacists and social workers, have identified that there may be many people who access services who may have loneliness 'at the root' of attendance. There is a real risk that people are given prescriptions for antidepressants ('over medicated') due to the lack of time GP's have to thoroughly explore the wider determinants of health. GP's recognise that the model currently used by many GP practices is not necessarily providing the most appropriate service for the patient.

16. There are many other options available within communities to help with lower level medical complaints, to provide support and advice to citizens before they develop a problem, and this does not require the intervention of a GP or nurse. Social support to communities and strengthening communities is central to this, including social prescribing. There is a need to focus on those individuals within our communities who at risk, giving them the support that they need to improve their health and well-being rather than 'pick them up' in a health setting once they become unwell.

17. While many people who are lonely or isolated visit health or social care services, research has highlighted that being isolated can impact upon older people's ability to access services, which can then impact upon their health and well-being. In the Older People's Commissioner for Wales' research,[xiv] older people reported that barriers to them accessing healthcare included the following: difficulty with GP booking systems (needing to keep calling due to busy phone lines to get an appointment); consultation processes (phone consultation rather than face-to-face); getting to hospital or appointments due to lack of transport; services not meeting individual needs (e.g. cultural needs).

Ways of addressing problems of loneliness and isolation in older people, including interventions to specifically address the problems and other projects with wider aims. Evidence for what works and the outcomes for older people in terms of health and wellbeing;

18. The ways in which loneliness and isolation can be addressed are multi-faceted and will not be a 'one size fits all' approach. Researchers agree that there is a lack of high quality, robust evidence around which interventions are the most effective in addressing loneliness and isolation.[xvxvi] However, research evidence has demonstrated that low-intensity support (emotional, social, practical and housing support) has direct and tangible effects in reducing loneliness and isolation. Crucially, older people need to be at the centre of decisions about what services and activities would benefit them the most, rather than the professionals assuming what they might need.

19. Group activities in particular have been seen to be helpful in enabling people out of loneliness and isolation.[xvii] This supports the view that effective interventions are;
    a. Group interventions with an educational themes or specific support functions;
    b. Interventions that target specific groups, for example women, carers or people with health needs;
    c. Interventions where participants are involved in setting up and running the group (co-production);

d. Interventions developed within or run by an existing service;
e. Interventions with a sound theoretical basis; and
f. Interventions with a technological element, for example using video-conferencing or the internet.[xviii]

20. Identifying people at risk of loneliness can be difficult, but targeting those disproportionately affected by loneliness – lower socio-economic, groups, the widowed, the physically isolated, people who have recently stopped driving, those with sensory impairment, carers who lose their careering role and the very old – has proven most effective. Sometimes, people will require longer term support such as social care, but other times they need flexible support which just provides that 'little bit of help'. The 'right kind' of help, delivered when it is needed and appropriate can make a huge difference to older people, enabling them to potentially avoid the need for more formal support, stay living in their own homes for longer and keep their independence.[xix]

21. The initiatives that have been introduced to support people affected by loneliness and isolation includes the multi-agency "Ffrind i mi" Partnership Board in Aneurin Bevan UHB. As highlighted in Aneurin Bevan UHB written response to the Committee's inquiry, "Ffrind i mi/Friend of mine" is a partnership approach to combatting loneliness and social isolation across their communities. Led by Aneurin Bevan UHB, and chaired by the Vice Lord Lieutenant of Gwent, the Partnership Board includes a range of organisations including: the Health Board, Local Authorities, Gwent police, Age Cymru, 1,000 Lives (Public Health Wales NHS Trust), United Welsh, Coleg Gwent and GP/ Neighbourhood Care Network Leads. "Ffrind i mi" has enabled a 'social movement', encouraging statutory and voluntary partners and wider communities to think about innovative ways to support those at risk of loneliness and social isolation to reconnect with their community. Recognising their rich community assets, "Ffrind i mi" also aims to recruit as many people as possible as volunteers, 'plugging the gaps' of existing social support.

22. In Cwm Taf UHB they have used the Intermediate Care Fund to work with social services, housing, third and independent sectors to invest in projects that benefit frail/ elderly residents (65+) and their family to combat loneliness and isolation. In Cardiff and Vale UHB the "Age Connects Cardiff & the Vale" has delivered a range of projects which have demonstrated a reduction in social isolation and loneliness for older people. These include the "Friendly Advantage Project", which reported that of the people who said they were lonely at baseline, 84% said as a result of being involved in the project their social interaction and well-being had increased. The "Healthy and Active Partnership Programme" delivered by Age Connects reported that over a 4 month reporting period, 78% of clients show an improvement in their experience of loneliness. The "Senior Health Shop" provides older people with a place to go to meet others, gather information and take part in activities, and 82% of people say that attending has reduced their isolation or loneliness.

23. Working in many of our communities are local area or community co-ordinators. These individuals, through their local contacts, often hear about or are asked to help a person who may be house bound or with no social contact. As example, the co-ordinator's assistance could: connect the person with a health or social care professional to improve their quality of life; make referrals to a third sector agencies that can provide a chaperone for appointments or support to access shopping services; and help to make introductions with local social groups.

24. Furthermore, there are a number of social prescribing projects currently active across Wales. Social prescribing initiatives provide new life opportunities for those who need them most; opportunities to form new relationships, be creative and independent while improving both physical and mental health. Examples include voluntary work agencies, exercise classes, self-help groups, book groups, social or lunch clubs and hobby clubs among others.

The extent to which initiatives to combat loneliness and isolation experienced by other groups may also help to address these issues for older people;

25. There needs to be a wider scoping of current initiatives and a better understanding of their impacts on the individuals/groups they support in order to determine transferability to other groups/older people. Greater evidence is required to inform effective interventions and treatment. It is suggested that a national measurement tool to identify use of services by those affected by loneliness could be very useful.

Current policy solutions in Wales and their cost effectiveness, including the Ageing Well in Wales programme. The approach taken by the Welsh Government in terms of maintaining community infrastructure and support, and using the legislative framework created in the Fourth Assembly, e.g. the *Social Services and Wellbeing (Wales) Act 2014 and the Wellbeing of Future Generations (Wales) Act 2015.*

26. The current Wales legislative framework provides an ideal opportunity to try to address the impact of isolation at an early stage. The Well-Being of Future Generations Act 2015, The Social Services and Well-Being Act 2014 and the Ageing Well in Wales programme all provide a real opportunity for statutory bodies and its partners to better consider and plan for strategies that are aimed at combatting social isolation and loneliness.

27. Within the Social Services and Well-being Act 2014 a key element is for public bodies to signposting people to services and support and early intervention. This provides the platform for being able to identify older people who may be at risk of loneliness and isolation during the needs assessment.

28. As well as the Social Services and Well-being Act 2014 the well-being goals under the Well-being of Future Generations Act 2015, and public sectors responsibilities under the Corporate Health Standard, should provide the vehicle to driving forward initiatives that combat social isolation and loneliness. Some examples include:
    - *A Prosperous Wales:* better use of our community assets with an increased focus on the recruitment of volunteers from all walks of life;
    - *A Healthier Wales:* There is a real opportunity to influence innovative approaches where people's physical and mental well-being is maximised.
    - *A Wales of Cohesive Communities:* volunteering service initiatives across communities with a wide range of partners will direct a partnership approach to innovation that enables a prudent approach to community cohesion.

29. As well as legislation, it is important that the public and communities are engaged on the health and well-being impacts of loneliness and social isolation. Community mobilisation is important and any healthcare initiatives will be readily owned by a community if the leaders, the citizens, and youth are fully engaged in mobilising the community, educating stakeholders, and implementing evidence-based interventions. Community mobilisation is a capacity building process through which community individuals, groups, or organisations plan, carry out and evaluate activities on a participatory and sustained basis to improve health and other needs on their own initiative or stimulated by others. Communities need to be enabled to help themselves and others. As well as improving well-being, this may in turn reduce reliance on public sector services, including the NHS.

Conclusion

30. As highlighted in our response loneliness and isolation are both a social and health issue. Evidence has demonstrated the impact loneliness and isolation has on physical and mental well-being but

more needs to be done to identify individuals who are, or may be at risk of, loneliness and isolation. Furthermore a better understanding of the support services available at a local level needs to be developed to ensure this support is tailored to an individual's needs and that people are engaged to enable them to access local opportunities and reconnect with their communities.

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[i] Local Government Association, January 2016. Combating loneliness: a guide for local authorities.
[ii] Age UK, 2015. Loneliness and Isolation Evidence Review.
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WLGA • CLILC

ADSS Cymru
Leading Social Services in Wales
Yn arwain Gwasanaethau Cymdeithasol yng Nghymru

Inquiry into Loneliness and Isolation

Introduction

1. The Welsh Local Government Association (WLGA) is a membership organisation that represents all 22 local authorities in Wales, the 3 fire and rescue authorities and the 3 national park authorities as associate members.

2. The WLGA represents the interests of local government and promotes local democracy in Wales. Its primary purposes are to promote better local government, to promote its reputation and to support authorities in the development of policies and priorities which will improve public service and democracy.

3. The Association of Directors of Social Services Cymru (ADSS Cymru) is the professional and strategic leadership organisation for social services in Wales and is composed of statutory Directors of Social Services, and the Heads of Service who support them in delivering social services responsibilities and accountabilities; a group of 80 or so social services leaders across the 22 local authorities in Wales.

4. There is growing recognition that loneliness and isolation is a serious problem, with far reaching implications, not just for individuals, but also for wider communities. Whilst in the past, loneliness and isolation was sometimes viewed as a trivial matter, it is increasingly understood to be a serious condition which can have a significant impact on a person's mental and physical health.

5. The terms loneliness and social isolation are often used interchangeably, but it is possible for people to be isolated but not lonely and vice-versa. Loneliness is a subjective state – a response to people's perceptions and feelings about their social connections and well-being – rather than an objective state. Therefore, loneliness requires a more subtle response, often going beyond efforts simply to maintain number, or frequency, of social connections.

6. Given the population predictions, where we will see large increases in the number of older people living alone, particular in the 85+ age range, the issue of loneliness and social isolation is likely to continue to be a significant issue for public services and partner

organisations to respond to. All of this takes place against a background of severe financial challenges facing public services in the delivery of services.

7. A recent study featured in the BMJ (formerly the British Medical Journal) found that loneliness and isolation are associated with a 30 per cent higher risk of having a stroke or developing heart disease. The health impact of loneliness is also said to be the equivalent of smoking 15 cigarettes a day. This has a significant impact on public services and in particular on health and social care and we believe that this means that loneliness and isolation must be recognised as a major public health issue.

