Agenda – Health, Social Care and Sport Committee

Meeting Venue:
Committee Room 3 – Senedd
Meeting date: Thursday, 29 June 2017
Members pre-meeting: 09.15
Meeting time: 09.45

For further information contact:
Sian Thomas
Committee Clerk
0300 200 6291
SeneddHealth@assembly.wales

Informal pre-meeting (09.15 – 09.45)

1 Introductions, apologies, substitutions and declarations of interest

2 Scrutiny of the Welsh Government budget 2017-18 – in-year financial scrutiny – Cabinet Secretary for Health, Well-being and Sport and the Minister for Social Services and Public Health

(09.45 – 11.30) (Pages 1 – 66)

Vaughan Gething AM, Cabinet Secretary for Health, Well-being and Sport
Rebecca Evans AM, Minister for Social Services and Public Health
Andrew Goodall, Director General, Health
Alan Brace, Finance Director, Health
Albert Heaney, Director, Social Services and Integration

3 Paper(s) to note

Inquiry into loneliness and isolation – additional information from the Welsh NHS Confederation

(Pages 67 – 106)

Letter from the Finance Committee regarding the Scrutiny of the draft Budget

(Pages 107 – 108)

Inquiry into primary care - additional information from the Cabinet Secretary for Health, Well-being and Sport

(Pages 109 - 110)

4 Motion under Standing Order 17.42 to resolve to exclude the public from the remainder of the meeting and from the meetings on 5 July and 13 July

- On 5 July, for consideration of the Committee's forward work programme.
- On 13 July, for consideration of the Committee's draft report on primary care.

5 Scrutiny of the Welsh Government budget 2017-18 - in-year financial scrutiny - consideration of evidence

(11.30 - 11.45)

Agenda Item 2

Document is Restricted

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

Rebecca Evans AM
Minister for Social Services and Public Health

3 May 2017

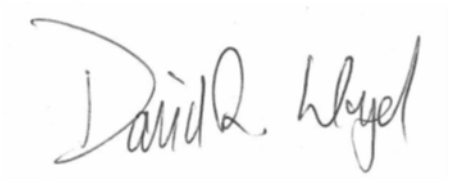
In-Year scrutiny of Welsh Government Budget 2016-17 and 2017-18

Dear Cabinet Secretary and Minister

Thank you for agreeing to attend the Health, Social Care and Sport Committee's meeting between 9.30 and 11.30am on the morning of Thursday 29 June 2017 for an in-year scrutiny session on the Health, Social Care and Sport budget.

In advance of the session, the Committee would be particularly grateful to receive further financial information on the matters highlighted in the annex. It would be helpful if you could provide the Committee with a bilingual paper by 14 June 2017 in relation to these matters.

Yours sincerely,



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

Cynulliad Cenedlaethol Cymru
Bae Caerdydd, Caerdydd, CF99 1NA
Seneddlechyd@cynulliad.cymru
www.cynulliad.cymru/Seneddlechyd
0300 200 6565

National Assembly for Wales
Cardiff Bay, Cardiff, CF99 1NA
SeneddHealth@assembly.wales
www.assembly.wales/SeneddHealth
0300 200 6565

Annexe: 2017-18 budget scrutiny

The budget scrutiny session on 17 November 2016 was the first annual budget scrutiny session of the new Assembly. Our correspondence at the time noted that our discussions had been fairly wide ranging but high level and represented the baseline for the whole of the Fifth Assembly. We outlined at the time that there would be many issues that we would want to return to in more detail. This session represents part of that ongoing scrutiny process.

We also highlighted at the time that the Committee is keen to focus its attention on both outputs and outcomes, and how these demonstrate value for money. As such, we will continue to focus attention on both the financial choices you make and the outcomes you expect to receive as a result.

The Committee would particularly like to receive information on the following issues:

1 Additional funding and service transformation

The most substantial change in the 2016-17 and 2017-18 budget for health and social care was the additional investment of £200m and respectively £240m to support the NHS in Wales. In your letter of 30 November 2016 to the Committee regarding the draft budget, you outlined that:

> *The first call on this funding will, inevitably, be to enable NHS organisations to meet normal cost growth,[…]*
>
> *[…]In addition, we intend to use some of this funding to push further with our aim to provide more care closer to home. We are considering options on how best to incentivise further progress on this, and further details will be provided to the Committee on this in due course.*

Can you provide an update on:

- What specific outcomes the additional investment in 2016-17 has delivered in terms of reform, service improvements and levering service change;

- What outcomes you now expect for the additional investment in 2017-18 and how these outcomes will be measured;
- The extent to which the additional funding has been deployed to sustain existing NHS Wales services;
- How the Welsh Government's investment is ensuring the development of a workforce able to meet future health and care needs;
- How funding allocations reflect the Welsh Government's aim of moving services from the hospital to the community;
- A breakdown of how the £50m additional funding for winter pressures was allocated, and what outcomes were secured;
- Evidence of how the Welsh Government is monitoring activity to ensure delivery of meaningful reform to services and positive outcomes to patients;
- Details of the specific outputs and outcomes achieved through Intermediate Care Funding in 2016-17 and what you expect to be achieved through the continuing investment in 2017-18.

2 Performance and efficiency

The Committee would welcome information on:

- The key 2016-17 efficiency and performance targets in the health sector, how NHS Wales has performed against these targets and how funding is being used to address any areas of concern;
- How the £30 million 2016-17 allocation for older people and mental health, and the primary care, delivery plan, health technology funding has been deployed and the outcomes for this investment.

3 Financial planning and the financial position of LHBs

This issue does continue to cause some concern to the Committee. We noted during the budget scrutiny process the allocation of an additional £68 million revenue to the Health Social Care and Sport Department to address the forecasted overspends for 2016-17 by Betsi Cadwaladr and Hywel Dda University Health

Boards; in addition, both Abertawe Bro Morgannwg and Cardiff and the Vale UHBs have significant projected 2016-17 end of year deficits.

The Committee would welcome information on:

- Your view on the likely end of year position that these UHBs can achieve in 2016-17;
- Whether you have concerns about 2017-18 and LHBs longer-term financial position;
- Whether you remain confident that the overall Main Expenditure Group for 2016-17 will balance.

We believe the three-year planning horizon set out in the NHS Finance (Wales) Act 2014 has been a useful tool for LHBs in terms of linking strategic and financial planning. We are, however, concerned that:

- A number of organisations are still operating on the basis of a one-year Integrated Medium Term Plan (IMTP) because you 'felt unable' to approve their three-year plans;
- The existing three-year framework for IMTPs is coming to an end and there is a need for clarity on the next stage in relation to how financial planning and management will be delivered in NHS Wales.

We are keen to hear your views on these issues.

4 Prevention

The Committee would welcome information on:

- The evidence available about the impact of the preventative spend on demands on NHS services;
- How funding changes in local government budgets, and in particular social services, have impacted on both social care and healthcare particularly in light of the recognition that local government social services are a key factor in reducing demand for NHS services.

5 Financial position of Local Government and social care

Additional funding was provided for social services in 2017-18, totalling £55 million, including £10m to help meet workforce cost pressures which was in the final 2017-18 budget settlement and £20 million announced on 27 March 2017. The Committee would welcome your thoughts on the extent to which this will help the sector to meet workforce pressures and increasing demand for services.

In relation to 2016-17, the extent to which changes in local authority budgets have impacted on social services expenditure and social services performance measures.

Whether there is any indication that the Social Services and Wellbeing (Wales) Act 2014, which has now been in force for a full year, is having an impact on social services spending.

6 Sport and physical activity

We note your evidence that the majority of the Welsh Government's work on sport is delivered through Sport Wales which, as a result, receives a "vast amount" of the sport budget. We would be interested to hear from you on:

- For 2017-18, the budget allocations within your portfolio for sport and physical activity; the outcomes you expect to be delivered for the investment; and the timeframe for the realisation of these outcomes.

7 Capital investment

The availability of capital funding is a key lever in terms of service transformation across the sector, and we know that there are a number of ambitious projects underway requiring significant capital investment. The Committee would welcome information on:

- The current position in terms of capital funding, including the availability of resources and what the process is for prioritisation;

- How the capital funding issues in primary care are being addressed, given the concerns about the primary care estate and the limited availability of capital funding;
- Innovative funding models being considered for raising capital funding for future capital schemes, including the use of NHS and primary care estate as levers in any projects.

8 Provision for legislation

The Committee would welcome information on:

- The extent and location of allocations to provide for legislation in the health and social services portfolio;
- The amounts and location in the budget of allocations for Welsh legislation that is (a) currently being passed in this Assembly or (b) planned in the legislative programme;
- The amounts allocated for implementation of the Social Services and Well-being (Wales) Act 2014 and the Regulation and Inspection of Social Care (Wales) Act 2016;
- Whether there are any plans to take forward the option, set out in the Green Paper 'Our Health, Our Health Service', to give to health boards capital borrowing powers to invest in capital projects.

Additional funding and service transformation

- **What specific outcomes the additional investment in 2016-17 has delivered in terms of reform, service improvements and levering service change.**
- **What outcomes you now expect for the additional investment in 2017-18 and how these outcomes will be measured.**

The 2017-18 Budget provided for additional investment of £240million revenue funding to recognise the cost and demand pressures facing the NHS in Wales which were outlined in the 2014 Nuffield Trust report, and more recent 2016 Health Foundation report – The path to Sustainability.

2017-18 Health Board discretionary allocations have been increased by £90 million to meet pay awards for NHS employees, the costs to NHS Wales of the UK Government's Apprenticeship Levy and other inflationary cost pressures. This equates to a 2% increase on the recurrent discretionary and ring fenced allocation. A further £20million has been set aside to meet inflationary costs on primary care contracts (including £12.7million to fund the uplift for GP pay and expenses for 2017-18) and centrally held NHS budgets.

Investment in general medical services will increase by approximately £27million in 2017-18. This includes the uplift for GP pay and expenses referred to above, and £14.3million new investment to fund new enhanced services covering care homes, warfarin management, diabetes and the delivery of secondary care initiated phlebotomy tests. The agreed changes to the GMS contract for 201718 provides a strong platform for GPs to continue to provide high quality, sustainable, healthcare in these challenging times.

Additionally, £20million has been allocated to health boards on the ring-fenced mental health allocation in line with the budget agreement with Plaid Cymru. This will support progress towards delivery of the *Together for Mental Health* delivery plan.

We have still to make decisions on the allocation of the balance of the additional NHS investment. It is our intention that it will be used to incentivise continued improvements in medium term planning, and will support local service transformation, moving care closer to home.

However, we will also need to consider ongoing financial risks still in the system, primarily in those four health boards in escalation. Consequently, we are not planning to make a full allocation of this funding at this stage, and will hold the funding back to ensure the NHS is in balance overall.

- **The extent to which the additional funding has been deployed to sustain existing NHS Wales services.**

As outlined above, £110 million of the additional £240 million revenue funding has been provided to meet normal inflationary cost growth to sustain existing

NHS services. This is in line with the Welsh Government commitment to recognise the cost and demand pressures facing the NHS in Wales as evidenced in the independent 2014 Nuffield Trust report, and more recent 2016 Health Foundation report – The path to Sustainability.