Scale, Causes and Impact

8. A Local Government Association report, 'Combating Loneliness', published in January 2013 recognises a number of potential risk factors for loneliness, including: living alone; poor health; being aged 80+; loss of friends; having no access to a car/ never using public transport; living in rented accommodation; living on low income or on benefits as main income; having no access to a telephone; hearing and sight loss. Variables can include, but are not limited to, households that: have a head of household aged 65-74, or 75+; have one occupant; report various health issues including mental illness, anxiety and depression; do not own a car; speak to their neighbours less than once a month or never;; have a low annual income; require help with bin collection; have bereaved older people.

9. Social isolation has been identified as an important health inequality issue. The 2010 Marmot Review found that 'individuals who are socially isolated are between two and five times more likely than those who have strong social ties to die prematurely'. The UCL Institute of Health Equity builds on this work. In a joint initiative with Public Health England, the Institute produced a practical resource summary called 'Reducing Social Isolation Across the Lifecourse'. It comments that 'social isolation is a health inequality issue because many of the associated risk factors are more prevalent among socially disadvantaged groups. Social disadvantage is linked to many of the life experiences that increase risk of social isolation, including poor maternal health, teenage pregnancy, unemployment, and illness in later life.'

10. During 2015, a group of independent researchers were asked by the Social Services Improvement Agency (SSIA) to find out what helps and what gets in the way of wellbeing for older people and those caring for them. This research looked at what the fundamental building blocks of a good life are, importantly in relation to loneliness and isolation they include:
    - **Being independent**: people did not want to have to rely too much on other people
    - **Being connected to other people**: there was huge diversity in the relationships that mattered to people – friendships with younger people, neighbours who 'pass tomatoes over the garden fence', shopkeepers who say 'hello', as well as partners, family and long-standing friends.
    - **Being active**: being able to participate in interests and pleasures which give meaning to life.

11. The research also considered what helps or hinders older people achieving wellbeing, identifying the following:

- **Transport**: over half of those spoken to still had access to a car – those in rural areas felt this was essential; although there were criticisms of bus services, the free bus pass was very popular and buses can also be key social hubs for older people.
- **Home environment**: being able to remain in your own home was central to maintaining control for many, though upkeep, utility costs and accessibility were often challenging.
- **Neighbourhood**: the availability of local facilities; the sense of community safety (or the fear of crime); and the sorts of relationships they had within the local community all impacted on wellbeing.
- **Money**: some people reported that poverty was causing them to feel anxious and isolated.
- **Information Technology**: Some people were using the internet to improve their wellbeing in a range of ways, from ordering food and other shopping to be delivered online; using Skype to keep in touch with dispersed family; or emailing fellow members of social groups. However, fear of scams was a key barrier here, along with knowledge, skills and confidence; cost; poor connectivity; and disability (especially arthritis and visual impairment).

12. This research also included the production of a literature review entitled, 'The anatomy of resilience: helps and hindrances as we age: A review of the literature'. This document identifies relevant published research evidence from Wales, the UK, and further afield. Important strands emerge, such as, "Social connectedness" and the importance of finding and building on the strengths in individuals, families and communities. How we plan for and cope with (or not) key life events and transitions. What assists us to seek (or stops us from seeking) timely advice? And what can trigger (or arrest) abrupt declines?

13. It is important to appreciate that anyone can experience loneliness and/or social isolation. Although much social policy and practice has focused on tackling the effects of loneliness in later life, it is a problem that exists at all life stages. A poll for the Campaign to End Loneliness in 2013 found that over three quarters of GPs said they were seeing between one and five lonely people a day. There are key triggers that can disrupt lives and create a situation in which loneliness or isolation become the norm. These include becoming a new mum at a young age, retirement, experiencing long-term health issues or mobility limitations, dealing with bereavement or going through a family breakdown, such as divorce or separation. The relationship between loneliness and these key factors needs to be better understood, with attention given to the experience of loneliness in younger adults, those in middle age and older people. This will ensure interventions are relevant and appropriate to individuals at different times of life.

14. One of the biggest challenges for youth services in engaging young people, for example, is the 'pull' of social media which can lead to more young people isolating themselves in bedrooms, which can cause a number of issues – inability to socialise and form relationships, depression, anxiety/agoraphobia, lack of exercise and obesity. Work pressures for parents can also compound this as parents are not able to spend as much time with their children – or, in the case of a recent Children's Society report, 'Troubled Teens: A study of the links between parenting and adolescent neglect' many teenagers are left to their own devices too early at home.

Ways of Addressing Problems of Loneliness and Isolation

15. Despite extensive research into the nature and scale of loneliness, there is a lack of high quality evidence to demonstrate the impact of different interventions to combat its effects. There are also differences of opinion about the relative impact of interventions that work at either an individual or a community level. Whilst hard cost benefit analysis of loneliness is still scarce, there is some data that indicates good returns on investment. Given the high cost of the health, social care and other services required by lonely individuals if their circumstances are not addressed, there is a strong case for investment in this area.

16. We have seen in England more and more councils, which have responsibility for public health, launching new initiatives to tackle loneliness, as it becomes an increasing public health priority. For example, Barking and Dagenham, Havering and Waltham Forest councils are piloting video-calling tablets to help adults over 55 feel socially included. Gloucestershire has also compiled loneliness "maps" which calculate where lonely residents are likely to live, in order to target the right areas.

17. This demonstrates the benefit of more joined up and integrated approaches to tackle issues such as loneliness and isolation. In terms of the Welsh Government's agenda around wellbeing, the WLGA believe that the time is right for a full examination of the creation of a public health improvement role, located within local government. This would provide an opportunity for local authorities to have a significant influence and more joined up approach over the broader determinants of people's health – their local environment, housing, transport, employment, and their social interactions – all of which are linked to local authorities core roles and functions and can play an important role in helping to reduce the impact of problems such as loneliness and isolation.

18. As highlighted earlier transport can help people to stay connected; and accessible and affordable transport links are part of the solution to tackling social isolation, playing a vital role in supporting people's wellbeing. The majority of local authorities have a budget for subsidising bus routes which are not commercially viable but are considered necessary routes. However, it is becoming increasingly difficult for local authorities to protect this level of subsidy during times of austerity and a number of authorities have had to look at reducing or in some cases ending this funding. Local authorities continue to contribute to the Concessionary Fares Scheme which entitles over 60s (and some other categories) to free bus transport, which again supports people, but this is impacted if bus routes are reduced due to financial constraints. Local authorities continue to look for innovative solutions to these problems and we have seen examples being developed, for example, Bwcabus in Carmarthenshire/South Ceredigion and Pembrokeshire which is multi partner project with a grant from EU Rural Development Fund and in Monmouthshire where the Council operates its own community transport company which connects outlying rural areas with towns in Monmouthshire.

19. A key part of the Social Service and Well-being (Wales) Act is the production of regional population assessments. Whilst the assessments are still in development and are yet to be finalised the emerging findings suggest that loneliness and isolation is being recognised as an issue. Importantly, concerns around the impact of loneliness and isolation are not confined to older people and it is seen as an issue across a number of other groups, including:

- People with a physical disability
- People with a sensory impairment
- Minority ethnic groups with a social care need
- Adult mental health, specifically dementia for some regions
- People with a learning disability
- People with autism and the parents of children and young people with autism
- Care leavers
- Young carers
- Veterans
- Victims of physical and sexual abuse (victim isolation)

20. Ways of addressing loneliness and isolation are already being implemented by authorities, with a number of identified services / approaches across the regions, including:
    - Day opportunities
    - Housing options
    - Community connectors

21. The Social Services Improvement Agency (SSIA), Data Unit Wales and the North Wales Single Point of Access (SPoA) programme group, working in partnership, have developed the Dewis Cymru information and advice website for citizens. Dewis Cymru provides quality information about how people can maintain or improve their well-being, and about organisations which can help them. First and foremost, Dewis Cymru is intended to promote people's well-being by making it easier for them to find out about how to improve their well-being, and the sources of advice and support which can help them, including on topics such as loneliness and isolation. In doing so Dewis Cymru also helps local authorities to comply with the duty under the Social Services and Well Being Act to provide information, advice and assistance.

22. We have also seen the Intermediate Care Fund (ICF) being used across regions to help reduce the impact of loneliness and isolation. For example, in Cwm Taf the 'Project 5 ways to wellbeing' is designed to challenge the isolation and loneliness in their older person's population, together with promoting independence at home. ICF funding has also been used to fund community connectors, community co-ordinators and community agents across a number of different authorities. These roles work with all partner agencies in key locations such as Single Points of Access, GP practices and community settings, with the intention of helping to reduce the impact of social isolation and loneliness, helping to reduce hospital admission and support hospital discharge, and promote independence and overall wellbeing.

Current Policy Solutions / Opportunities

23. All 22 Welsh Local Authorities have signed up to the Dublin Declaration on Age friendly cities and communities, making a commitment to work towards the creation of Age Friendly communities. Local Government has also been involved in the Ageing Well in Wales Programme from the beginning, with the WLGA working with the Commissioner's Office in establishing the Programme, building on a similar campaign undertaken in England. We are supportive of the key strands of the Programme – creating age friendly communities; tackling loneliness and isolation; preventing falls; developing dementia supportive communities; and addressing employment and skills needs for older people.

Progress on these 5 areas of work will lead to measurable improvements to the quality of life of older people, with local authorities taking a key role in supporting this work. It will be important for local authorities to work closely with local communities and partner organisations to consider how services can be delivered in the future, during a time of severe public spending constraint, by doing things differently.

24. Prevention has been at the heart of the Welsh Government's legislative programme. The Well-being of Future Generations (Wales) Act aims to make public bodies think more about the long-term, work better with people and communities and each other, looking to prevent problems and take a more joined-up approach. The Social Services and Well-being (Wales) Act also has prevention as one of its key principles – the need to ensure that services promote the prevention of escalating need and make sure the right help is available at the right time. Prevention is fundamental to improving health and well-being and helping to reduce the increasing pressures being placed on services.

25. The pressures being faced across public services have increased the importance of providing preventative activity and services aimed at early intervention (with the intention of holding off more costly and potentially intrusive interventions at a later stage). We all agree with the benefits of early intervention and prevention in the first case, in terms of better life experiences and well-being for individuals and families, as well as reduced costs for public services, particularly in the longer term.

26. The next few years will continue to be extremely challenging, local government is facing a cumulative shortfall of nearly £750m by 2019-20. For Social Services alone, £92m worth of pressures are being faced in 2017-18. The recent Health Foundation report 'The path to sustainability: Funding projections for the NHS in Wales to 2019-20 and 2030-31', recognises that social care budget pressures are rising higher than the pressures in the NHS, as social care services are heavily concentrated on the most elderly (a group that is seeing the fastest population growth) and the growing proportion of the population with learning disabilities. The health and well-being of the population depends on far more than the quality of health care services. There is a need to transform health and care by shifting investment away from treatment and towards prevention, investing in local services who provide a range of preventative approaches which can delay the point at which an individual's needs warrant a more intensive and costly intervention.

27. Local government shares the view of the importance of preventative council services and appreciate these make a vital contribution to reducing pressure on other public services in Wales, such as the NHS. However, reduced budgets have placed increasing pressure on the availability of preventative services, most of which are non-statutory. While new models of service have been established in many authorities, it is likely that any further cuts will continue to see a decline in some community services that promote well-being and help to tackle problems such as loneliness and isolation.

Health, Social Care and Sport Committee Inquiry into Loneliness and Isolation

Response from the British Red Cross in Wales (deadline 10th March 2017)

About us:

1. The British Red Cross helps millions of people in the UK and around the world to prepare for, respond to and recover from emergencies, disasters and conflicts. We are part of the global Red Cross and Red Crescent humanitarian network and we refuse to ignore people in crisis.

We provide support at home, transport and mobility aids to help people when they face a crisis in their daily lives.

Through our delivery of more than 200 independent living services across the UK, including almost 40 schemes across Wales, the British Red Cross supports thousands of people each year who are vulnerable and isolated.

Through our partnership with the Co-op, from May 2017 we will supplement our existing independent living schemes by introducing new services in 39 communities across the UK – including 4 in Wales – which over the next two years will together provide direct support for up to 12,500 people experiencing or at risk of loneliness and social isolation.

We are also one of the 13 partner organisations in the Jo Cox Commission on Loneliness, working together to start a national conversation on the widespread scale and impact of loneliness in the UK.

We welcome the opportunity to submit evidence to the Health, Social Care and Sport Committee Inquiry into Loneliness and Isolation.

The evidence for the scale and causes of the problems of loneliness and isolation:

2. As evidenced in research with our staff, volunteers and service users[1], a worryingly high number of people using our services live alone and struggle with the day-to-day tasks. They exhibit high levels of social isolation and even higher levels of loneliness. Social isolation and loneliness were mentioned most frequently as the underlying problems facing our service users. This research concluded that loneliness and social isolation is a crisis we cannot ignore.

3. Our recent report *'Trapped in a Bubble'* (2016)[2], commissioned by the British Red Cross in partnership with Co-op, highlighted that 88% of respondents to a nationally representative public survey – and 90% of respondents from Wales – consider loneliness a very serious issue

[1] The Crises Facing Our Independent Living Service Users, available at http://www.redcross.org.uk/en/What-we-do/Health-and-social-care/Independent-living/Loneliness-and-isolation/~/media/BritishRedCross/Documents/What%20we%20do/UK%20services/The%20crises%20facing%20our%20IL%20service%20users.pdf

[2] Available at http://www.redcross.org.uk/~/media/BritishRedCross/Documents/What%20we%20do/UK%20services/Co_Op_Trapped_in_a_bubble_report_AW.pdf

in the UK. Findings from the survey also indicate that loneliness is something that most people have experienced to some degree, and many are dealing with levels of loneliness that may have a negative impact on their quality of life. Half of those surveyed feel lonely at least sometimes and only one in five said they have never felt alone. 18% feel lonely 'always' or 'often' – the equivalent of almost 458,000 people in Wales.

4. The research brought together this public survey with qualitative evidence from more than 100 people with personal experience of loneliness and over 45 experts. It looked in particular at how transitions, particularly role transitions, act as key triggers for loneliness. Examples of life transitions include retirement, bereavement, a break-up of a relationship and health issues. These disruptions in a life can challenge self-identity and damage or sever social connections and make it harder to create new connections, particularly if barriers also exist across individual, community and social levels. Once a person becomes disconnected, loneliness itself becomes a barrier to connection as individuals question their own self-worth and the possibility of making connections creating feelings of vulnerability and anxiety. By failing to respond and provide appropriate support to people going through such transitions, loneliness can transition from a temporary situation to a chronic issue, further impacting on individuals and society.

5. Participants in the research also identified a wide range of other causes of loneliness which were often interconnected. These barriers are categorised by four drivers:

- Individual – a loss of sense of self, poor health, low income/poverty, a lack of energy, low confidence, negative emotions and perceptions
- Connections – a loss or lack of friends and acquaintances, family and colleagues
- Community – lack of social activities and statutory services, lack of or cost of transport, neighbourhood safety
- Society – social and cultural norms around who can connect with who, work/life balance, stigma of being lonely, lack of personal connection created by a digital age, insular communities, stigma created by the political landscape and financial hardships.

6. The WHISC evaluation (2016) of the Red Cross *Gofal* project in Wales, which provided outcome focused befriending support to people over the age of 50, identified that many of the individuals accessing the service lived alone, had lost family and friends through bereavement and their social contact was limited. Many were physically impaired through age or ill-health, suffering from depression and anxiety, or had lost their independence and confidence following a stay in hospital. Service users reported being isolated due to no access to transport and/or living in a rural area or having lost their social connections due to health issues or as a consequence of moving home.

The impact of loneliness and isolation on older people

7. On the surface, it can be hard to tell who is feeling lonely or isolated. This hidden issue is problematic because it affects people's health and wellbeing and impacts on public services. Our literature review bringing together findings from more than 100 published studies from over 40 years[3] set out many of the impacts. A lack of social connections can be linked to cardiovascular health risks and increased death rates, blood pressure, signs of ageing, symptoms of depression and risk of dementia. It could be as damaging to health as smoking and as strong a risk as obesity. Lack of social networks can be linked to poor diet, heavy drinking and increased risk of re-hospitalisation after an illness. Increased service usage by older people experiencing loneliness could cost up to £12,000 per older person over the next 15 years.
The *Trapped in a Bubble* report identifies the negative impacts of loneliness across a range of biological, psychological and social domains. The physical implications of loneliness often make it harder for people to undertake everyday tasks and routines and make it more difficult to engage with others. Respondents reported feeling tired, in poor health, anxious and existing symptoms being exaggerated. Loneliness was also recognised as leading to a lack of confidence, feeling alone, depression, and negative thoughts which at worst triggered thoughts of self-harm and suicide.

8. Although the report recognises minimal differences in the overall causes of loneliness between rural and urban settings, rurality is identified as presenting specific barriers to social connection contributing to isolation in the form of fewer and more expensive support services and a lack of or unaffordable transport options.

9. It is also important to stipulate that loneliness does not just affect older people. Many other groups in society, from young mums to those recently bereaved, experience feelings of loneliness and isolation. Indeed, our research found that self-reported loneliness was higher among 16 to 34 year olds than any other age range.

Ways to address loneliness and isolation in older people

10. Without the right support, loneliness can transition from a temporary situation to a chronic issue and can contribute to poor health and pressure on public services. What is clear is that there is no one-size-fits-all solution to tackling these issues. Different people need different kinds of support.

11. There is a strong case for intervening to prevent chronic loneliness, given its devastating wider effects on health and wellbeing – and resultant pressure on NHS and care services. Preventing minor situations escalating into crises is more cost-effective than picking up the pieces – and better for the individual. Our long-established record of service provision shows that providing low level support – such as assisting somebody to return home from hospital, making sure they have enough to eat or take their medication, rebuilding their confidence and independence – can generate real impacts in individual's lives, as well as generating savings to

[3] Isolation and loneliness: An overview of the literature. Available at http://www.redcross.org.uk/en/What-we-do/Health-and-social-care/Independent-living/Loneliness-and-isolation/~/media/BritishRedCross/Documents/What%20we%20do/UK%20services/CoOpIsolationLonelinessA444ppAW.pdf

the public purse. An independent economic analysis of such services identified cost savings related to a reduced need for care and support equivalent to £880 per person.[4]

12. Expert responders to the *Trapped in a Bubble* research identify that a key challenge in helping people to get support was due to a lack of awareness of what was available and poor signposting. The public survey supported this barrier to accessing support – with 75% of people who are regularly lonely saying they do not know where to turn for support. The report highlights that those experiencing loneliness tend to be reluctant to travel far from home to access opportunities, this is particularly challenging for those living in rural areas or those affected by health and mobility issues.

13. Responders expressed that one-off interventions and short-term support without clear ongoing pathways for building independence or resilience were detrimental.

14. They also identified a need for informal community led, peer centred support and a need for existing services to be more joined up in terms of signposting and creating structured pathways for people experiencing loneliness.

15. The research highlights the need for a mix of tailored support at different stages which is preventative, responsive and restorative with some element of face-to-face connection.

16. Services should give a sense of purpose; be peer-led or co-designed with people in similar circumstances; be local and easy to access; be free or affordable; instil a positive sense of identity; provide clear goals and pathways to reconnection; provide benefits to others (such as through volunteering) and community developments opportunities; bring people together around shared interests.

17. The WHISC evaluation identifies the existence of varying models of service delivery to support older people. New models have developed in response to technological progress however it is important to refer back to the challenges of digital technology identified by the *Trapped in a Bubble* report where loneliness and isolation can be exacerbated by a lack of personal connectivity. Digital solutions clearly have a role to play – but their value is in supplementing and facilitating face-to-face contact, not replacing it. The report highlights that there has been an increase in service models such as social prescribing and collaborative working across sectors, but that there is still need for further development.

18. According to the WHISC *Gofal* evaluation, service users' emotional health, social networks and feelings of loneliness were improved as a consequence of the service. All beneficiaries of the service reported that having someone to talk to did reduce their feelings of loneliness and isolation and expressed a preference for face-to-face interaction. Beneficiaries also reported that their confidence had grown which enabled them to leave the house and socialise and they had built long-term opportunities to maintain social contact within their communities.

Examples of services which address issues of isolation and loneliness:

[4] Personal Social Services Research Unit, LSE & Research, Evaluation and Impact team, British Red Cross (January 2014), An Analysis of the Economic Impacts of the British Red Cross Support at Home Service: pssru.ac.uk/archive/pdf/dp2869.pdf

19. Community Connectors – In response to the research outlined above, and using funds raised by the Co-op, from May 2017 we are introducing a brand new network of Community Connectors in 39 communities across the UK where we have identified low levels of current support and high levels of need – including Conwy, Carmarthenshire, Newport and Torfaen. The programme brings together elements of best practice identified in our existing services and through our research. Specialists in psychosocial support and safeguarding will work with people who are experiencing loneliness and social isolation, along with teams of volunteers. The connectors, , will provide up to 12 weeks of intensive, person-centred care, identifying relevant activities, interest groups and services to support individuals re-establish social connections and build independence and resilience.

20. Positive Steps - a collaborative service between the Red Cross and Royal Voluntary Service supporting people over 50 years of age to regain their independence and reconnect with their community. The aim is for the individual to take charge of their situation and, with support, become more independent and live more fulfilled lives.

This often means connecting with groups and organisations in their community. It might be a case of building confidence. It could also mean talking through issues and finding practical solutions to any obstacles or barriers which are holding them back.