- **How the Welsh Government's investment is ensuring the development of a workforce able to meet future health and care needs.**
  Despite challenging financial settlements, we continue to invest in and develop the NHS and social care workforce in Wales to meet health and care needs now and in the future. Some examples include;
  - Our primary care fund of £42.6million
  - Continued investment in education and training for health professionals
  - £95million package to support education and training programmes
  - £8million social care workforce development programme
  - £0.733million to fund a number of additional medical training places across Wales
  - An ongoing £1million available per year thereafter
  - Continuing social work bursaries and extending the NHS Bursary arrangements
  - Committed to delivering Health Education Wales by April 2018
  - £19 million to assist the sector in implementing the National Living Wage

  We have requested the timescales for decisions made about both medical and dental training places and non medical training places are brought together. The 2018-19 process is currently underway.

- **How funding allocations reflect the Welsh Government's aim of moving services from the hospital to the community.**
  To support a healthier Wales and to ensure sustainable health services, the Welsh Government's aim is to move the health system away from a focus on illness and hospitals towards one focused on health improvement, with people having equity of access to the majority of the care they need to do what matters to them as close to home as possible, underpinned by an ethos of coproduction.

  The Budget for 2017-18 supports this strategic aim through a number of specific funding allocations, including the primary care fund, the integrated care fund, funding for the national delivery plans, the fund for efficiency through technology and funding for older people and mental health.

- **A breakdown of how the £50million additional funding for winter pressures was allocated, and what outcomes were secured.**
  The £50 million was distributed to health boards in Wales as detailed in the table below, to help maintain an improved performance trajectory over the winter period.

However, to ensure that the funding was only used to deliver performance improvements, £5.1million was clawed back from Abertawe Bro Morgannwg University Health Board at the year end as it did not deliver against its agreed plans.

	Fairshare split (£m)
ABMU	9.33
Aneurin Bevan	9.97
BCU	11.09
Cardiff and Vale	7.50
Cwm Taf	5.80
Hywel Dda	6.31
All Wales	**50.00**

Over the winter period, RTT performance was generally better than it was the previous year, with the end of March 2017 26-week performance at 88% which is 1.2 percentage points higher than March 2016; 36-week numbers were 28% lower than March 2016 and the best they had been since March 2014; diagnostic eight-week waits were the lowest they have been for six years; cancer 62-day performance was the best it had been since November 2014.

In addition, whilst unscheduled care performance was not where we would want it to be, four-hour performance over the winter period was generally better than it had been the previous winter.

Ambulance performance against the red eight minute target has been better each month compared to the same month last year and has been consistently above 70%.

On postponed procedures, postponements on the day or day before, were 564 (4%) fewer over this winter than the previous winter, with those postponed due to a lack of a bed, either on the day or day before, 965 (38%) lower.

- **Evidence of how the Welsh Government is monitoring activity to ensure delivery of meaningful reform to services and positive outcomes to patients.**
  The annual delivery requirements for the NHS are captured within the NHS outcome and delivery framework. The framework is split across seven domains which identify the priority areas that patients, clinicians and stakeholders wanted the NHS to be measured against. The seven domains are:
  - Staying healthy
  - Safe care

- Effective care
- Dignified care
- Timely care
- Individual care
- Our staff and resources

The NHS Wales Delivery Framework measures the NHS throughout the year on the delivery of services and process that contribute towards a set of agreed national outcomes.

- **Details of the specific outputs and outcomes achieved through Intermediate Care Funding in 2016-17 and what you expect to be achieved through the continuing investment in 2017-18.**
The Intermediate Care Fund (ICF) was established in 2014-15 to drive partnership working through the delivery of integrated and innovative services across health, social services, housing and the third sector. It has since been renamed the Integrated Care Fund to better reflect its purpose.

In 2016-17, £50million revenue and £10million capital was made available. Regional partnership boards, established under Part 9 of the Social Services and Well-being (Wales) Act 2014, have oversight and are responsible for ensuring the effective use and delivery of ICF.

The ICF has been used to establish a range of different models of care and support which have reduced pressure on the hospital system, including reduction in unnecessary hospital admissions, inappropriate admissions to residential care, and delayed hospital discharge. These include:

- Single Point of Access services
- housing adaptations to help prevent falls and enable people to remain in their own homes
- Step Up/Step down community rehabilitation beds
- Dementia friendly communities and
- Grants to third sector organisations to help reduce social isolation for older people and improve provision and access to community services. These services have resulted in additional capacity and helped maintain focus on keeping Delayed Transfer of Care (DToC) figures in Wales beneath 400.

During the last financial year a £15million element of the ICF was allocated to support the requirements in the 2014 Act to provide preventative services including preventing the development of care and support needs. Additionally, elements of the ICF have been specifically allocated to support implementation of:

- the **Integrated Autism Service for Wales** - a consistent approach for providing care and support for people with autism across Wales and

- The **Welsh Community Care Information System** – which enables greater integration between health and social care teams by providing for a shared record of care.

Expectations for 2017-18
The Programme for Government includes a commitment to retain this important fund and £60million in total has again been set aside this financial year.

The rebranded *Integrated* Care Fund will more explicitly be a key delivery mechanism for the Social Services and Well-being (Wales) Act. The objectives of the ICF are therefore linked to regional partnership boards priority areas of integration:

- Older people with complex needs and long term conditions, including dementia
- People with learning disabilities
- Children with complex needs due to disability or illness and
- (for the first time) Carers, including young carers.

Performance and efficiency

- **The key 2016-17 efficiency and performance targets in the health sector, how NHS Wales has performed against these targets and how funding is being used to address any areas of concern.**

In 2016-17, there has been a national refocus on driving improved efficiency through the establishment of a national Efficiency Board chaired by the Chief Executive of NHS Wales.

Within the enhanced nationally-led approach on efficiency and value, through the Efficiency Board, there are a number of programmes and themes being taken forward under two distinct themes;

- An Efficiency and Productivity Framework and Efficiency Targets for 2017 have been signed off and issued to LHBs and NHS Trusts for incorporation into the March submissions of the 2017-18 IMTPs and Annual Plans.
- During 2017-18 the Efficiency Group's programme of work, that will then be taken forward by individual NHS organisations and the All Wales Executive and Professional groups will include the following:

- Clinical variation led by Medical Directors
- Medicines management led by Chief Pharmacists Optimal nurse rostering led by Nurse Directors
- Digital and IT enabled efficiencies led by NIMB.

This national focus has also re-identified priority areas for health boards to demonstrate improvement to support their delivery of national performance targets such as referral to treatment and unscheduled care targets. While additional monies were provided to support the improved delivery against these targets, delivery of efficiency is required to build more sustainable service change going forward.

This work on sustainability has also been supported by the respective national programmes providing additional efficiency and improvement areas. Examples include:

- The national planned care Board has highlighted and monitors a list of procedures of limited effectiveness across the four delivery areas
- Development of alternative pathway management to reduce both new and outpatient demand across the planned care programme areas
- Through the national outpatient programme "Did not attend" DNA rates have been prioritised to improve capacity - significant improvements have been seen across a number of health boards
- The unscheduled care programme has challenged on emergency lengths of stay through a national focus on discharge processes such as improving the number of discharges before 11am. And improved use of community beds
- Through a theatre national group a new focus on national measures has commenced and there have been two national events sharing good practice and service improvements.

As part of the planning process for 2017-18 IMTPs each health board received a targeted efficiency report to highlight their areas for their additional focus and planning as part of their IMTP submissions. Progress against these plans will be monitored in year.

End of year position – March 2017

RTT

At the end of March 2017:

- 26-week performance was 88.0%, an improvement of 1.2 percentage points compared to March 2016. This is the best performance since March 2014
- There were 12,354 people waiting over 36 weeks, an improvement of 4,836 (28%) compared to March 2016. This is the lowest number since March 2014.

Diagnostics

At the end of March 2017:

- There were 4,741 people waiting over eight weeks for one of the specified diagnostic tests. This is 4,061 (46%) lower than March 2016. This is the lowest number waiting over eight weeks since March 2011.

Therapy Services

At the end of March 2017:

- There were 2,477 people waiting over 14 weeks for therapy services. This is 94 (4%) lower than March 2016.

A&E
During March 2017:

- 4 hour performance was 80.9% against the 95% target. This is 4.4 percentage points higher than March 2016
- The number of 12-hour waits was 3,206. This is 1,187 (27%) lower than March 2016.

Ambulance
During March 2017:

- 77.9% of red calls received a response within eight minutes. This is 12.2 percentage points higher than March 2016
- 56.3% of people were handed over from ambulance staff to A&E staff within 15 minutes. This is 10.3 percentage points higher than March 2016
- 1,924 people waited over an hour to be handed over from ambulance staff into the care of A&E staff. This is 1,610 (46%) lower than March 2016.

Cancer – 62 day During
March 2017:

- 62-day performance was 89.3%. This is 3.6 percentage points higher than March 2016.

Delayed Transfers of Care During
March 2017:

- There were 389 delayed transfers of care for both mental health and nonmental health reasons. This is 135 (26%) lower than March 2016.

Stroke

- In March 2017, 45.4% of people had a direct admission to a stroke unit in less than four hours across Wales. This is an improvement of 7.2 percentage points compared to March 2016
- In March 2017, 95.3% of people received a CT scan in less than 12 hours across Wales. This is the same as March 2016
- In March 2017, 85.2% of people were assessed by a stroke nurse in less than 24 hours across Wales. This is an improvement of 10.4 percentage points compared to March 2016
- In March 2017, 27.3% of people were thrombolysed door to needle within 45 minutes across Wales. This is a deterioration of 14.8 percentage points compared to March 2016.

How the £30 million 2016-17 allocation for older people and mental health, and the primary care, delivery plan, health technology funding has been deployed and the outcomes for this investment.

Older people and mental health £30million budget

This funding is being utilised in priority areas that have been highlighted within the Programme for Government and associated strategies including the *Together for Mental Health* delivery plan.

The areas of focus in 2016/17 have included:

- The creation of hospital-based flexible resource teams to improve patient experience by reducing the use of agency staff on general wards, improving liaison between the emergency departments and psychiatric liaison and between mental and physical health staff.
- Additional sessions at memory clinics which aim to reduce waiting times for an initial assessment for a dementia diagnosis. By December 2016, around 700 sessions had been provided – we are currently seeking an update from health boards on progress to the end of March 2017.
- Improving access to evidence-based psychological services through the provision of additional capacity for services. We have previously committed to report on a 26-week referral to treatment target in secondary specialist mental health services and it is intended to introduce this reporting structure by year end. In the meantime, health boards are being asked to work towards achieving this target – management information indicates progress is being made.
- Additional investment in local primary mental health support services (LPMHSS) to further support delivery of mental health services under the Measure has also showed improvements on an all-Wales basis. December 2016 (published stats Wales data) showed 85.7% of assessments were undertaken within 28 days from the date the referral was received and 77.1% of therapeutic interventions were started within 28 days following an LPMHSS assessment. From the information provided by LHBs in their end of year performance discussions with us, they are confident that the 80% target for assessment and interventions will have been exceeded on an all-Wales basis. This compares favourably to the position in March 2016 where neither the 80% target for assessment or intervention was achieved on an all-Wales basis.
- Development of transition / recovery support workers within CAMHS which are based in early intervention psychosis teams, to promote active recovery by accessing social, educational and employment opportunities for young people with severe mental illnesses. Health boards have been encouraged to collaborate with third sector bodies to maximise the available funding, with all apart from two health boards having appointed staff by April 2017, with the remaining two anticipating having staff in post imminently.
- Provision of serious illness conversation training to provide basic communication skills to health care staff that confront all aspects of

serious illness and care for dying patients as part of their day to day work but who are not trained or working in specialist palliative care.

Work is ongoing in relation to further developing services that will support the dementia strategy (when published), projects directly supporting *Taking Wales Forward* priorities (including social prescribing, well-being bond, CAMHS school liaison and loneliness and isolation) and further supporting the workforce.