21. Community Navigators – A Denbighshire County Council initiative facilitated by employees from the Red Cross and Age Connects. Community Navigators work to develop a community-focussed approach to social care and well-being. They work closely with the Single Point of Access (SPoA) to develop and support local networks and communities, promoting a range of help available within the community. Community navigators provide a link between health and social care, the citizen, their family and carers, and sources of support within the community and third sector. This is, effectively, a social prescribing service that links patients with non-medical sources of support within the community.

22. Dewis Cymru - an online public directory of information on resources available within communities including private, public and third sector information to support the well-being of individuals living in Wales.

Current policy

23. We welcome the progress of the Ageing Well in Wales programme and believe it has made tangible impact across the five streams. However, we would suggest that it is more challenging to demonstrate the impact of the programmes achievements in specifically addressing loneliness and isolation compared to that of the four other areas. We would also offer that it is more challenging to achieve complete community ownership of combating loneliness and isolation without the support of organisations.
It is noticeable that the issue of loneliness and isolation has become more recognised and believe this is the result of the programme and other influencing factors.

24. In our experience, our service users continue to cite shrinkage in community infrastructure as exacerbating their feelings of loneliness and isolation, be it the lack of or unaffordability of transport, a loss of local services and meeting places such as day centres, local post offices/shops and luncheon clubs.

25. We welcome the intentions of the Social Services and Well-being (Wales) Act 2014 and Well-being of Future Generations (Wales) Act 2015 and believe that the framework of underpinning legislation provides opportunity to addressing the issue of isolation and loneliness. This is supported by our experience that loneliness and isolation are more frequently identified through the “What Matters Conversation”. However, the resourcing of specific and varied services is necessary as part of a wider community based preventative approach.

Agenda Item 6

Glamorgan Voluntary Services

Response from Glamorgan Voluntary Services (GVS) to the National Assembly for Wales, Health, Social Care and Sport Committee Inquiry on loneliness and isolation

Introduction to GVS

Glamorgan Voluntary Services (GVS) is an independent charity and has a flourishing membership of voluntary and community organisations active in the Vale of Glamorgan. We help to improve the quality of life of people and communities by supporting volunteers, volunteering opportunities and voluntary groups.

GVS delivers an array of quality services to meet the needs of voluntary groups. We are a one stop shop for the voluntary sector. We champion best practice throughout voluntary organisations so that they excel in delivering their aims and objectives.

GVS empowers voluntary groups, providing many channels of engagement and quality services to enable them to excel at serving their communities. Our role is to provide information, advice and guidance on all aspects of volunteering for both volunteers and recruiting organisations.

The Health and Social Care Facilitator in GVS supports the third sector and statutory partners in a number of ways:

- Promoting partnership working within the sector and across sectors
- Promoting third sector organisations and services to statutory partners and vice versa
- Representing the third sector at strategic planning and partnership groups
- Engaging the sector in consultations and engagement about health and social services

The answers in this response will focus primarily on how the third sector can address loneliness and isolation, identifying areas of good practice in the Vale and Cardiff and areas for future development.

Answers to Inquiry questions

1. **The evidence for the scale and causes of the problems of loneliness and isolation.**

The issues of loneliness and isolation have been well researched and the evidence base is extensive. In addition, there is evidence which shows the adverse effect that loneliness and isolation can have on mental and physical health. This response will not therefore go into detail on the evidence, but highlights below some headlines from relevant research:

- Greater involvement in leisure activities is associated with better health in older age (Chang et al, 2014).
- Social disconnectedness and perceived isolation are independently associated with lower levels of self-reported physical health (Cornwell & Waite, 2009).

- Participatory interventions and those involving social activity and support are more likely to be beneficial in terms of reducing loneliness (Dickens et al, 2011).
- The connection between social isolation and loneliness is complicated, for example socially isolated people are not necessarily lonely (Dahlberg & McKee, 2014).
- The Campaign to End Loneliness produces research bulletins and guides, including a guide for commissioners and local authorities. http://www.campaigntoendloneliness.org/research-bulletin/
- The RVS found that nearly three quarters of people over 75 who live alone feel lonely. http://www.royalvoluntaryservice.org.uk/our-impact/reports-and-reviews/loneliness-amongst-older-people-and-impact-of-family-connections
- Ageing Well in Wales highlights research which indicates that loneliness has an effect on mortality that is similar in size to smoking 15 cigarettes a day.
- Age Cymru in it's No one should have no one campaign states that 75,000 older people in Wales have reported "always or often" feeling lonely. http://www.ageuk.org.uk/Global/Age-Cymru/Policy_and_Campaigns/English%20Manifesto.pdf?epslanguage=en-GB-CY?dtrk=true

Given the evidence base already in existence, and the clear indication of the extent of the problem and its effects on older people's wellbeing, it would seem that there is a real need for concerted action on behalf of statutory authorities and the third sector to develop sustainable services which alleviate loneliness and isolation.

2. The impact of loneliness and isolation on the use of public services, particularly health and social care.

As already noted loneliness and isolation are different. Each will have a different impact on the use of public services.

The negative effect on wellbeing brought about by loneliness is likely to result in a continuing cycle of loneliness. Lonely, older people may experience depression, be reluctant to leave their house and lose confidence in their ability to be socially active and play a full role in their community. Without support, there is a risk that lonely older people will become more disengaged from the wider community and more reliant on the services which they already know about, which in many cases is likely to be their GP.

GVS works with GP surgeries in Barry and each one has an identified Third Sector Champion who is usually a practice manager or member of reception staff. Anecdotal evidence from them highlights that loneliness and isolation is a key factor facing their elderly patients, with some people calling surgeries because they have no one else to call.

United Welsh provide a service called Wellbeing4U which has Wellbeing Co-ordinators based in GP surgeries in Cardiff and the Vale. They work on a one to one basis with people who experience loneliness and isolation and help them link to local services. This can alleviate pressure on GP surgeries and improve people's wellbeing as they increase their interaction with their communities.

The British Red Cross and RVS provide a service called Positive Steps in Cardiff and Vale which works with older people who have lost confidence following an illness or hospitalisation. They will support them to achieve goals they have identified, which may

be something as small as being able to go to their local café, and will then provide a befriending service once the person has regained their confidence.

Age Connects Cardiff and the Vale has a Senior Health Shop in Barry with a café run by volunteers. The Shop not only provides older people with an opportunity to socialise and have a hot meal, but there are also a range of weekly information sessions on topics such as house adaptations, Telecare, welfare benefits.

All the third sector services mentioned in this response help to reduce loneliness and isolation and also help to support people to remain independent and be less reliant on public services.

3. Ways of addressing problems of loneliness and isolation.

The evidence base identifies a range of services which could help alleviate loneliness and isolation in older people. They include quite simple solutions. Age Cymru in their No one should have no one campaign outline that older people have asked for lunch clubs, free or subsidised transport, a regular visitor/befriender and/or a regular phone call.

All of these are tried and tested solutions, can be relatively easy to set up and are cost effective. There are numerous examples of third sector organisations which already provide these services or which have provided them in the past.

However, these services require funding and cannot always be reliant on community action only. Unfortunately, many of these essential third sector services, which were funded by statutory sources of funding, have been lost or reduced as local authorities have had to identify savings.

GVS managed a Lottery funded befriending project called Friendly AdvantAGE which provided a range of befriending services for older people, from 2012 to 2016. Partners were Age Connects Cardiff and the Vale, Dinas Powys Voluntary Concern (DPVC), Scope and C3SC, with each partner delivering a specific strand.

The project has now finished, however Age Connects and DPVC have been provided with funding from the Intermediate Care Fund (ICF) to continue some of the elements in the Vale of Glamorgan. It is hoped this funding will continue from April 2017.

Friendly AdvantAGE was independently evaluated by Welsh Institute of Health and Social Care, who evidenced the following:

- During its four and half years of operation Friendly AdvantAGE delivered excellent value for money, providing either 1-2-1 befriending or group activities to over 1,000 beneficiaries **at a cost of less than £4,** per beneficiary, per week.
- 60% of beneficiaries who admitted to being lonely, agreed that their social interaction or well-being had increased
- 76% of beneficiaries who had low levels of confidence, agreed that their confidence has increased during their time with the project.
- The volunteer led project recruited 175 volunteers, who provided over 11,500 hours of volunteering to support older people reduce loneliness and social isolation.

It shouldn't be forgotten that loneliness and isolation is not just an issue which affects older people. Age Connects Cardiff and the Vale has a Third Sector Broker who is based in the Contact1V Centre in the Vale of Glamorgan, funded via the ICF. Their remit is to work

with frail older people and ensure they have in place the services they need. The main reason for their referrals is loneliness and isolation, especially as they experience a deterioration in their mobility and health.

However, in addition to this, they have also received a lot of referrals in relation to younger people, in their 30s and 40s with long term conditions, who are isolated and lonely. There is clearly a need for support to help them access social activities.

The range of third sector services highlighted here are essential. They clearly align to the Social Services and Wellbeing (Wales) Act, the preventative agenda and are likely to receive more referrals as statutory sources constrict.

4. Current policy solutions in Wales.

It is encouraging that the Minister for Social Services and Public Health recognises loneliness and isolation as an important public health issue. It would be useful to know how this will translate into planning of local health and social care services and how local authorities and Health Boards will be encouraged to support the development of local preventative services, at a time of restrictive finances.

The national indicator, for the Wellbeing of Future Generations (Wales) Act, which relates to the percentage of people who are lonely is also to be welcomed. Again, it would be useful to know how performance against the national indicators will be measured, the outcomes of the performance and how this will translate into planning of local health and social care services.

If you would like further information, please contact:

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Glamorgan Voluntary Services
Tel: [redacted]
Email: [redacted]

http://www.gvs.wales/

8th March 2017

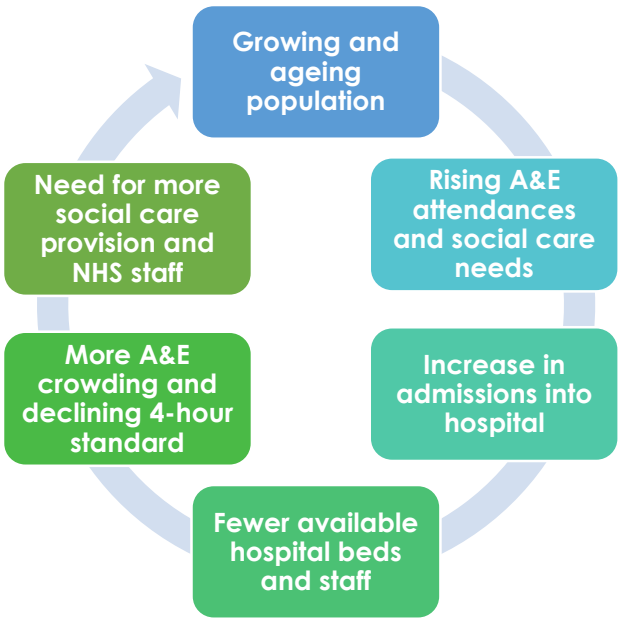
RCEM Wales

Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Health, Social Care and Sport Committee
HSCS(5)-18-17 Papur 6 / Paper 6

Winter Pressures in Welsh Emergency Departments Explained

NHS Wales' medical workforce faces a significant challenge to meet the health needs of a growing and ageing population with increasingly complex conditions. Winter 2016-17 saw extreme pressures on services resulting in declining 4-hour standards, crowded departments and 'exit block', effecting the overall quality of care that patients received.