Primary Care Fund
This Fund provides recurrent funding of £42.6million to support health boards' plans. The three priorities for this funding are to help achieve service sustainability, improve access and to deliver more services in the community.

The Fund met the cost of the national professional lead for primary care and a small number of central initiatives such as Public Health Wales' primary care innovation and development hub and expanding occupational health services to GPs.

The majority of the Fund was allocated to health boards. £26.081million was allocated to health boards for their primary care plans set out in their integrated medium term or annual plans.

Examples of how this funding has been used in 20161-7 and outcomes include:

- **In Abertawe Bro Morgannwg University Health Board** investment has been made in increased capacity, such as respiratory physiotherapists and to upscale and enhance its existing community based pulmonary rehabilitation services.
- The health board reported in March 2017 that service delivery has moved out of hospital with classes operating in each of the 11 clusters.
- The health board has reported that waiting lists significantly reduced – previously 12-18 months, now 2-5 months.
- **In Aneurin Bevan University Health Board** investment has been made in a model which supports patients to successfully self-manage their diabetes as far as practically possible, by supporting practices and community services to deliver care closer to home.
- The health board reported in March this year that between March 2016 and February 2017 there was a 14% reduction in new attendances at Aneurin Bevan University health board emergency department sites.
- **In Betsi Cadwaladr University Health Board** investment has been made in its primary care based audiology services.
- This new service model involves training and appointing advanced practice primary care audiologists whom people can access directly without seeking a referral from their GP.
- As a result of this investment people have access closer to home avoiding the need to travel to hospital.

£4.948million supported a national programme of innovative pathfinders and pacesetters to test new ways of planning, organising and delivering primary care. Examples of how this funding has been used in 2016 – 17 include:

- **In Cwm Taf**, *Your Medicines, Your Health Pathfinder* – the aim of this pacesetter is to generate and embed a cultural change with respect to the responsible use of medicines by patients and the wider public, educating and allowing patients to have greater ownership of their own care which will contribute to overall improved sustainability of services.
- **In Powys**, investment has been made in a pilot of a nurse triage model combined with enhanced multi-disciplinary team working to release GP capacity and ensure patients are seen by the most appropriate healthcare professional.
- As a result of this investment reported by the health board in March this year - 20.34% of all contacts (telephone and nurse triage) resulted in advice only; 8.68% of all contacts were provided with a routine GP appointment, this has continued to reduce since the December report (9.85%).
- A total of 4,852 GP appointments have been avoided for the accumulative period up to February 2017.
- Investment has been made in three Wet AMD pilots in Aneurin Bevan University Health Board, Hywel Dda University Health Board and Powys Teaching Health Board.
- These pilots have moved assessment and treatment services for Wet AMD out of hospitals and into local communities, where they are being delivered by optometrists and nurses, overseen by an ophthalmologist.

As a result of this investment:

- **In Aneurin Bevan:** in the last year, the total number of patients assessed 2254 and the total number of injections administered 2227.
- **In Hywel Dda**: in the last year, there were 554 Patient appointments made with 528 attendances (95%) and 285 treatments (Injections) showing a 51% treatment rate within a Community setting.
- **In Powys**: in the last year, there were 474 individual patient assessments completed with 259 treatments administered.

£10million was allocated for the primary care clusters to determine how to use this funding to implement their local solutions and priorities. Examples of how this funding has been used in 2016-17 and the outcomes include:

- **In Hywel Dda**: in one cluster 505 Stay Well Plans have been completed this year.
- In total since commencement of the cluster's frailty initiative in September 2015, 976 patients across the locality now have Stay Well Plans in place.
- **In Cardiff and Vale**: one cluster has in place a 12-month agreement with Cardiff MIND to support patients with low level mental health conditions - reports in March this year - 192 referrals made since mid December 2016.

- **In Aneurin Bevan**: one cluster has supported practice nurses to develop skills in wound management.
- The district nurses work alongside practice nurses to undertake a clinic within the surgery setting, whereby they will support the assessment and development of treatment plans for wound care patients.

Delivery Plan funding
£1 million has been allocated to each of the nine major health condition delivery plans (cancer, diabetes, respiratory health, liver disease, heart conditions, neurological conditions, critical care, stroke and end of life), and this funding is now contained within the local health board revenue allocations.

Each of the major health conditions has an implementation group which is responsible for the oversight and allocation of the £1million. This funding is used by the implementation groups to make progress in respect of achieving the objectives as set out in each major health condition delivery plan but also the yearly priorities identified by the implementation group.

In addition, £6.4million annually is allocated to health boards to support specialist palliative care services provided by hospices throughout Wales. This ensures there is a service available to give advice to those professionals caring for patients in their homes, in hospices and in hospitals across the country.

We have provided an additional one-off £1million this year to progress the End of Life Care objectives. The End of Life Care Board has provisionally identified that this funding will be used to pursue a compassionate community approach to end of life care, for telemedicine, to further roll out the serious illness conversations training to support the development of an all-Wales advanced care planning record, to take forward research priorities and to support GP clusters in Wales.

In support of the delivery of the Healthy Ageing Programme Age Cymru has been provided with funding of £241,950. This funding supports individual interventions that focus on Health Initiatives, Gwanwyn Festival of Arts and Creativity and Physical Activity Initiatives.

Health Technology funding
The Efficiency Through Technology (ETTF) programme is intended to accelerate the demonstration, evaluation and adoption of new products and services into practice, increasing efficiency and providing patients with better outcomes in accordance with the principles of prudent healthcare. The types of efficiencies typically expected through health technology funding projects include:

- Reduced hospital admissions (related to specific conditions)
- Reduction in travel (measured by time and cost)
- Reduction in use of prescribed products (drugs and consumables e.g. dressings)

- Reduced patient length of stay
- Improved patient experience (feedback)

The ETT fund supports health and care organisations to quickly evaluate promising technologies and to scale up their adoption to regional or national level. In addition to the £10million allocated to the fund by the Welsh Government in 2016-17, there was £4.2million in matched funding contributions from our projects. This match funding ratio is a conservative representation as it does not take into account the match in other resources (staff/building overheads) which is harder to quantify.

Financial planning and the financial position of LHBs

- **Your view on the likely end of year position that these UHBs can achieve in 2016-17.**
- **Whether you have concerns about 2017-18 and LHBs longer-term financial position.**
- **Whether you remain confident that the overall Main Expenditure Group for 2016-17 will balance.**

Local health boards have a statutory duty to balance their books over three financial years, in line with NHS Finance (Wales) Act 2014. The statutory accounts of the Local Health Boards and NHS Trusts in Wales for 2016-17 have now been audited and laid before the National Assembly. I made a written statement to members on 9th June detailing the outcome of this process.

We managed the 2016-17 deficits reported by the four health boards within the overall health budget, and as a consequence, we are confident that the Health, Well-being and Sport Main Expenditure Group budget for 2016-17 has balanced, and that this will be confirmed once the audit of the Welsh Government resources accounts is completed later in the summer.

We will be making a statement in due course on the assessment and approval of Integrated Medium Term Plans of Local Health Boards and NHS Trusts when this process has completed.

- **We believe the three-year planning horizon set out in the NHS Finance (Wales) Act 2014 has been a useful tool for LHBs in terms of linking strategic and financial planning. We are, however, concerned that: A number of organisations are still operating on the basis of a one-year Integrated Medium Term Plan (IMTP) because you 'felt unable' to approve their three-year plans.**

Since the first planning cycle commenced in 2014-15 when four organisations were approved we have seen a number of organisations mature and develop.

By 2016-17 six organisations achieved approval for their three-year IMTPs (Aneurin Bevan, Cwm Taf and Powys UHBs and Public Health Wales, Velindre and Welsh Ambulance Services NHS Trust).

Four organisations (Abertawe Bro Morgannwg (ABMU), Betsi Cadwaladr (BCU), Cardiff and Vale (C&V) and Hywel Dda (HD) University Health Boards were unable to submit three-year plans, that their Boards could approve, that were sustainable and financially balanced in line with the legislation. As their boards were unable to do this we could not approve their plans.

The removal of approval from two organisations is evidence of the competence and discipline that must be applied. It demonstrates the rigour of the process that maintains the standards and criteria in the assessment of plans.

ABMU and C&V had previously had approved IMTPs but, following robust scrutiny and assessment, the plans were found to be unsustainable and were not financially balanced. These organisations have not progressed in terms of the maturity of their financial and planning arrangements in line with those of other NHS organisations that have approved plans.

Following the failure to submit approvable plans and discussion at the tri-partite meeting with HIW and WAO, ABMU and C&V UHBs were escalated to 'Targeted Intervention', BCU remained in 'Special Measures'. To maintain increased scrutiny, and support these organisations going forward, these four organisations were required to provide officials with annual operating plans.

Annual operating plans provide us with an opportunity to work closely with organisations and to gain assurances on important areas of quality and performance. Linked to escalation arrangements, this is a mechanism to challenge and support organisations to improve and work towards being able to submit an approvable three-year plan in the future.

These arrangements also demonstrate that governance is in place to ensure organisational plans are in place and continue to develop when organisations fail to achieve an approvable three-year IMTP.

- **The existing three-year framework for IMTPs is coming to an end and there is a need for clarity on the next stage in relation to how financial planning and management will be delivered in NHS Wales.**

  The end of this first three-year cycle is an opportunity to take stock of the progress so far on integrated planning. We will be considering what learning we need to take from our evaluation and from any other external reviews. The NHS Planning Framework is reviewed and re-issued every year.

It is the mechanism for communicating key policy expectations and priorities, as well as more fundamental changes to planning, that we expect to see across the system.

The development of the Framework for 2018 to 2021 is about to begin and will take account of any learning and feedback from NHS organisations, and from the expected Wales Audit Office publication following their review of the "Implementation of the NHS Finances (Wales) Act 2014 (integrated Medium-term planning)". The NHS Planning Framework will be issued to the service in the autumn.

The Director General, and Health and Social Care Group Directors, meets monthly with organisations that are in escalation to monitor their plans and support organisations to work towards approving achieving an approvable threeyear plan in the future. As part of this we commissioned financial governance and other reviews of organisations in targeted intervention to establish a clear position and to understand the strategic and operational challenges facing organisations.

Prevention

The health benefits of prevention are intuitive. It is wiser to prevent a disease than to face its consequences at a more advanced stage. *Making a Difference: Investing in Sustainable Health and Well-being for the People of Wales,* sets out research evidence and expert opinion in support of preventing ill health and reducing inequalities.

The report was developed by Public Health Wales and £88.7 million in core funding has been allocated for 2017-18.

The funding allocation is not ring fenced for any particular activity to allow maximum flexibility in managing their resources to meet a wide range of priorities and commitments.

Obesity

Illnesses associated with overweight and obesity is estimated to cost the NHS in Wales over £86million. At current rates the cost to the NHS will increase to £465million per year by 2050 and the cost to society and the economy in Wales could reach £2.4billion[1]. The Welsh Government is taking a multi-faceted approach to tackling obesity, recognising the complex factors at play in influencing lifestyle behaviours.

[1] Source: Public Health Wales Report p.41. Additional figures relating to 2050 were extrapolated from the UK data by the Public Health Observatory p.8
http://www.wales.nhs.uk/sitesplus/documents/888/Making%20A%20Difference_Evidence%28E_web%29.pdf

Smoking
The National Institute for Clinical and Health Excellence suggest that smoking cessation is one of the most cost-effective healthcare interventions[2].

The majority of the expenditure on smoking cessation services is contained within Public Heath Wales' core funding allocation. Whilst it is difficult to attribute exact costs to smoking cessation work, in 2015-16 Public Health Wales' spend on NHS smoking cessation services was £1.856million and the Welsh Government spent £263,000 on smoking control and cessation. If the Welsh Government's aim of reducing adult smoking prevalence to 16% were achieved, this investment is likely to result in significant savings to Wales.

Workplace Health
Poor lifestyle choices impact on the individual, the NHS and the economy. Healthy Working Wales is one element of our broader approach to improve health and work.

The programme has been jointly funded by the Health and Economy departments, with £196,000 contributed by Health and £617,000 from Economy in 2016-17. Funding for the programme for a three year funding period (20172020) is currently under consideration.

Immunisation
We continue to respond to advice from the UK Joint Committee on Vaccination and Immunisation on national immunisation programmes. The funding for the majority of our well established programmes is now part of the health board allocations. It is estimated £1.35 would be returned for every £1 spent on targeted flu vaccination[3].

The children's flu vaccination programme (£3.7million in 2016/17) will be extended again this coming winter (approximately £700,000).

In addition to the planned extension in 2017-18, the Welsh Government has recently agreed accelerate the roll-out by add two school years in 2018-19 at an additional cost of £1.4million.

Screening
Population screening is an important preventative service, the majority of programmes are classed as secondary prevention, identifying conditions at an early and more easily treatable stage in supposedly healthy people and,

[2] Source: NICE costing report https://www.nice.org.uk/guidance/ph45/resources/costing-report-69105277
[3] Source: Public Health Wales Evidence Paper – Pg 85.
http://www.wales.nhs.uk/sitesplus/documents/888/Making%20A%20Difference_Evidence%28E_web%29.pdf

therefore, avoiding costly interventions and treatments at a more advanced stage and improving length and quality of life for those individuals.

Public Health Wales' funding is not ring-fenced for any single activity however we know through its Integrated Medium Term Plan that Screening Division has a budget of approximately £37million.

Targeted disease prevention
The National Exercise Referral Scheme is a Welsh Government funded scheme, delivered by Public Health Wales (£3.5million was transferred to Public Health Wales' core allocation in 2012-13). It has been developed to standardise exercise referral opportunities across all local authorities and local health boards in Wales. Examples include:

- **The Stroke Implementation Group** (SIG) provided £78,000 in 2016-17 and 2017/18 to support the 'Stop a Stroke, who cares wins' model in Cardiff and Vale University Health Board.
- The model involves working with primary care clusters to improve the recognition and management of Atrial Fibrillation (AF).
- **The Designed to Smile programme** has been in existence for a number of years.
- The programme costs £3.7million per year and around 91,000 children are taking part.

 How funding changes in local government budgets, and in particular social services, have impacted on both social care and healthcare particularly in light of the recognition that local government social services are a key factor in reducing demand for NHS services.
Core funding for local government is a matter for the Cabinet Secretary for Finance and Local Government. In 2017-18, the Welsh Government will be providing local authorities with £4.114billion of hypothecated revenue funding, through the local government settlement- an increase of £10million (0.2%) compared to 2016-17.

The local government settlement for 2017-18 includes £25million in recognition of the importance of strong local social services to the long-term success of the health service in Wales and in recognition of the growing pressures which social services face.

Local government social services are a key factor in reducing demand for NHS services
The Welsh Government has prioritised social care as a sector of national strategic importance and continues to invest directly in social care in order that we support the NHS and other public services in preventing more costly interventions in the longer term.

The Health Foundation report 2016 – The Path to Sustainability - highlights that adequately funded social care is critical to a sustainable health service.

Integration and collaborative working are key principles of the transformative Social Services and Well-being (Wales) Act. The legislative framework also promotes an early intervention and prevention approach. These principles are embedded in the continued investment in social care in the budget for 2017-18.

That Act provides for new regional partnership boards to deliver integrated care services that improve well-being outcomes. These new boards should also ensure the best use of resources and are required to pool funds, including in relation to the provision of adult care home places. In parallel to the new legal framework, the Integrated Care Fund (ICF) was established to provide regional boards with significant revenue and capital funding to support the development of new and innovative models of integrated working between social services, health, housing, third and independent sectors.

The fund has provided pump-priming money to build on existing good practice as well as developing new and innovative models of care and support. It is widely regarded to have driven transformational change in the development and delivery of services so they become more resilient. As a result, reports submitted by regions show the funding has been used to reduce pressure on the hospital system, including reduction in unnecessary hospital admissions, inappropriate admission to residential care and delayed transfers of care from hospital. Data for the April 2017 census period marks the fourth consecutive month during which the total has been below 400 - an unprecedented achievement over the 12 years of recording the DToC statistics.

Taking Wales Forward includes a commitment to retain this fund and funding of £60million has been set aside for 2017-18, inclusive of £10million of capital. ICF continues to support the requirement to provide or arrange preventative services contained in section 15 of the Social Services and Well-being (Wales) Act. ICF for 2017-18 will continue to focus on the following areas:

- Older People with complex needs and long term conditions, including dementia
- People with learning disabilities
- Children with complex needs due to disability or illness
- It will also include for the first time carers, including young carers

For example, during 2016-17 the regions delivered a number of different projects that successfully supported improvements to DToC figures that were bespoke to local circumstances:

- In West Wales, £235,000 was used to fund the Pembrokeshire Intermediate Voluntary Organisations Team (PIVOT). In January, over 1000 bed days had been reported saved and over 100 hospital admissions avoided by the third quarter of the year.

- In North Wales, £95,000 was utilised to establish a seven-day multi disciplinary discharge team in Gwynedd, seeking to avoid admissions to acute wards, triages, and signpost patients to community services. 297 patients were assessed by the multi-disciplinary team, and 119 (40%) were discharged home.
- In Cardiff and Vale, £727,000 was used to support an Accommodation Solutions project, including provision of Step Up/Step Down accommodation. Over 116 patients from the delayed transfer of care list used the service with 1,550 bed days avoided (saving of £426,250)
- Gwent utilised £150,000 to provide intermediate care beds to help facilitate hospital discharges. This has resulted in 40 admissions to Step Up/Step Down beds with an estimated 1928 bed days saved.
- In Western Bay, a specialised nursing team was funded to improve hospital admissions avoidance. The service resulted in 80 admissions being avoided.
- In Powys, £217,000 was used to support improved patient flow. This has resulted in a 20% reduction in delayed transfers of care from community hospitals with an estimated 176 beds saved.
- The Complex Discharge Team in Cwm Taf received £100,000 to support joined up services between primary care, secondary care, community care, social care and voluntary organisations. Nearly 300 people were supported by this scheme.

Performance measurement

New performance measures were introduced in 2016-17 as part of the performance measurement framework for local authorities in relation to their social services functions, as detailed in the code of practice in relation to measuring social services performance, issued under section 145 of the Social Services and Well-being (Wales) Act.

The performance measurement framework is intended to:

- Enable people to understand the quality of social services and to make informed decisions about their care and support
- Reinforce local authorities' strategic planning to enable targeted resources and improvement activity. Support local authorities to compare and benchmark their performance against others and learn and improve
- Evidence responsibility and accountability for local delivery to the Welsh Ministers and inform national policy development; and
- Support and inform the regulation, inspection audit and scrutiny regime.

The performance measures set out in the code of practice will replace all current performance measures for local authority social services and must be collected on the commencement of the Act. Local authorities are in the process of submitting 2016-17 data to Welsh Government, and this will be published in October 2017.

Local government settlement funding
In 2017-18, we will be providing local authorities with £4.114billion of hypothecated revenue funding, through the local government settlement - an increase of £10million (0.2%) compared to 2016-17.

The funding provided through the local government settlement is unhypothecated, meaning that authorities have the freedom and the responsibility to spend this funding according to their own individual needs and priorities.

The final settlement announcement for 2017-18 included a floor mechanism so no authority will see a reduction of more than 0.5% compared to 2017-18.

The funding provided by the Welsh Government through the annual settlement is the largest single component of local government financing but it is not the only one. Authorities receive funding through council tax, income from sales, fees and charges and from other government grants.

The local government settlement for 2017-18 includes £25million in recognition of the importance of strong local social services to the long-term success of the health service in Wales and in recognition of the growing pressures which social services face.

Local government settlement formula
The core revenue funding we provide to local authorities each year is distributed according to relative need, using a formula which takes account of a wealth of information on the demographic, physical, economic and social characteristics of authorities.

This funding formula has been developed in consultation with local government through the Distribution Sub Group (DSG); a technical working group whose members include senior local government officers from across Wales, the WLGA and independent experts to ensure fair treatment of the different factors.

In the interests of transparency, the detailed methodology is published in an annual *Green Book*. The formula is kept under a continual programme of review and improvement overseen by the DSG. The Group produces an annual report for consideration by the Finance Sub Group (FSG) of the Partnership Council for Wales.

In each of the four most recent years, a funding floor was implemented to ensure no authority suffered a disproportionate reduction compared to the other authorities. In the most recent two years, this floor was fully funded by the Welsh Government at a cost of over £4million.

In 2016, the Finance Sub Group agreed to implement a phased introduction of changes to the Personal Social Services elements of the settlement formula to recognise the cost of travel time within the social services sector. The first phase took place for the 2017-18 settlement, with the remaining phase due to take place for 2018-19 settlement.

£19million for social care workforce pressures

In addition to the local government settlement, a £10million Health and Social Care grant was announced at the time of the budget, subsequently increased to £19million in recognition of the particular financial challenges arising from care provision including workforce pressures.

Financial position of Local Government and Social Care

- **Additional funding was provided for social services in 2017-18, totalling £55 million, including £10m to help meet workforce cost pressures which was in the final 2017-18 budget settlement and £20 million announced on 27 March 2017. The Committee would welcome your thoughts on the extent to which this will help the sector to meet workforce pressures and increasing demand for services.**
- **In relation to 2016-17, the extent to which changes in local authority budgets have impacted on social services expenditure and social services performance measures.**
- **Whether there is any indication that the Social Services and Wellbeing (Wales) Act 2014, which has now been in force for a full year, is having an impact on social services spending.**

£20million extra recurrent funding has been made available from 2017-18 through consequential funding following the UK Government's March budget.

It will be invested in three key areas:

- £9million will increase funding already made available to manage workforce costs, and promote the stability of the social care market (this is in addition to the £10million previously announced).
- £8million will support work to prevent children from entering care and improve outcomes for those experiencing care
- £3million will be provided to local authorities to support respite for carers given the critical role they play.

This £20million funding takes additional investment in social care for 2017-18 to £55million.

As part of a wide-ranging review of the Social Services and Well-being (Wales) Act 2014 and evaluation of performance measure framework will be undertaken.

Discussions are already underway between officials and local authorities to understand how the measures are working in the early stages and can be improved. Findings will be available towards the end of this year.

We have always been clear about the importance of evaluating the impact of the Social Services and Well-being (Wales) Act 2014 to assess how well the Act has succeeded in its aim to improve the well-being of people who need care and support and carers who need support. This is a crucial and long-term piece of work which will be carried out in collaboration with a wide range of stakeholders and include:

- monitoring policies under the Act during the initial year of implementation to understand whether policy is being implemented as intended and to support policy improvement
- Undertaking an on-going evaluation through the national outcomes framework and the local authority performance measurement framework
- A one-off evaluation which will commence in the third year of the implementation of the Act.