A continuous cycle



Hospital beds

-14.6%

There has been a steady decline in the number of hospital beds between 2009 and 2016 by 1,872 beds or -14.6%:

- 12,806.7 beds in 2009/10
- 10,934.7 beds in 2015/16.

Hospital staff

The number of consultants per attendance has also deteriorated:

- 1 to every 11,575 in 2013-14
- 1 to every 12,230 in 2014-15.

Population growth

The number of people aged 65+ has risen by 2% in only one year:

- 614,747 in 2014
- 624,773 in 2015.

By 2039, the population of Wales is forecast to grow by at least 5% whilst the number of 65+ will rise by 44%.

ED attendances

A&E attendances have increased by 5.4% in 3 years, equal to the number seen in a standard Welsh DGH ED:

- 306,739 Oct-Jan '14
- 323,429 Oct-Jan '17.

Attendances during October 2016 to January 2017 rose by 379 visits compared to the previous year:

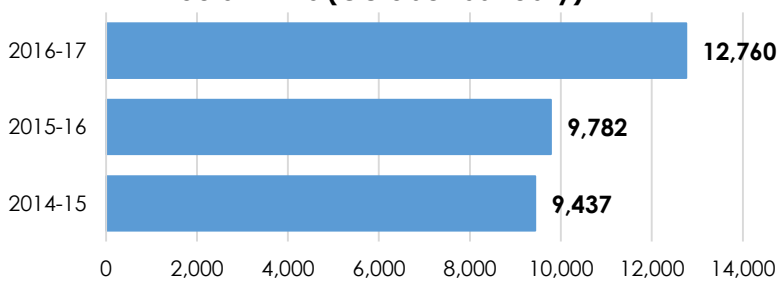
- 323,050 Oct-Jan '16
- 323,429 Oct-Jan '17.

A&E performance

4-hour performance has decreased from 87.5% (Dec 2013) to 75.9% (Dec 2016) in major departments – far below the target of 95%.

The number of people waiting over 12 hours has risen by 35% in only two years. In Jan 2017 alone, 5.2% of ED patients waited more than 12 hours.

Number of people waiting more than 12 hours in EDs (October-January)



Recommendations

- Exit block and overcrowding must be tackled. More social care in the community and an increase in the number of hospital beds would help minimise these prevailing issues.
- More social care provision is also paramount to keep to pace with the growing and ageing population and relieve pressure off primary and secondary services.
- Safe and sustainable staffing levels must be achieved. To fill the current workforce spaces and to keep up with demand, more emergency medicine trainee places are essential.
- Primary care facilities should be co-located with ED services including frailty teams, pharmacists, mental health specialists and GPs so patients receive the correct treatment as quickly as possible.
- To adequately prepare for winter 2017-18, we believe that planning needs to start now.

Royal College of Physicians | Coleg Brenhinol y Meddygon (Cymru)

Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Health, Social Care and Sport Committee
HSCS(5)-18-17 Papur 7 / Paper 7

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Health, Social Care and Sport Committee
National Assembly for Wales
Cardiff CF99 1NA

06 June 2017

Dear Dai Lloyd AM,

I am writing today on behalf of the Royal College of Physicians (RCP) in Wales to ask the Senedd Health, Social Care and Sport Committee to consider holding a follow up session on the inquiry into winter preparedness 2016/7 which concluded earlier this year.

While we were not invited to give oral evidence to this inquiry, we did submit detailed written evidence (attached) and we were invited by the Welsh Government to give evidence to the National Programme for Unscheduled Care (NPUC) Board evaluation of the resilience of health and care services over winter 2016/17. I have attached our evidence to this evaluation, which was written after direct consultation with our fellows and members. We also published a short report in April 2017, *Feeling the pressure*, which highlighted the pressures faced by our doctors following a snapshot survey carried out in January 2017 (also attached).

Our fellows and members identified three top priorities for next winter:

1. Clinically-led, whole system forward planning
   Clinically-led, appropriately funded winter care planning should be started as early as possible every year. This should take a whole system approach to planning surge capacity, bringing in colleagues from across medicine, surgery, social care, and specialist services: winter planning must be the responsibility of *everyone* working in the NHS and social care. Innovative, patient-centred solutions should be encouraged; job planning should recognise that acute clinical input should concentrate on delivering planned care and research in the spring and summer, with a renewed focus on unscheduled care in the winter months.

2. Increased resources and staff capacity
   The NHS workforce is now at breaking point and the recruitment crisis in medicine is getting worse – last year, we were unable to fill 40% of consultant physician vacancies in Wales and there are major trainee rota gaps in every hospital in Wales. The NHS must focus on providing enough medical beds, supported by a safe and consistent level of staffing across medicine, nursing, the therapies, and allied and support services, including

phlebotomy. The Welsh Government and NHS Wales must develop an enforced all-Wales locum strategy which includes maximum fees for doctors.

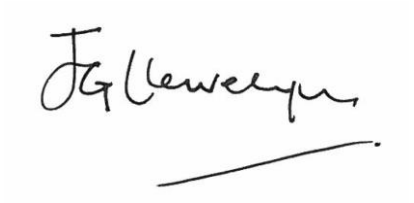
3. Social services and integrated care
   Social care must be an integral and forward thinking partner in winter care planning. Improved collaborative team working across health and social care should break down boundaries, with social services proactively encouraged to speed up the transfer of care out of hospital. This will require extra resource for social care teams across Wales, especially for those based in hospitals and working on the front line of winter care.

We remain unconvinced that health boards have learned from past experience. Winter planning should have begun already, with strategies being introduced now to plan ahead for the autumn. One of the biggest pieces of feedback we received from our members was that the most important interventions this past winter simply did not happen in time to make a real difference to patient flow, outcomes and experience.

The Committee may want to consider following up on this piece of work with the health secretary and the health boards, and the RCP would be happy to support this with any written or oral evidence that you may find useful.

If you would like any further information, please contact my colleague Lowri Jackson, RCP senior policy and public affairs adviser for Wales, by emailing Lowri.Jackson@rcplondon.ac.uk.

With best wishes,



Dr Gareth Llewelyn
RCP vice president for Wales
Is-lywydd yr RCP dros Gymru

Royal College of Physicians | Coleg Brenhinol y Meddygon (Cymru)

Inquiry into winter preparedness 2016/17

RCP Wales response

Key points

- The challenges facing health boards as they prepare for winter are complex. They reflect wider pressures on the NHS and social care.
- Health boards are operating in an under-funded, under-doctored and overstretched context. This is resulting in an increasing demand on hospitals.
- Recent RCP research shows that 40% of advertised consultant physician vacancies in Wales were unfilled last year; in the majority of cases, this is because there are simply no applicants. This is having a significant impact on the ability of doctors to deliver high quality care for patients.
- A stretched social care system, staffing shortages, and lack of hospital beds all contribute to delayed transfers of care.
- The RCP, through its Future Hospital Programme and our work with hospitals in Wales, is exploring new and innovative ways of delivering care.
- This includes better coordination of care and treatment of patients to prevent unnecessary hospital admission and to help them leave hospital as soon as possible. We are also developing telehealth projects in north Wales and encouraging partnership working between hospital and community services.

For more information, please contact:

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Health, Social Care and Sport Committee
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09 September 2016

Inquiry into winter preparedness 2016/17

1. Thank you for the opportunity to respond to your consultation on the National Assembly for Wales committee inquiry into winter preparedness 2016/17. Our response is based on the experiences of our fellows and members, and all quotations unless otherwise referenced, are taken from evidence submissions we received from RCP fellows and members.

2. The Royal College of Physicians (RCP) aims to improve patient care and reduce illness, in the UK and across the globe. We are patient centred and clinically led. Our 33,000 members worldwide, including 1,100 in Wales, work in hospitals and the community across 30 different medical specialties, diagnosing and treating millions of patients with a huge range of medical conditions.

3. There are a number of barriers preventing hospitals from dealing effectively with unscheduled care winter pressures. The barriers include delayed transfers of care leading to ineffective management of patient flows. Studies from England suggest that as many as 40% of patients who die in hospital do not have the medical needs that require them to be there[1]. Furthermore, at least 25% of hospital beds are occupied by people with dementia, many of whom are likely to stay more than twice as long in hospital than other patients aged over 65[2]. This is often because of a lack of community based care. The situation is compounded by the challenging financial circumstances in which the NHS operates.

4. Managing the patient flow between the emergency department, the acute medical unit and specialty wards depends on effective transfers of care and timely discharge of patients. Underfunding of social care, a lack of beds and issues with recruitment and retention of doctors mean that hospitals often struggle to effectively transfer patients while maintaining a high level of care.

> *I do not think there is any serious planning. An increase in capacity is what is needed. This is the lesson that needs to be learned and it has not been.*
> [Consultant physician in Wales]

[1] Royal College of Physicians 2014. National care of the dying audit for hospitals, England: May 2014
[2] Alzheimer's Society. *Fix Dementia Care in Hospitals*. 2016

5. Our members and fellows are working in an, under-funded, under-doctored and overstretched health service. Patient demand matched with significant workforce gaps are making it difficult to care for patients. In 2014-2015, 21% of UK consultant physicians reported 'significant gaps in the trainees rotas such that patient care is compromised'[3]. These figures are concerning because the specialties most closely associated with alleviating winter pressure on unscheduled care are seeing the highest staffing gaps, with geriatric and acute medicine reporting the greatest number of cancelled and failed consultant appointments.

A growing workforce crisis

6. This staffing crisis is having a major impact on physicians' ability to swiftly assess patients after they present at emergency departments, to tailor their care plans and to achieve safe and timely transfers of care. This can negatively impact on patient experience and leaves wards unable to alleviate pressures on emergency departments. Targets are difficult to achieve unless there are enough staff to treat patients or transfer them into social care in a timely manner.

7. There is currently no real national strategic approach to medical workforce planning in Wales. Over the years, this has contributed to recruitment and retention challenges in the medical workforce, especially among trainee doctors. **We strongly support the development of a clinically led national medical workforce and training strategy for Wales.** Wales has a real opportunity to develop an innovative model, and we urge that clinical leadership be placed at the very centre of that process.