Sport and physical activity

- **For 2017-18, the budget allocations within your portfolio for sport and physical activity; the outcomes you expect to be delivered for the investment; and the timeframe for the realisation of these outcomes.**

The total budget available for sport and physical activity in 2017-18 is £22.767million. This includes total grant-in-aid to Sport Wales of £22.515million including Revenue Funding of £21,313million and Capital of £423,000 to support the ongoing refurbishment of the National Centres.

Sport Wales' 2017-18 Remit Letter requires it to invest proactively to address the health, equalities and tackling poverty agendas.

In supporting the delivery of "*Taking Wales Forward*" Sport Wales should support young people from deprived areas and develop new opportunities for our poorest young people, people who are disabled and other under-represented groups.

Investments should provide programmes that engage people within communities who do not undertake sport and physical activity or do so below the activity levels recommended by the Chief Medical Officer.

Sport Wales will explore how new partners and innovative routes to engagement, can deliver a step change, piloting new programmes where appropriate.

Investments should also support the pathway for those already participating in sport and physical recreation, to encourage sustained regular participation and to identify and develop talent.

Sport Wales will continue work to develop a new approach to community sport and physical recreation.

Sport Wales is to commission an external review of its school sport programmes and both Free Swimming schemes and report to the Minister for Social Services and Public Health by autumn 2017.

The revenue funding also includes continued provision for delivering the Free Swimming Initiative (£3.75million).

The balance of £252,000 is allocated to support sport related projects such as:

Gemau Cymru	£55,000
Homeless World Cup	£5,000
Sports Facilities Review	£40,000
Special Olympics	£10,000
Armed Forces Free Swimming	£75,000

Capital investment

- **The current position in terms of capital funding, including the availability of resources and what the process is for prioritisation.**

The 2017-18 capital budget for Health, Well Being and Sport is £251.971million.

This includes £36.689million non recurrent funding from Welsh Government reserves to support specific investment in genomics (£1.5million) and the primary care estate (£5million), with the balance of the non recurrent funding being targeted at the maintenance of the estate and replacement equipment.

Investment in NHS infrastructure continues to be a key priority and the published budget shows we will be investing over £1billion of capital funding over the next four years. In terms of the availability of capital funding, the budget is supporting a number of significant projects over the coming period.

This includes the construction of the Specialist Critical Care Centre in Cwmbran, completing the redevelopment of Ysbyty Glan Clwyd and the modernisation and expansion of neonatal facilities at the University Hospital of Wales, Cardiff; Prince Charles Hospital, Merthyr Tydfil; and the Sub Regional Neonatal Intensive Care Centre in Bodelwyddan, North Wales.

Funding is also earmarked to take forward a number of other schemes across Wales as well as national programmes supporting developments in primary and community care, imaging and diagnostics, and ICT.

The forward investment programme is based upon phased priorities identified by NHS bodies through their Integrated Medium Term Plans, and these are also assessed in terms of fit with the NHS Wales investment criteria, namely health gain, revenue sustainability, performance and efficiency, clinical skills and sustainability.

- **How the capital funding issues in primary care are being addressed, given the concerns about the primary care estate and the limited availability of capital funding.**

The development of the primary and community estate is a key area of focus for NHS capital investment and is reflected in *Taking Wales Forward* through the commitment to develop a pipeline of integrated facilities across Wales.

These are intended to further drive the development of collaborative service models and facilitate local and immediate access to a range of public and third sector providers in one location.

We previously announced capital funding of £40million across the next four years to support the delivery of these facilities, and we will announce the first phase of investment in the autumn.

In addition, outside of this targeted funding, the current programme is also supporting a number of developments in primary care which are due to complete in this financial year.

These include facilities in Blaenau Ffestiniog, Flint, Bala, Criccieth, Aberdare, Phase 1 at Dewi Sant in Pontypridd, and Dyfed Road in Neath.

- **Innovative funding models being considered for raising capital funding for future capital schemes, including the use of NHS and primary care estate as levers in any projects.**

As part of our new capital borrowing powers originally set out under the Wales Act 2014, the Welsh Government has developed a programme of work to enable £1.5billion of additional investment to be made in social and economic infrastructure in Wales over the course of the next six years.

At the heart of this £1.5billion programme are three major capital projects to be delivered through a new form of public-private partnership, the Mutual Investment Model (MIM), which was launched in March 2017.

The new Velindre Cancer Centre, with an estimated capital value of £210million, is one of the cornerstone projects to be delivered using this funding mechanism.[4]

Our officials are currently exploring how the NHS can further link with local authorities and Registered Social Landlords (RSL) to deliver housing requirements as well as primary, community and social services.

We are expecting the final business case for the Cylch Caron scheme in Tregaron before the end of the year, which uses a blend of grant funding and RSL borrowing to bring health, social care and housing under one roof.

In terms of raising capital, it is not proposed that local health boards in Wales have borrowing powers.

There is an active programme of disposal of surplus land across NHS Wales and organisations are able to target reinvestment of sales proceeds into local infrastructure priorities.

The Welsh NHS has a good track record of working with other public sector bodies to examine opportunities to use existing land and facilities for the wider benefit of communities.

Collaboration is encouraged between NHS Wales and other public sector bodies to improve the management and utilisation of land and buildings.

This has been achieved through the establishment of an all Wales Public Sector Property Database (ePIMS).

Provision for legislation

- **The extent and location of allocations to provide for legislation in the health and social services portfolio.**

Legislation	Amount of Funding	Action
Human Transplantation (Wales) Act 2013	£0.2m	Delivery of Targeted NHS Services
	£0.2m	Delivery of Core NHS Services
Social Services & Well- Being (Wales) Act 2014	£0.2m	Social Services Strategy
	£2.8m	Local Government Funding (via RSG)

[4] In 2013-14 prices

Regulation & Inspection of Social Care (Wales) Act 2016	£1.8m	Sustainable Social Services

- **The amounts and location in the budget of allocations for Welsh legislation that is (a) currently being passed in this Assembly or (b) planned in the legislative programme.**
  For the 'Quality and Governance in health and care in Wales' White Paper, at this stage we do not envisage that the legislative proposals are likely to carry significant costs or savings since they are largely concerned with enabling and building on existing arrangements.

  However, the costs and savings are being considered as the policy work on the proposals develops. Initial discussions have been initiated and this is an area that will be further progressed once the outcome of the White Paper is known.

  Public Health (Wales) Bill
  The Bill was passed by the National Assembly on 16 May and, subject to Royal Assent, implementation costs will start to be incurred from 2017-18 onwards.

  The estimated financial implications of implementing the Bill are set out in the Regulatory Impact Assessment (RIA). This identified potential costs for a range of sectors, including the Welsh Government and local government. The estimated costs to Welsh Government and local government over a five year period are summarised below:

	2017-18 (£)	2018-19 (£)	2019-20 (£)	2020-21 (£)	2021-22 (£)	Total (£)
Welsh Government	198,400	42,300	11,500	27,200	25,300	304,700
Local authorities	365,900	683,600	362,500	390,900	342,800	2,145,700

  Welsh Government implementation costs will be met from the budget of the Division within the Health and Social Services Group with lead policy responsibility for each area within the Bill. In most cases this will be from the Health Improvement and Healthy Working budget.

  It is recognised local government will be a key sector in implementing the legislation, particularly through its existing enforcement responsibilities.

  Efforts have been made across the Bill to minimise the financial burden on local authorities, for example through creating new funding streams such as from special procedure licences and fixed penalty notice receipts.

It has been recognised that there may be a need to identify additional transitional funding for local authorities to support early implementation of the Bill.

In addition, it is envisaged that there will be opportunities for reducing costs compared with those outlined in the RIA, if certain aspects of implementation are co-ordinated across different areas of the Bill.

- **The amounts allocated for implementation of the Social Services and Wellbeing (Wales) Act 2014 and the Regulation and Inspection of Social Care (Wales) Act 2016.**

Social Services and Well-Being (Wales) Act 2014

£0.2million is being retained to support national activity to ensure consistent approaches to common processes across the regions delivering duties under the Act (e.g. performance management, new approaches of practice), whilst £2.8million is being added to the local government settlement to support delivery through regional partnership boards.

Regulation and Inspection of Social Care (Wales) Act 2016

The annual difference in cost between business as usual and the development of a new regime, combining the fundamental elements of protection alongside an outcome based approach to regulation, is forecast to be £1.765million.

This figure assumes a full implementation of the entire Act but will be lower if some elements are phased (such as ratings).

The cost of £1.765million is from the published Regulatory Impact Assessment (RIA). The RIA set out a five-year cost profile for full implementation in which, for purposes of illustration, the first full year was 2017-18.

As announced in the last administration, the service regulations under the Act are being developed and are expected to come into force from April 2018 with the expectation that the Act will be fully implemented by April 2019.

It is forecast that the costs for CSSIW related to implementation of the Act during 2017-18 will be in the region of £1million.

The Welsh Government has allocated £2.780million in 2017-18 to support the implementation of the Social Services and Well-being (Wales) Act 2014 and the Regulation and Inspection of Social Care (Wales) Act 2016.

- **Whether there are any plans to take forward the option, set out in the Green Paper 'Our Health, Our Health Service', to give to health boards capital borrowing powers to invest in capital projects.**

Following on the Green Paper consideration has been given to borrowing powers for local health boards to invest in capital projects.

As detailed in the Green Paper “Consultation – summary of responses” report published in February 2016 there were mixed responses to the question of borrowing powers.

Some were in favour of borrowing powers, highlighting the ability to accelerate capital investments and more effective planning and business case development, while others were not in favour, highlighting borrowing powers would carry significant risks with a view that health boards had not shown the planning delivery or financial maturity to support such a provision.

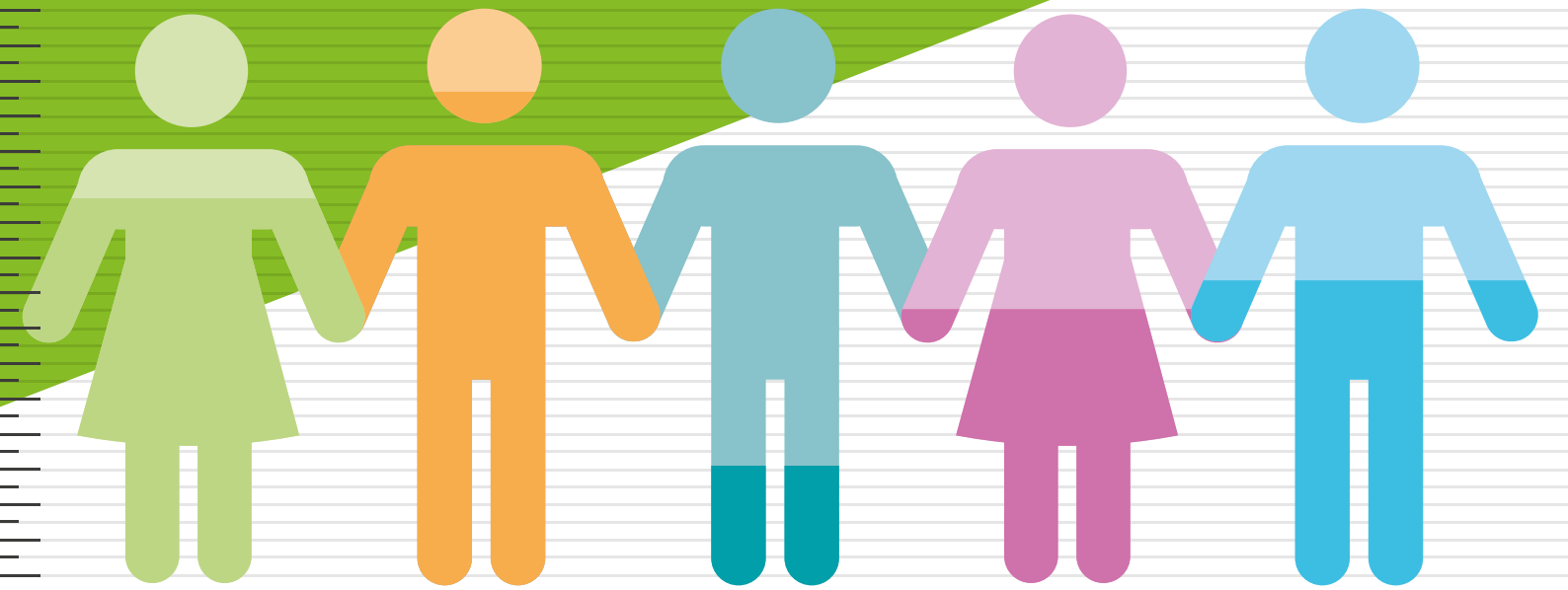
The Wales Act 2014 provided new borrowing powers for the Welsh Government through either the National Loans Fund (NLF) or another lender, allowing Welsh Government to borrow from April 2018.

As any LHB borrowing would count against this Welsh Government borrowing limit, and given the mixed responses, it is not proposed that health boards borrowing powers be taken forward.

Agenda Item 3.1

MEASURING YOUR IMPACT ON LONELINESS IN LATER LIFE

Campaign to EndLoneliness
CONNECTIONS IN OLDER AGE



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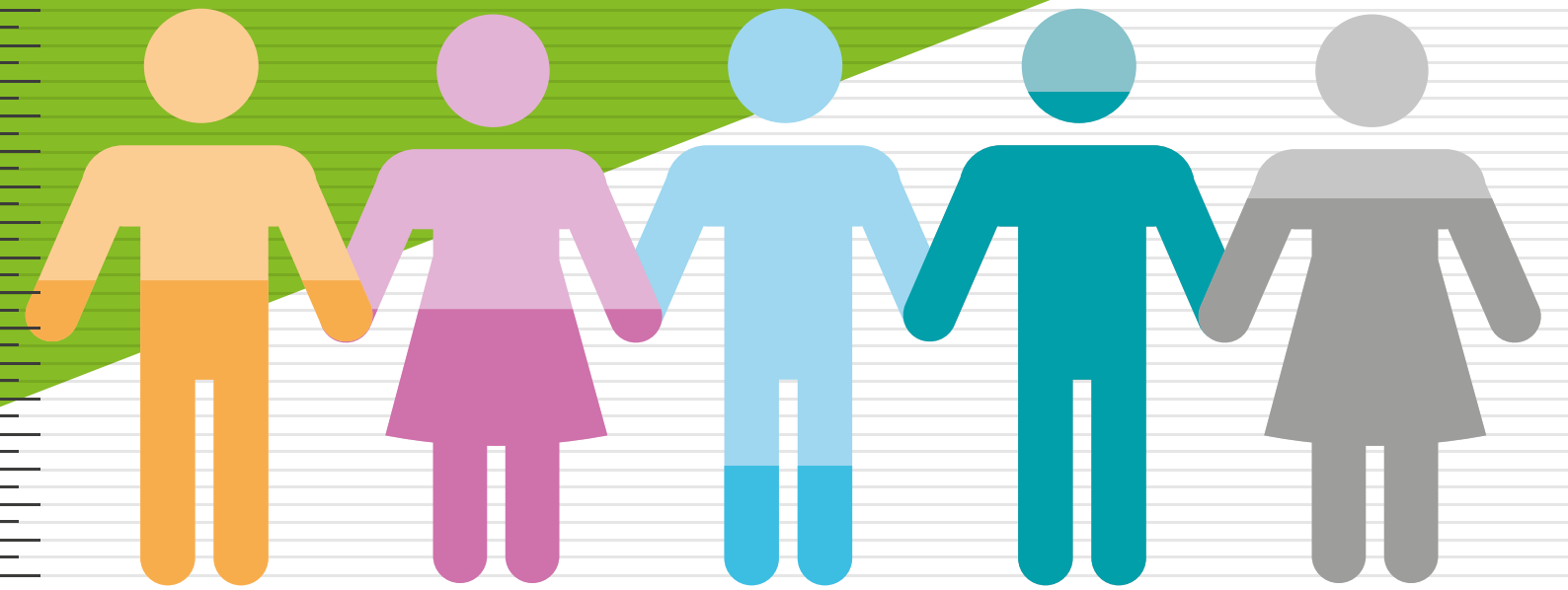

What does this guidance cover?

Are you working to prevent or reduce loneliness in your community?

Can you articulate the difference you are making to the lives of older people?

We're all working in an increasingly competitive funding environment, and we all need to be able to demonstrate robustly that we make a difference. Funders across the public, voluntary and private sectors also face their own financial pressures and need evidence that the programmes they fund are delivering real change for the people they support.

This guidance offers information and advice on choosing and using a scale to measure the impact of your services on loneliness in older age.

Why measure loneliness?

In a recent report, published with Age UK, we demonstrate that there is a lack of good quality evidence on the impact of different types of services on loneliness.[1] This concerns us, as feeling lonely is linked to risk of an earlier death[2], depression[3], dementia[4] and poor self-rated health[5]. We need to know more about 'what works' to prevent or alleviate it.

You might be thinking about measuring how your service is reducing social isolation or improving wellbeing. Whilst isolation and wellbeing are linked to feelings of loneliness, they are distinct experiences and concepts (we talk more about this later on, in the Introduction to this guidance). We would like to encourage you to measure loneliness for two reasons. Firstly, loneliness has a negative impact on our quality of life, and mental and physical health. Secondly, measuring loneliness will help you to demonstrate the positive impact of your work on the way people ***feel*** about their relationships and connections – and give you a more detailed understanding than a wellbeing measure can.

1 Jopling, K. 2015. *Promising approaches to reducing loneliness and isolation in later life.* Age UK and Campaign to End Loneliness: London.

2 Penninx, B., van Tilburg, T., Kriegsman, D. Deeg, D., Boeke, J. and van Eijk, J. 1997. Effects of Social Support and Personal Coping Resources on Mortality in Older Age: The Longitudinal Aging Study Amsterdam. *American Journal of Epidemiology.* 146(6) pp. 510-519

3 Green B. H, Copeland J. R, Dewey M. E, Shamra V, Saunders P. A, Davidson I. A, Sullivan C, McWilliam C. 1992. Risk factors for depression in elderly people: A prospective study. *Acta Psychiatrica Scandinavica* 86(3) pp.213–7

4 Holwerda, T. J. Deeg, D., Beekman, A. van Tilburg, T.G., Stek, M.L., Jonker, C., and Schoevers, R. 2012. Research paper: Feelings of loneliness, but not social isolation, predict dementia onset: results from the Amsterdam Study of the Elderly (AMSTEL) *Journal of Neurology, Neurosurgery and Psychiatry*

5 Stickley, A., Koyanagi, A., Roberts, B., Richardson, E., Abbott, P., Tumanov, S. and McKee, M. 2013. Loneliness: Its Correlates and Association with Health Behaviours and Outcomes in Nine Countries of the Former Soviet Union. *PLOS One*

Why use a scale?

A scale is simply a way of numerically measuring an opinion or emotion, and it one way to gather evidence about the effectiveness of a service. There are other approaches to collecting information, for example qualitative methods collect evidence without focusing on numbers. They can be used to gain an in-depth understanding about ***how*** or ***why*** someone came to feel lonely, and allow you to produce detailed case studies about how you've helped prevent or alleviate it. Examples of qualitative research techniques include one-to-one interviews and focus groups.

However, facing continued financial pressures, services across the health, social care and voluntary sectors need more 'hard' evidence on the effectiveness of loneliness interventions. Using a scale will enable you to ask about loneliness in a more structured way – and produce numbers that can help you illustrate ***how much*** of a difference you've made. Using a scale could also allow you to compare the impact of different activities or services on loneliness.

Choosing the right scale for you

As you read through this guidance and look at the different scales we suggest, you may also want to bear the following questions in mind to help you make a decision about the right tool for you:

- Are you comfortable asking **direct questions** about loneliness or painful experiences?
- How much **time** do you have to ask people about loneliness?
- **Who** will be asking the questions, and analysing the results?
- What does your service or activity **do**? For example, are you only addressing the 'social' dimension of loneliness?
- How much **time and money** can you allocate to monitoring and evaluation?

Summary of Scales

In this guidance we describe four different scales, which have been developed by different people, and have their own strengths and limitations. We encourage you to read on to learn more about their particular strengths and limitations, but this page presents their 'vital statistics' – four initial categories to help you compare them:

- **Length** – how many questions does the scale contain?
- **Language** – are the questions negatively or positively worded, or both?
- **Initially developed for...** – was this originally intended for use by researchers or services?
- **Mentioning the 'L' word** – does it ask directly about loneliness, or ask around the topic?

The Campaign to End Loneliness Measurement Tool

Scale 1

Length: 3 Questions

Language: Positive wording

Initially developed for: Service providers

Does it mention loneliness? No

This scale is for you if: you want a short and sensitively-worded tool that is easy to use.

De Jong Gierveld Loneliness Scale

Scale 2

Length: 6 Questions

Language: Mixes positive and negative wording

Initially developed for: Researchers

Does it mention loneliness? No

This scale is for you if: you want an academically rigorous tool that distinguishes between different causes of loneliness.

The UCLA Loneliness Scale

Scale 3

Length: 3 Questions

Language: Negative wording

Initially developed for: Service providers

Does it mention loneliness? No

This scale is for you if: you want a short and academically rigorous tool, with a simple scoring system.

Single-Item 'Scales'

Scale 4

Length: 1 Question

Language: Negative wording

Initially developed for: Researchers

Does it mention loneliness? Yes

This scale is for you if: you want to get to the heart of the issue with just one question.

Introduction

In 2013, a survey of Campaign to End Loneliness supporter organisations found over half said that they would value more support in evaluating their impact on loneliness. The brief was clear: services said they wanted a straightforward, flexible loneliness measurement tool that was suitable to use with older people who may be vulnerable.

What is loneliness?

It may surprise you to learn that there is no agreed definition of "loneliness" in research. One explanation of loneliness is that it is a painful feeling that occurs when this is a gap, or a mismatch, between the number and quality of social relationships and connections that we have, and those we would like.[6]

Others suggest that there are two dimensions to loneliness: social and emotional. Social loneliness occurs when someone is missing a wider social network and emotional loneliness is caused when you miss an "intimate relationship".[7]

On the whole, loneliness is described as an unwelcome, painful and unpleasant feeling.[8] There is a general agreement that loneliness is distinct from social isolation and wellbeing. Social isolation is an objective state that only measures the number and/or frequency of social contact.[9] Wellbeing is a broader concept, which examines our psychological and physical resources, as well as social connections.[10]

Loneliness is a fluid experience: it can come and go over a short time, or persist in the longer term. Recent research found that over 8 years, 7% of older people in England said they were always lonely, 10% of people moved out of loneliness, 9% moved into loneliness and 9% fluctuated in and out of loneliness.[11]

It is worth thinking about what the different tools and questions in this document are measuring, and how this relates to your service or activity.

6 Perlman, D. and Peplau, L. A. Chapter 2: Toward a Social Psychology of Loneliness, in Duck and Gilmour (eds.) 1981. *Personal Relationships in Disorder.* London: Academic Press.