8. It is also crucial that Wales makes a more concerted effort to attract its own students to medical school in Cardiff and Swansea. These students may be more likely to stay in Wales for their postgraduate training, and if they do leave, they are more likely to return home afterwards. Only 30% of students in Welsh medical schools are Welsh domiciled. This compares to 55% in Scotland, 80% in England and 85% in Northern Ireland.[4] **Medical schools must offer more undergraduate places to Welsh domiciled students in order to grow and retain a home-grown workforce**, and they should invest in outreach programmes which encourage applications from rural, remote and Welsh speaking communities.

Bed shortages and a lack of capacity

9. Hospital bed shortages also compound problems with patient flow. The UK has the second lowest number of hospital beds per 1,000 of the population among 23 European countries . Our members and fellows often cite that moving patients from acute medical units to general or specialty wards can be problematic because there are no beds available. These are older patient who are deemed well enough to receive care in the community but cannot be transferred due to a lack of services in community settings.

10. There is clear evidence that well run acute medical units (AMU) help reduce mortality, length of stay and readmissions[5]. AMUs staffed by multidisciplinary teams and led by acute medicine physicians have the potential to improve the quality and the safety of care of a significant proportion of acutely ill patients. We would urge health boards to invest in their general medical

[3] Federation of the Royal College of Physicians of the UK. *Census of consultant physicians and higher specialty trainees in the UK 2014-15.* London: Royal College of Physicians, 2016.
[4] NHS Education for Scotland. *Domicile of UK undergraduate medical students*. March 2013
[5] Scott, I; Vaughan, L; Bell, D. Effectiveness of acute medical units in hospitals: a systematic review. *International Journal for Quality in Health Care,* 2009; Volume 21, Number 6: pp. 397 –407.

workforce and AMUs to enable hospitals to respond more effectively and safely to the increasingly complex demands placed on the hospital with regard to acute medical care.

Redesigning the ambulatory care system

11. Some clinical teams, including those in Abertawe Bro Morgannwg University Health Board and Cwm Taf University Health Board have recognised that a new approach is needed to deal with the considerable pressures faced by emergency departments, and have successfully redesigned their systems to implement ambulatory emergency care (AEC) as part of the solution[6]. Ambulatory care is clinical care which may include diagnosis, observation, treatment and rehabilitation, not provided within the traditional hospital bed base or within the traditional outpatient services[7].

12. Implementing AEC ensures that where appropriate, emergency patients presenting to hospital for admission are rapidly assessed and streamed to AEC, to be diagnosed and treated on the same day with ongoing clinical care. Processes are streamlined, including review by a consultant, timely access to diagnostics and treatments all being delivered within one working day. This has improved both clinical outcomes and patient experience, while reducing costs. Clinical teams using this approach report managing significant numbers of emergency patients quickly, without the need for full admission, converting at least 20–30% of emergency admissions to AEC[8].

13. AEC can be particularly valuable in the assessment and management of frail, older patients being managed with pathways supported by a multidisciplinary team with good links to services in primary care, the community and local authorities. These links can offer rapid assessment and interventions for older people, which can avoid an inpatient stay. For older people, access to these services is important to live safely at home and avoid unnecessary readmission.

> *In my health board, the real positive aspects [of] winter planning have been quality improvement training for care home staff (and resultant anticipatory care planning), emphasis on proactive care planning for people with co-morbidities or those with frailty, and integrated working with the council and third sector.*
>
> [Trainee physician in Wales]

Developing new models of care to prevent hospital admission

14. The RCP is also working with local clinical teams through our flagship Future Hospital Programme (FHP) to develop innovative models of care to help meet patient need using current resources[9]. One Future Hospital site is based in north Wales, and has piloted the use of telehealth patient consultations over video link between hospital specialists and community healthcare teams.[10] However, two RCP Future Hospital sites in England are specifically working

[6] Royal College of Physicians. Acute Care Toolkit 10. Ambulatory Emergency Care. October 2014
[7] Royal College of Physicians. *Acute medical care: The right person, in the right setting – first time. Report of the Acute Medical Task Force.* London: RCP, 2007: p xxi. Endorsed by The College of Emergency Medicine, 2012.
[8] Blunt I. *Focus on preventable admissions: Trends in emergency admissions for ambulatory care sensitive conditions, 2001 to 2013.* London: The Health Foundation and the Nuffield Trust, 2013.
[9] RCP Future Hospital Programme
[10] RCP Future Hospital development site: Betsi Cadwaladr University Health Board

to reduce the admission of patients to hospital and ensure that they receive care in the community: Mid Yorkshire NHS Hospital Trust and East Lancashire Hospitals Trust.

15. Mid Yorkshire NHS Hospitals Trust has established a Rapid Elderly Assessment Care Team (REACT) within the acute admissions unit at Pinderfields Hospital in Wakefield. REACT are a multidisciplinary team made up of geriatric consultants, specialist nurses and therapists who work together to assess patients aged 80 and over, or those aged 65 and older who are care home residents, within 24 hours of their arrival at hospital. The team meet daily to coordinate the care and treatment of patients to help them leave hospital as soon as possible and prevent unnecessary hospital admission. The multidisciplinary nature of the team means that they are able to offer person centred care because they provide people both the health and therapeutic services they need.

16. Since the REACT team was established in 2014, Pinderfields Hospital has seen significant improvements in the number of patients receiving care in the community rather than being admitted to hospital. Comparing data from 2014 to 2015, there has been a 24% increase in the number of people with frailty being transferred to community care rather than moving onto a ward in hospital. The total number of hospital ward admissions for patients aged over 80 also decreased by 14% during the same period in 2014 to 2015. This quick assessment by a multidisciplinary team at the front door of the hospital ensures that patients are able to access the care most suitable to their individual needs and relieved some of the pressures faced by staff in the rest of the hospital.

17. The REACT team in Pinderfields Hospital has also been working closely with third sector providers to improve the transfer of care from the hospital to the community. Age UK regularly come into the acute assessment unit at the hospital to provide safe transfers of care into the community[11]; they offer transport and a grocery shopping service so that vulnerable older people are not discharged without adequate support. Working collaboratively with health and social care professionals outside of the hospital building has enabled frail older people to receive personalised care, which has helped them to maintain their independence and prevent readmission.

18. Another FHP development site at East Lancashire Hospitals Trust aims to identify frail older patients who are available for discharge the same day they present at hospital. The medical assessment unit (MAU) nurse monitors the acute intake of frail older people in order to identify patients suitable for rapid discharge, arranges their comprehensive geriatric assessment and liaises with secondary and social care professionals to plan for safe same-day discharge.

19. Preliminary data from the East Lancashire Hospitals Trust project suggests that 59% of admissions were avoided using this care model since the project started in 2014[12]. If admission can be avoided by streamlining the patient journey from the MAU through to social care, frail older people can be supported to leave hospital quickly and to live independently in the community.

20. In both these case studies, partnership working between hospital and community services has reduced delayed discharge. Integrated secondary and social care for older people can achieve

[11] Age UK. *Frailty in secondary care*.

[12] Temple, M; Dytham, L; Bristow, H. *Action learning at the Future Hospital development sites.* Future Hospital Journal 2016 Vol 3, No 1: 13–5

lower rates of bed use and the Kings Fund has found that hospitals operating in an integrated way also tend to have lower admission rates which provide a better patient experience.[13]

21. The problems facing emergency departments particularly during winter are complex and cannot be solved using a single solution. Reducing the volume of delayed transfers of care will go some way to alleviating pressures on emergency departments. The impact of an underfunded social care system is adding to the pressures being experienced in hospitals, with patients staying longer in hospital than necessary due to lack of services in the community. Furthermore, there is an ever-pressing need to find a national solution to problems with recruitment and retention of doctors. Without enough doctors on the ground, patient care will be compromised.

22. As the FHP project teams show, effective multidisciplinary working and the integration of healthcare services achieve better patient outcomes and experiences, thus alleviating winter pressures. This is why the RCP believes that we need to move away from a model of care in which we invest in either primary or secondary care, and towards integrated team working, where hospital specialists hold more of their clinics in the community, and GPs spend part of their time working with colleagues at the front door of the hospital.

A new integrated model of healthcare is needed

23. We would welcome a mature conversation about the future of service design in Wales, and the vision needed at a national level to develop a new way of working. It is important that future investment into the health service does not go towards propping up the old, broken system. The Welsh Government must promote innovative models of integration and introduce shared budgets that establish shared outcomes across the local health and care sector. Spending money on the existing system will not change anything in the long term; health boards must invest in prevention and treatment of chronic conditions and allow clinicians to innovate.

24. Those living in rural and remote areas must not be forgotten either; it is these areas where the crisis in primary care is hitting hardest, and where a new ambitious model of care has the most potential. All of this will need a drastic change in mind-set, stronger clinical leadership and engagement, and more joined-up thinking between primary, secondary, community and social care teams.

For more information, please contact Lowri Jackson, RCP senior policy and public affairs adviser for Wales, at Lowri.Jackson@rcplondon.ac.uk.

With best wishes,

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Is-lywydd yr RCP dros Gymru

Dr Andrew Goddard
RCP registrar
Cofrestrydd yr RCP

[13] Imison C, Poteliakhoff E, Thompson J. *Older people and emergency bed use. Exploring variation*. London: The King's Fund, 2012.

Royal College of Physicians | Coleg Brenhinol y Meddygon (Cymru)

Evaluation of health and care winter resilience 2016/17

RCP Wales feedback

About us

The Royal College of Physicians (RCP) aims to improve patient care and reduce illness, in the UK and across the globe. We are patient centred and clinically led. Our 33,000 members worldwide, including 1,200 in Wales, work in hospitals and the community across 30 different medical specialties, diagnosing and treating millions of patients with a huge range of medical conditions.

Amdanom ni

Mae Coleg Brenhinol y Meddygon yn amcanu at wella gofal cleifion a lleihau salwch, yn y DU ac yn fyd-eang. Rydym yn sefydliad sy'n canolbwyntio ar y claf ac sy'n cael ei arwain yn glinigol. Mae ein 33,000 o aelodau o gwmpas y byd, gan gynnwys 1,200 yng Nghymru, yn gweithio mewn ysbytai a chymunedau mewn 30 o wahanol feysydd meddygol arbenigol, gan ddiagnosio a thrin miliynau o gleifion sydd ag amrywiaeth enfawr o gyflyrau meddygol.

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20 April 2017

Evaluation of health and care winter resilience 2016/17

Thank you for the opportunity to respond to your consultation on the evaluation of health and care winter resilience 2016/17. The Royal College of Physicians (RCP) has worked with consultants, trainee doctors and members of our patient carer network in Wales to produce this feedback, and we would be happy to organise further written or oral evidence if that would be helpful.

Key recommendations

What should be considered the top three priorities for next winter?