7 de Jong Gierveld, J. and van Tilburg, T. 2006. 6-Item Scale for Overall, Emotional, and Social Loneliness: Confirmatory Tests on Survey Data *Research on Ageing* 28(5) pp. 582-598

8 Hauge, S. and Kirkevold, M. 2010. Older Norwegians' understanding of loneliness. *International Journal of Qualitative Studies on Health and Well-being* 5: 4654

9 Victor, C., Scambler, S., Bond, J. and Bowling, A. 2001. Being alone in later life: loneliness, social isolation and living alone. *Clinical Gerontology* 10(04) pp. 407 - 417

10 Dodge, R., Daly, A., Huyton, J., & Sanders, L. 2012. The challenge of defining wellbeing. *International Journal of Wellbeing* 2(3), 222-235.

11 Victor, C. 2013. Professor Christina Victor, Brunel University - Who is lonely and when? [video online] Available at: https://www.youtube.com/watch?v=U7u1kvDFAng [Accessed 15 March 2015]

Who experiences loneliness?

Loneliness is also a common emotion and it is likely that, at some point in our lives and whatever our age, we will experience it. Various studies estimating the levels of loneliness in Great Britain show that 5 – 16% of people aged 65 or over report feeling lonely all or most of the time and up to a further 30% say they feel lonely "sometimes".[12] As our population ages, there may be an increase in the real numbers of older people experiencing loneliness. You can learn more about the triggers for loneliness in the Campaign's recent report: ***Hidden Citizens: how can we identify the most lonely adults?***[13]

Why evaluate?

Evaluation can help you to demonstrate that you are really helping the people your service has contact with. It can also help you better understand how a particular service or activity works. Anyone can collect and use data, and you needn't be discouraged from evaluating your intervention just because you don't have past experience of doing this.

In essence, planning an evaluation involves asking yourself the following things:

- What are your desired outcomes
- What services or mechanism is delivering these outcomes
- How they will be measured
- Who will measure them – and when
- How long the evaluation will run for
- How will the information be used

A good evaluation has been shown to have two overarching principles. Firstly, ***independence***, i.e. those carrying out an evaluation can produce independent and objective reports. Secondly, ***transparency*** – the research methods used and findings are accessible and available to all. There are a number of comprehensive resources – from the Charities Evaluation Services[14] and Joseph Rowntree Foundation[15] – about evaluating the work of charities and community projects, which may be helpful to read alongside this guidance.

12 Cann, P. and Jopling, K. 2011. *Safeguarding the Convoy: A call to action from the Campaign to End Loneliness.* Oxfordshire: Age UK Oxfordshire. http://tinyurl.com/njsgx6z

13 Goodman, A., Adams, A., & Swift H.J. 2015. *Hidden citizens: How can we identify he most lonely older adults?* The London: Campaign to End Loneliness. http://www.campaigntoendloneliness.org/hidden-citizens/

14 Charities Evaluation Services. *Tools and Resources:* http://www.ces-vol.org.uk/tools-and-resources/tools-and-resources [Accessed 27 April 2015]

15 Joseph Rowntree Foundation. *Evaluating community projects A practical guide:* http://www.jrf.org.uk/system/files/1859354157.pdf [Accessed 27 April 2015]

About these scales

In the following section, we have described and provided advice on how to use the following four loneliness scales:

- **The Campaign to End Loneliness Measurement Tool**
- **The De Jong Gierveld Loneliness Scale**
- **The UCLA Loneliness Scale**
- **Single-item 'scale'**

We have chosen these four scales because we think they have a range of different strengths and limitations. For example, the Campaign tool has been developed specifically for people providing services or running activities, whilst the Gierveld scale is a well evaluated measure of different types of loneliness.

However, you'll see that loneliness scales can vary in a number of ways. This is because they have been developed for different contexts and circumstances. For example, the De Jong Gierveld Scale was developed in the Netherlands for use in large surveys but has since been adapted for smaller questionnaires and evaluating interventions.

All the scales in this publication can measure the ***intensity*** of loneliness and, if you use them regularly, how it ***changes over time***. However, you can only ask about how often loneliness occurs in someone's daily life by asking this directly, for example: in the past month, how often would you say you felt lonely?

There are a number of limitations to these scales that you should bear in mind.

- Firstly, they only give you a 'snapshot' of how someone is feeling on a particular day because feelings of loneliness can fluctuate
- Whilst the scales are designed to pick up small changes in loneliness we cannot know, exactly, the intensity that the different scores represents. For example someone with a score of "4" may not be half as lonely as someone with a score of "8" (although we can confidentially say one is less lonely than the other)
- It may also be difficult to tell if another person, experience or circumstance – independent of your service – is having a positive or negative impact on changes in someone's loneliness. However, we do make some suggestions for how to overcome this in "Asking open follow-up questions" on page 27)

The following sections outline the structure and design of four different scales, explains how to score and interpret your results, and sets out their strengths and limitations.

The Campaign to End Loneliness Measurement Tool

Scale 1

This tool contains the following statements:

1. **I am content with my friendships and relationships**
2. **I have enough people I feel comfortable asking for help at any time**
3. **My relationships are as satisfying as I would want them to be**

To each of these statements, ask your respondents to give one of the following answers:

Strongly Disagree / Disagree / Neutral / Agree / Strongly Agree / Don't Know

In order to avoid a 'response set' – where people give the same answer to a question almost by rote, it is important to alternate the direction of answers. E.g. for questions 1 and 3 you start with the 'Strongly Disagree' end of the scale and for question 2 you start with 'Strongly Agree'.

Asking all three of these questions together produces the most reliable information on people's experience of loneliness. You can see a copy of the questions in full scale form in Appendix A.

Using this scale: how to score and interpret your results

In order to score somebody's answers, their responses should be coded as follows:

Response	Score
Strongly disagree	4
Disagree	3
Neutral	2
Agree	1
Strongly agree	0

The scores for each individual question need to be added together. This gives a possible range of scores from 0 to 12, which can be read as follows:

So someone with a score of 0 or 3 can be said to be unlikely to be experiencing any sense of loneliness, whereas anyone with a score of 10 or 12 is likely to be experiencing the most intense degree of loneliness. Scores in-between these two extremes are on a spectrum of feelings of loneliness; however it is not possible to say that each point on the scale represents an equal increase or decrease in the degree of loneliness someone might be feeling.

The main purpose of this tool is to measure the change that happens as a result of an intervention to address loneliness. The key thing to focus on is how people's scores change over time. If someone scores "9" at one point, and then "7" three months later (after having been matched with a befriender, for example) it is reasonable to assume that their experience of loneliness has decreased. You should not say "this person's loneliness has decreased by 22%" because it is not possible to say by how much it has decreased – just that it has improved.

SUMMARY

The Campaign to End Loneliness Measurement Tool

Scale 1

Length: **3 Questions**

Language: **Positive wording**

Initially developed for: **Service providers**

Does it mention loneliness? **No**

This scale is for you if: **you want a short and sensitively-worded tool that is easy to use.**

STRENGTHS

- **Positive language about a tricky issue:** The particular strength of this tool is that it is written in language which is non-intrusive and unlikely to cause any embarrassment or distress.
- **Practical:** It is therefore a very practical resource for organisations in the field to use in their face-to-face work with older people.
- **Co-designed:** It has been designed with a number of different people and organisations, to try and ensure it is appropriate for a ranges of contexts.
- **Length:** It has been kept as short as possible and is easy to score.
- **Validity:** The tool has undergone academic tests to ensure it is valid and reliable.

LIMITATIONS

- **Newness:** This tool has not yet been used extensively by services, so we do not yet know how it picks up changes over time – although the Campaign to End Loneliness will be working with services in 2015 and 2016 to monitor how it performs, and it worked well in an initial pilot.
- **Only using positive language:** The use of only positive worded questions could also lead to respondents under-reporting their loneliness, although we cannot test for this.
- **Not a screening tool:** Finally, we strongly advise organisations not to use these questions as a "screening tool" to establish eligibility to their services. It has not been designed for this purpose and may therefore give misleading results.

How was this tool developed?

All tools should be based upon a way of seeing the issue (a conceptualisation) and the Campaign to End Loneliness Measurement Tool is based upon the following definition: loneliness occurs when there is a gap between the number and quality of relationships and contacts that we have, and those that we want. This is sometimes known as a cognitive discrepancy theory of loneliness.[16]

This tool was developed over the course of 2014 by the Campaign, in partnership with over 50 older people, service providers, commissioners and housing associations. Three focus groups were held with older people in Bristol and London. These were followed by three design workshops, during which the organisations and older people present created an outcome 'map' of the steps that can be taken to address loneliness, and wrote questions reflecting these outcomes.

These draft questions were then reviewed and short-listed. Four prototype tools were drafted, and voted upon, and two prototypes were tested across 18 organisations and 785 older people (over 350 people per tool), alongside the De Jong Gierveld Scale which is considered by many researchers specialising in older age as the gold standard for measuring loneliness.

A statistical validation process was conducted on the results, and the tool that was shown to be the most accurate measure of loneliness was selected. You can request a report from the Campaign that explains this validation process in more detail, if you are interested in learning more.[17]

16 Perlman, D. and Peplau, L. A. Chapter 2: Toward a Social Psychology of Loneliness, in Duck and Gilmour (eds.) 1981. *Personal Relationships in Disorder.* London: Academic Press.

17 Please email info@campaigntoendloneliness.org.uk

The De Jong Gierveld 6-Item Loneliness Scale

Scale 2

In this 6-item scale, 3 statements are made about 'emotional loneliness' and 3 about 'social loneliness'. (Social loneliness (SL) occurs when someone is missing a wider social network and emotional loneliness (EL) is caused when you miss an "intimate relationship".[18])

1. **I experience a general sense of emptiness [EL]**
2. **I miss having people around me [EL]**
3. **I often feel rejected [EL]**
4. **There are plenty of people I can rely on when I have problems [SL]**
5. **There are many people I can trust completely [SL]**
6. **There are enough people I feel close to [SL]**

The scale generally uses three response categories: **Yes / More or less / No**

See Appendix B for the scale and responses in full.

Using this scale: how to score and interpret your results

To score the answers to the scale, the neutral and positive answers are scored as "1" on the negatively worded questions (in this instance, questions 1-3). On the positively worded items (questions 4-6), the neutral and negative answers are scored as "1". Therefore, someone's responses to the negative, emotional loneliness questions should be coded as follows:

Response	Score
Yes	1
More or less	1
No	0

To score somebody's answers to the positive, social loneliness questions, use the following coding:

Response	Score
Yes	0
More or less	1
No	1

18 de Jong Gierveld, J. and van Tilburg, T. 2006. 6-Item Scale for Overall, Emotional, and Social Loneliness: Confirmatory Tests on Survey Data Research on Ageing 28(5) pp. 582-598

Note: this does mean that an answer of 'more or less' is given the same score as 'yes' or 'no', depending on the question. This produces an emotional loneliness score, ranging from 0 (not emotionally lonely) to 3 (intensely emotionally lonely) and a social loneliness score, also ranging from 0 (not socially lonely) to 3 (intensely socially lonely). The scores for each individual question can be added together although you should also look at the individual scores for emotional and social loneliness. This gives a possible range of scores from 0 to 6, which can be read as follows:

You can use the complete scale, or the 3 question emotional or social loneliness subscales separately.

SUMMARY

De Jong Gierveld Loneliness Scale

Scale 2

Length: 6 Questions

Language: Mixes positive and negative wording

Initially developed for: Researchers

Does it mention loneliness? No

This scale is for you if: you want an academically rigorous tool that distinguishes between different causes of loneliness.