1. Clinically-led, whole system forward planning
   Clinically-led, appropriately funded winter care planning should be started as early as possible every year. This should take a whole system approach to planning surge capacity, bringing in colleagues from across medicine, surgery, social care and specialist services: winter planning must be the responsibility of *everyone* working in the NHS and social care. Innovative, patient-centred solutions should be encouraged; job planning should recognise that acute clinical input should concentrate on delivering scheduled services and research in the spring and summer, with a renewed focus on acute unscheduled care in the winter months. There are also several targeted system interventions that would help: for example, addressing RTT deadlines earlier in the year and enforcing an all-Wales patient repatriation policy.

2. Increased resources and staff capacity
   The NHS workforce is now at breaking point and the recruitment crisis in medicine is getting worse – last year, we were unable to fill 40% of consultant physician vacancies in Wales and there are major trainee rota gaps in every hospital in Wales. The NHS must focus on providing enough medical beds, supported by a safe and consistent level of staffing across medicine, nursing, the therapies, and allied and support services, including phlebotomy. The Welsh Government and NHS Wales must develop an enforced all-Wales locum strategy which includes maximum fees for doctors.

3. Social services and integrated care
   Social care must be an integral and forward thinking partner in winter care planning. Improved collaborative team working across health and social care should break down boundaries, with

social services proactively encouraged to speed up the transfer of care out of hospital. This will require extra resource for social care teams across Wales, especially for those based in hospitals and working on the front line of the winter care crisis.

Our response

What is your experience of how resilient the whole system has been when providing care during the winter months?

The changing patient demographic

Our members told us that while there is indeed a peak in the number of medical emergencies over the winter period, they do not see a *huge* spike in numbers. However, the patient illnesses at this time of year are often more serious, particularly in respiratory medicine. Our members told us that they also saw an increase in emergency surgery due to the aging population this year. Figures from one major teaching hospital in south Wales show that there has been a steady increase in the number of patients over 65 admitted to hospital over recent years. An average of 10 more older patients are admitted every week in winter compared with summer – and these patients tend to stay in hospital longer.

Missed deadlines and poor project management

While several of our fellows and members in Wales reported an improvement in whole system working this winter, we also found that some key projects, funded by the Intermediate Care Fund, were not in place in time for the winter months, due to long lead times for appointing hospital-based social workers. This could have made a huge difference to patient care and delayed transfers.

> *'The whole system was severely challenged. Due almost entirely to the lack of outflow, unscheduled care was under huge pressure and scheduled surgery was severely curtailed.'*
>
> Consultant physician in diabetes and general medicine, NHS Wales

Finance and staffing

Our members told us that they did not receive enough financial resource to cope with the demands of winter this year, and those areas which were not funded coped worst – for example, bringing in extra senior decision-makers for medical outliers in surgical wards. Capacity was a significant issue and the numbers of outliers in surgical wards was high – often doubling the numbers of patients a medical team needed to care for. Length of stay for medical patients on surgical wards is far longer than for those on medical wards particularly for rehabilitation or complex care planning needs.

> *'Throughout the winter and most of the time we are under-resourced. The system is not resilient. However, there were considerable efforts to draw up contingency plans for the Christmas period and indeed other bank holiday periods. There are some very hardworking people (managerial and clinical) trying to make the system work for patients and staff, but the impact they can make is limited if the overall strategy is flawed.'*
>
> Consultant physician in geriatric and general medicine, NHS Wales

Staffing was also highlighted as a major problem, especially in nursing, which had an impact on the effectiveness of many initiatives. One member observed that even where extra funds were available, the health board was frequently unable to recruit both extra nursing and medical staff. This has a knock on effect on staff wellbeing and sickness rates at a time of year when flu, stomach bugs and other illnesses are far more common. We were told that in one hospital, the decision was taken to open extra beds without adequate staffing, a move which was reported as a patient safety risk via the safe haven system, and later closed down after a review.

It is also worth remembering that reduced staffing capacity has a major negative effect on the ability of senior doctors to teach and train the next generation of doctors. This in turn affects recruitment into trainee posts and junior doctor positions, and exacerbates the wider workforce crisis.

> *'The quality of those we could recruit to winter pressure posts was extremely variable. The acuity and volume of patient seen in winter months is always much more intense, and requires huge efforts by the nursing and medical teams.'*
>
> Consultant physician in endocrinology and general medicine, NHS Wales

One member suggested that an all-Wales policy on locum fees should be developed, arguing that the cost of employing locum nurses and doctors is exorbitant, and has a detrimental effect on the money available to the wider NHS.

Lack of wider corporate ownership of the winter pressures challenge

One member felt that there was a lack of wider corporate buy-in to winter resilience. He noted that surgical and specialist services are not currently included in winter planning processes, despite scheduled workload decreasing (because beds are taken up by medical inpatients and elective care is then cancelled due to a lack of beds). He argued that health boards should plan more strategically to redistribute nurses and doctors to support unscheduled care and increased winter admissions.

Competing service priorities

Fellows and members also told us that they would welcome a refreshed look at some of the service delivery deadlines. For example, hospitals are expected to achieve referral to treatment times (RTT) and GPs are asked to hit their Quality Outcomes Framework (QOF) targets at exactly the time when the NHS is struggling with winter pressures. This severely affects system resilience, and pulls health professionals in several directions at once. We recognise that the cabinet secretary has temporarily suspended most QOF requirements for practices in order to free up capacity to deal with winter pressures, but this deadline should be changed in the longer term.

> *'It is difficult for the system to focus on the front door as well as discharging patients when other priorities are around at the same time.'*
>
> Consultant physician in gastroenterology and general medicine, NHS Wales

To what extent were you engaged in the planning process for winter 2016/17?

There was an extremely mixed response to this question, suggesting that there is no overall strategic approach across health boards to involving clinicians in the planning process. Some members, especially those in management positions, told us that they had been heavily involved in the planning process.

> *'We have benefited greatly from clinical management-led winter planning. Preparation began in mid-summer, and was informed by experience in the previous year … many clinicians fed in to the process.'*
>
> Consultant physician in endocrinology and general medicine, NHS Wales

Others were much less positive:

> *'There was no meaningful clinical input requested regarding plans and little has happened regarding concerns about bed and staffing.'*
>
> Consultant physician in geriatric and general medicine, NHS Wales

Have local initiatives introduced as part of the winter plans been visible to you? What is your view/ experience of how successful they have been in improving service delivery to patients?

There was a general feeling among members that while local initiatives had been put in place in most areas, they were often either too late to make a difference, or could not cope with the pressures placed on them. These initiatives included an increased social work presence in hospital, a community response team, a dedicated pathway for minor injuries, and more nursing home places in the community.

What is your view on whether lessons have been learned from previous winters when considering delivery over winter 2016/17?

Members felt that while in many cases lessons have been learned, not all of these have been responded to in a timely manner. One member highlighted particular issues with significant nursing shortages which have been exacerbated by GP cluster recruitment from secondary care into primary care. Without sufficient numbers of nurses, hospitals are unable to open extra surge beds during particularly busy time periods.

Do you feel that local organisations are taking a whole system view when developing service enhancements for winter?

There was firm support for increased cooperation between social care and the NHS. While one member noted that their local authority had greatly improved their response this winter, supported by money from the Intermediate Care Fund, the most important interventions simply did not happen in time to make a concerted difference to outcomes.

To what extent did the additional planned actions support delivery of a standard of care you would expect to provide to patients?

> *'The problem was not the standard of care, it was inadequate capacity.'*
>
> Consultant physician in diabetes and general medicine, NHS Wales

Again, members reiterated the importance of joining up demand with service delivery deadlines. Meeting referral to treatment (RTT) targets before the winter begins would free up clinicians to treat patients at the front door over the busiest months. However, this means releasing RTT money before the winter begins.

What are your views on whether there was sufficient capacity available to support delivery of timely and quality care to patients over the Christmas period?

There was general agreement that there was not sufficient capacity available to support the delivery of timely and quality care to patients over the Christmas period.

> *'[It] fell short of ensuring a high standard of care. While efforts were made by the clinical staff to ensure good care, it fell short because of difficult circumstances. Patient experience (and that of their significant others) was significantly affected negatively (long waits in A&E and staying there for long periods before moving to a ward). I do not feel that there are enough beds for medical patients and yet [my health board] is still pursuing a policy of bed reduction (on the back of significant reductions … in the community and acute sectors). However, the adequate staffing of beds is a difficult problem as well.'*
>
> Consultant in geriatric and general medicine, NHS Wales

To what extent do you think there was sufficient preparation for the post-Christmas period?

It is the post-Christmas period which needs the most coordinated and effective social services response. There was some recognition that this was better this year than in previous years, and that health boards prepared in some detail, but in the end, it was felt they didn't have the resources to offer an effective service. One member also observed that some patients are disadvantaged if they are admitted into a hospital outside of their local authority area as it can often more difficult to organise social care or rehabilitation support for these patients when they are medically fit to be transferred out of acute care.

Have you observed evidence of integrated working between health and social care staff either in hospital or in the community?

There was a mixed response to this question. Some members told us that while integrated working had improved on previous years, it was still not as effective as it should be, and often broke down over local authority and health board boundaries. Others told that they were actually unable to see any evidence of systematic integrated working between social care staff and hospital staff. All agreed that there was a major resource and capacity problem in social care.

> *'We have excellent engagement with our social care colleagues, which varies depending on the care organisation, but what can be achieved with the limited resources available is often frustrating. The process of moving people out of hospital once they are admitted is difficult – it can take two weeks to achieve social work allocation, another week to move cases forward, and another week to obtain funding or obtain a place in a residential or nursing home. A month can pass quite easily for a patient with complex discharge needs.'*
>
> Consultant physician in endocrinology and general medicine, NHS Wales

One member suggested that NHS Wales develop a more robust repatriation policy, especially for those hospitals providing super-specialised services. Patients are currently transferred to specialist centres from all parts of Wales, and the current repatriation policy does not work for patients or organisations – patient flow is currently severely affected by delays in getting patients home.

For more information

Please note that more information about our policy and research work in Wales can be found on our website. If you have any questions, please contact Lowri Jackson, RCP senior policy and public affairs adviser for Wales, at Lowri.Jackson@rcplondon.ac.uk.

Agenda Item 8.3

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Our Ref: JAP/GJ/ses Direct Line: 01633 435958 6 June 2017

Dr D Lloyd AM
Chair, Health, Social Care & Sport Committee
National Assembly for Wales
Cardiff Bay
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Dear Dr Lloyd

Re: HEALTH, SOCIAL CARE AND SPORT COMMITTEE INQUIRY INTO GP CLUSTERS

Further to your letter of 16th May, please find below responses with regard to the specific questions raised.

When are you notified by the Welsh Government of your CDM allocation for the financial year ahead?
The Health Board is usually advised of their initial funding allocation for the forthcoming financial year at the end of December, prior to the new financial year. Further details are notified in subsequent months. For example, the Health Board received a letter from Welsh Government on the 5th of April 2016 detailing that there was £1.880m funding available for Clusters for Aneurin Bevan University Health Board in 2016/17 and that this funding was recurrent.

At what point in the financial year is the CDM Funding provided to you by the Welsh Government?
The funding is usually provided to the Health Board within the overall financial allocation made to the Health Board at the beginning of the financial year.

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What is the process for you to release that funding to the individual clusters in your area?

On an annual basis the Board agrees and delegates a budget to Accountable Officers, which is then delegated in line with the Health Board's Standing Financial Instructions. In relation to Primary Care, the Board delegates resources via the Chief Executive to the Chief Operating Officer, who then delegates the agreed Primary Care allocation to the Divisional Director for Primary Care. Within Primary Care, individual budgets have been established for each of the Health Board's twelve Neighbourhood Care Networks (NCN) or Clusters. Funding for each NCN is based on a weighted population share of the overall budget available. These budgets have been set recurrently and the 2017/18 allocation from Welsh Government is the same as the 2016/17 allocation received.

What were your total CDM allocations for the financial years 2014-15, 2015-16, 2016-17, 2017-18?

The cluster funding commenced in 2015-16 - there was no allocation for 2014-15.

Year	Initial Allocation	Additional Allocation	Total Allocation	Spend	Variance
2015-16	£1,128,000	£268,000	£1,396,000	£1,335,000	-£61,000
2016-17	£1,880,000		£1,880,000	£1,925,000	£45,000
2017-18	£1,880,000		£1,880,000	£1,880,000	£0

What was the total CDM spend for the financial years 2014-15, 2015-16, 2016-17 (with an explanation of any variance between spend and allocation)

The table above details the actual expenditure in the financial years 2015-16 and 2016-17 and the forecast expenditure for 2017-18.

There was a small underspend of £61,000 in 2015-16 which relates to a proportion of an allocation of £268,000 received in the latter part of the financial year, which the Health Board was unable to fully spend due to the timing of the final allocation.

There was a small overspend of £45,000 in 2016-17 which was funded from within the Health Board's overall funding allocation.

The Health Board intends to utilise the 2017-18 allocation in full.

A breakdown of what the CDM was spent on, including central LHB support to clusters?

The table below provides a breakdown of expenditure against these budgets.

	2015/16 Actual £000	2016/17 Actual £000	2017/18 Forecast £000
Pay			
Pharmacist	249	673	880
Community Phlebotomy	-	140	140
Clinical Governance Nurse	30	53	0
Physiotherapist	16	41	113
Dietician	14	29	25
*Independent Contractors	3	28	36
Wound Care Nurse		4	5
Non-Recurrent Spend			
IT Equipment, Software & Subscriptions	458	362	1
Training & Workshops	232	115	32
Practice Based Social Workers	101	185	150
Medical Equipment		83	3
USW Counselling Service	50	28	
Bowel Screening	40		
Other (incl. Top Slice & GP Recruitment)	68	102	76
Older Person's Pathway	30		
PG Diploma in Diabetes	20		
Social Prescribing	13	35	43
Staying Healthy at Home / Care & Repair	11	25	
Staff Costs for Note Storage Prep		22	
Schemes to be worked up / agreed			376
Total Expenditure	1,335	1,925	1,880
RECURRENT ALLOCATION	1,128	1,880	1,880
Additional Funds from Welsh Government	268	-	-
Total Allocation	1,396	1,880	1,880

Only Independent Contractor costs (*), shown separately above, are central Local Health Board costs. Neighbourhood Care Networks determine how CDM budget is committed, in line with local priorities and aligned to Health Board plans.

The Health Board has however separately appointed and funded 12 Neighbourhood Care Network leads (one for each NCN). The costs of these Health Board leads are shown below. In addition to these there are a number of Partnership and Network staff who are funded by the Health Board.

Year	NCN Leads Salary Costs
2015-16	£290,000
2016-17	£308,000
2017-18	£308,000

On average, for the past three years, what percentage of the CDM funding was held centrally to fund salaries of posts based in clusters?

As mentioned above, only the Independent Contractors – comprising an optometrist, a dentist and a pharmacist – are funded centrally using the CDM. The detailed percentages can be seen below:

	2015/16 Actual £000	2016/17 Actual £000	2017/18 Forecast £000
Independent Contractors	3	28	36
Total Allocation	1,396	1,880	1,880
%	**0.21%**	**1.49%**	**1.91%**

If you require any further information, please do not hesitate to contact me.

Yours sincerely

Judith Paget

Judith Paget
Chief Executive/ Prif Weithredwr

Cynulliad Cenedlaethol Cymru
Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

National Assembly for Wales
Health, Social Care and Sport Committee

Vaughan Gething AM
Cabinet Secretary for Health, Well-being and Sport

7 June 2017

Dear Cabinet Secretary,

Inquiry into Winter Preparedness

Thank you for your letter of 25 January 2017, in response to the Health, Social Care and Sport Committee's report and recommendations on winter preparedness. In your response you agreed to provide follow-up information in relation to a number of recommendations and I am writing to request updates in these areas.

In your response to our recommendation that arrangements should be put in place to evaluate the effectiveness of all Welsh Government campaigns relating to winter health and the lessons learned published quickly (recommendation 3), you confirmed that arrangements were in place to evaluate the effectiveness of the Choose Well campaign over the last winter period. You also advised that social research would be undertaken via the Beaufort Omnibus and that this evaluation would be available in Spring 2017. I would be grateful if you could provide the Committee with an update on the findings of these two pieces of work and also details of how the learning from this evaluation will be taken forward and incorporated into future all-year planning, including the campaign for this winter.

You also agreed to provide details of progress against targets for the additional £50 million investment by the Welsh Government in winter pressures.

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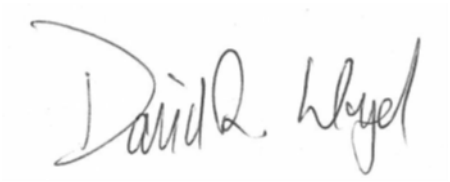
We also draw your attention to concerns recently expressed by the Royal College of Physicians and the Royal College of Emergency Medicine Wales. The RCP are concerned that health boards have not learned from past experience in respect of the winter preparedness for 2016-17. The RCEM have also provided information about winter pressures in Welsh Emergency Departments. In it they say that 'winter 2016-17 saw extreme pressures on services resulting in declining 4-hour standards, crowded departments and 'exit block', affecting the overall quality of care that patients received'.

It would be helpful if were able to provide this information by 5 July. I would also welcome your assurance that planning for this winter is well underway.

Yours sincerely,



Dr Dai Lloyd AM
Chair, Health, Social Care and Sport Committee

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University Health Board

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Our Ref: AH/DL/AM

Date: 7th June 2017

Private and Confidential
Dr David Lloyd AM
Chair, Health, Social Care and Sport Committee
National Assembly for Wales
Cardiff Bay
Cardiff
CF99 1NA

Dear Dr Lloyd

Health, Social Care and Sport Committee Inquiry into GP Clusters

Thank you for your letter dated 16th May 2017, in which you request information on Cluster Development Monies ("CDM"). I have listed below the Health, Social Care and Sport Committee's questions and associated ABMU Health Board responses for your convenience:

When are you notified by the Welsh Government of your CDM allocation for the financial year ahead?
The Health Board received notification of its General Medical Services allocation (which incorporates the CDM allocation) on 28 March 2017. In previous years, where the final details of the agreed allocation have not been able to be settled we have received notification of provisional allocations from Welsh Government in December and January.

At what point in the financial year is the CDM Funding provided to you by the Welsh Government?
CDM funding is included in the overall allocation from Welsh Government. As such, it is drawn down by Health Boards as part of the overall funding provided for the delivery of services.

What is the process for you to release that funding to the individual clusters in your area?
Over the period of operation of CDM, the Health Board has adopted the principles of "light touch" oversight. The Health Board views its role as one of support to the clusters. It assists each cluster in developing plans based on local evidence of need, and then supports the cluster in implementing those plans.

We notify each cluster lead of the expected allocation of funding (plus any unspent previous year allocation that we have rolled forward) in March / April each year. As such, there is no formal process for releasing funding; once the cluster has been notified of the total funding available to them for the period, they are free to commit expenditure against that funding immediately.

What were your total CDM allocations for the financial years 2014-15; 2015-16; 2016-17; 2017-18?

	2014-15	2015-16	2016-17	2017-18
ABMU cluster allocations	0	£1,045,185	£1,741,975	£1,741,975

What was the total CDM spend for the financial year 2014-15; 2015-16; 2016-17 (with an explanation of any variance between spend and allocation)?

	2014-15	2015-16	2016-17
ABMU cluster expenditure	0	£240,721	£1,637,579

Variance

	2014-15	2015-16	2016-17
ABMU cluster variance	0	£804,464	£104,406

The Health Board has recognised that the best interests of clusters are serviced by maximising the flexibility of expenditure plans. Rather than requiring clusters to utilise funding in each financial year - hence increasing the risk that short term expenditure strategies are pursued at the expense of a more planned and methodical approach - the Health Board has encouraged the carry forward of unspent allocations. Carry forwards are approved upon receipt of an agreed expenditure plan for utilisation in the following financial year.

A breakdown of what the CDM was spent on, including central LHB support to clusters.
The Health Board has not used any CDM for payment of central support to clusters. Whilst the Health Board has incurred significant additional costs for cluster support managers,

project managers etc., this is in addition to the allocations received from Welsh Government.

Key items from individual CDM expenditure plans over the last 12 months include:

- Cluster pharmacists - £462k
- Improvements to information and communications technology – £336k
- Initiatives to reduce likelihood of developing diabetes - £308k
- Targeted mental health support and counselling, cognitive behavioural therapy etc. - £266k
- General practice training and upskilling - £158k
- Increased capacity to support patients with chronic health conditions - £64k
- Young people and early years support - £48k
- Clinical equipment - £46k
- Improving home environments - £45k
- Increasing rates of vaccination and immunisation - £45k
- A range of small schemes to tackle needs identified by individual clusters e.g. sustainability issues, reductions in antibiotic prescribing, premises issues etc. - £280k

On average, for the past three years, what percentage of the CDM funding was held centrally to fund salaries of posts based in the clusters?
No expenditure has been held centrally to fund salaries of posts based in clusters. Where clusters have agreed that they wish to spend their allocations on employing staff, then as a convenience, staff will be employed by the Health Board and pay them through central payroll systems. In the last year, this totalled £460k.

I hope the information provided has answered your enquiries. If I can be of further assistance, please do not hesitate to contact me.

Yours sincerely

Alexandra Howells

ALEXANDRA HOWELLS
INTERIM CHIEF EXECUTIVE