STRENGTHS

- **Different types of loneliness:** The focus on both emotional and social loneliness produces results that can give insight into why someone might be experiencing loneliness. For example, are they lonely because they'd like larger social networks, or is it because of the loss of a key relationship?
- **Designed for older people:** The Gierveld scale was designed for use with older people, and also tested with large samples of people aged 18+.
- **Extensively used and tested:** This scale is widely used across Europe, and very well-tested and evaluated for use in a number of languages and countries.
- **Avoids automatic answers:** The mix of positive and negative can help avoid a 'response set' – where someone falls into giving automatic answers rather than considering what they are asked.

LIMITATIONS

- **Length:** a significant limitation – for service providers at least – is its length, which can make it difficult to insert into existing monitoring and evaluation. This could be because it was initially designed for use by researchers and larger population surveys.
- **Tricky questions on a tricky subject:** Some staff or volunteers may also find it difficult to ask negatively-worded questions, and may require some support and training to ask these sensitively.

How was this tool developed?

The scale was developed in the Netherlands in the early 1980s and was initially based on Weiss's 1973 theory which defines loneliness as a subjective experience that occurs when the number of friendships or relationships someone has is smaller than desired (social loneliness) or when someone is missing intimacy from their relationships, friendships or acquaintances (emotional loneliness). 34 questions were initially developed in the 1980s by analysing over 100 accounts written by people experiencing loneliness. The questions were then tested with a further 59 men and women, and refined to pick up less intense feelings of loneliness.

From this long-list of questions, an 11 question-long scale was developed with six questions asking about emotional loneliness, and five asking about dimensions of social loneliness. This was piloted and used extensively before a shorter 6 question version was created in 2006 for use in larger surveys. The shorter version of the scale has been tested for reliability and validity in seven countries, including the Netherlands, France, Russia and Japan.

The UCLA 3-Item Loneliness Scale

Scale 3

This scale comprises 3 questions that measure three dimensions of loneliness: relational connectedness, social connectedness and self-perceived isolation. The questions are:

1. **How often do you feel that you lack companionship?**
2. **How often do you feel left out?**
3. **How often do you feel isolated from others?**

The scale generally uses three response categories: **Hardly ever / Some of the time / Often**

See Appendix C for the scale and responses in full.

Using this scale: how to score and interpret your results

In order to score somebody's answers, their responses should be coded as follows:

Response	Score
Hardly ever	1
Some of the time	2
Often	3

The scores for each individual question can be added together to give you a possible range of scores from 3 to 9. Researchers in the past have grouped people who score 3 – 5 as "not lonely" and people with the score 6 – 9 as "lonely".[19]

19 Steptoe, A., Shankar, A., Demakakos, P. and Wardle, J. 2013. Social isolation, loneliness, and all-cause mortality in older men and women. *Proceedings of the National Academy of Sciences*. 110(15) pp.5797–5801

SUMMARY

The UCLA Loneliness Scale

Scale 3

Length: 3 Questions

Language: Negative wording

Initially developed for: Service providers

Does it mention loneliness? No

This scale is for you if: you want a short and academically rigorous tool, with a simple scoring system.

STRENGTHS

- **Widely used:** Both the longer and shorter versions of the UCLA loneliness scale are widely used across the world. The original paper has been cited over 1,500 times.
- **Can be used in different ways:** The tool has been found to be accurate when it is part of a self-completed questionnaire, and when an interviewer asks questions over the phone.[20]
- **Comparability to national studies:** The scale is regularly asked of over 12,000 people aged 50+ as part of the English Longitudinal Study of Ageing (ELSA). This means that UCLA results from a small population can be compared to a national sample, which may be of benefit to some services.

LIMITATIONS

- **Original development:** One of the main criticisms of the full UCLA scale is that it was developed in the USA with students – and therefore is not necessarily suitable for a UK context or use with older adults. However, the shorter, 3-item questionnaire has since been tested with older people.
- **Only uses negative wording:** Another limitation is that it does not use a mix of positive and negative wording, which could lead to a 'response set' – where participants give the same answer without really thinking about what they are being asked.
- **Easy to distort results:** The results of the UCLA scale across a population are sometimes turned into an average, e.g. a mean score of 4.2 in a group of 30 older adults. Creating a mean could prove unreliable as the scale does not quantify loneliness but simply gives it a numerical category.
- **Tricky questions on a tricky subject:** Some staff or volunteers may also find it difficult to ask negatively-worded questions, and may require support and training to ask these sensitively.

20 Hughes, M. E., Waite, L. J., Hawkley, L. C. and Cacioppo, J. T. 2004. A Short Scale for Measuring Loneliness in Large Surveys: Results from two population-based studies. *Research on Ageing*. 26(6) pp.655-672.

How was this tool developed?

Developed in the 1970s and revised in the 1990s, the scale uses the cognitive discrepancy theory of loneliness (i.e. loneliness occurs when there is a gap between the quantity and quality of connections we have and want). It is drawn from two older scales, including a 75-item scale based on statements describing loneliness from 20 psychologists. 25 questions were selected from these scales and tested with 239 students. Finally 20 items were selected, which aimed to measure both loneliness and social isolation.[21]

The longer scale was shortened to three questions in 2004 so that it could be used in larger surveys and over the telephone. The 3-item version was first tested with over 2,100 older adults and found to be a reliable and valid measure of loneliness by comparing the results against a self-identifying statement. The researchers concluded that the 3 question UCLA scale gauged general feelings of loneliness "quite well" and it was a robust measure of loneliness in self-administered questionnaires and telephone interviews.[22]

21 Russell, D., Peplau, L. A. and Ferguson, M. L. 1978. Developing a measure of loneliness. *Journal of Personality Assessment* 42(3) pp.290-294

22 Hughes, M. E., Waite, L. J., Hawkley, L. C. and Cacioppo, J. T. 2004. A Short Scale for Measuring Loneliness in Large Surveys: Results from two population-based studies. *Research on Ageing*. 26(6) pp.655-672.

Single-item questions

Scale 4

Single-item questions are sometimes known as self-rating measures of loneliness as they have to ask directly for the individual's assessment of how lonely they feel. There are many variants on this theme, and we suggest three here that come from different studies and use slightly different wording. The first example was first used by Joseph Sheldon in 1948.[23] He asked people:

Are you:

- Very lonely
- Lonely at times
- Never lonely

Our second example is currently used in the English Longitudinal Study of Ageing (ELSA):

How often do you feel lonely?

- Hardly ever or never
- Some of the time
- Often

The third example is adapted from the Center for Epidemiologic Studies Depression Scale (CES-D), which is commonly used screening questionnaire for depression. This is 20 questions long but includes one question about loneliness:

During the past week, have you felt lonely:

- Rarely or none of the time (e.g. less than 1 day)
- Some or a little of the time (e.g. 1-2 days)
- Occasionally or a moderate amount of time (e.g. 3-4 days)
- All of the time (e.g. 5-7 days)

23 Sheldon, J. 1948. *The Social Medicine of Old Age: Report of an Inquiry in Wolverhampton*. Arno Press.

24 See example on Counselling Resource website: http://counsellingresource.com/lib/quizzes/depression-testing/cesd/

SUMMARY

Single-Item 'Scales'

Scale 4

Length: 1 Question

Language: Negative wording

Initially developed for: Researchers

Does it mention loneliness? Yes

This scale is for you if: you want to get to the heart of the issue with just one question.

STRENGTHS

- **Short:** A single-item measure of loneliness has a number of benefits. It is short, asks directly about the issue of interest and is easy to administer and score. It may also be a starting point for a more in-depth conversation about experiences of loneliness.
- **Age-friendly:** Some research suggests that single questions are more appropriate with an older age group, particularly if someone is experiencing cognitive decline or has difficulty communicating.[25]
- **Academics use it:** Single, self-reporting questions are also the most commonly used measure in academic research studies.[26]
- **Challenges stigma?** There is an argument for asking directly about someone's loneliness as it challenges the stigma attached to the issues. This should be done in a private environment, where the interviewee has the opportunity to explain further about how they are feeling.

LIMITATIONS

- **May not be reliable:** These questions have never been thoroughly examined for their reliability, and ability to pick up change over time.
- **Ignores stigma?** There is also a concern that asking directly about loneliness can lead to underreporting, as the stigma that is attached to the experience means that people may be unwilling to admit to feeling lonely.[27]
- **May be too 'blunt':** Using a single-item scale will make it harder pick up on smaller gradations of change in loneliness, that you might expect after someone has had contact with a service.
- **Limitations of adding a time period:** a question that asks about loneliness over a certain time period (e.g. the CES-D question) may produce a misleading result, if that person has had an unusually stressful or difficult week or month.[28] It would also fail to reflect any long term feelings of loneliness.

25 Holmen, K., Ericsson, K., Andersson, L., and Winblad, B. 1992. Loneliness among elderly people living in Stockholm: A population study. *Journal of Advanced Nursing 17* pp.43-51

26 Pinquart, M. & Sorenson, S. 2001. Influences on loneliness in older adults: A meta-analysis. *Basic and Applied Social Psychology* 23 pp.245-266.

27 Victor, C., Scambler, S., Bond, J. and Bowing, A. 2001. Being alone in later life: loneliness, social isolation and living alone. *Reviews in Clinical Gerontology* 10(04) pp. 407 - 417

28 Pikhartova, J., Bowling, A. and Victor, C. 2014. Does owning a pet protect older people against loneliness? *BMC Geriatrics* 14(106) Available at: http://www.biomedcentral.com/1471-2318/14/106#B11 [Accessed 21 April 2015]

How to use your chosen scale

This section shares some advice on how to design and deliver a robust evaluation of your service. It recommends sampling techniques, how to introduce and complete a survey and suggests additional open questions, amongst other things, to help you to get the best results.

a. Introducing a survey

In most situations, it will be important to give some introduction and guidance about the questions and how to answer them, to those taking part in your evaluation. The following wording could be used:

> We would like to ask you a few questions to enable us to measure how helpful our services are. You can choose to answer all or none of the questions, and choosing not to answer will not affect your access to any of our services in any way. When answering the questions, you could take account of the following:
>
> - There are no right or wrong answers
> - We would like you to be completely honest
> - In answering the questions it is best to think of your life as it generally is now (we all have some good or bad days)
> - You don't have to answer any question you don't want to

You may like to remind people being interviewed that the research questions are separate from the rest of the support offered by your organisation, and that there will be other opportunities for them to tell you about their situation in more detail, and for you to provide support. You may wish to set time aside after an interview to make it easier to discuss any issues or questions that arise because of the questions.

This additional time, post-survey, can help you to feel comfortable asking direct questions about loneliness in a dispassionate style, as a 'researcher'. You could use wording such as:

> The questions are quite brief and only require brief answers. Some of the questions are quite personal, so if you want to have a chat about anything in more detail, let me know and we will make sure we talk about it afterwards or at a later date.

b. Encouraging staff or volunteers to use a loneliness scale

It can be difficult to ask people about how they feel, particularly when questions might evoke memories of a painful experience like loneliness. There are a number of things you could do to ensure that staff and volunteers get on board with your evaluation and help you survey your members, including:

- Clearly explaining to them the purpose and value of asking the questions, and giving them time to ask questions of you about the survey
- Ensuring that there is support available that staff can offer or signpost to, if the person being interviewed feels upset after the interview
- Reassuring staff that most people are happy to answer questions about loneliness (even negatively-worded ones) and may welcome the opportunity to talk about it with someone

It may also help to add an open-ended question at the end of the survey and invite the interviewee to make any further observations they want to. Sometimes, closed questions do not perfectly capture an experience or feeling and this might be frustrating for both the interviewer and the interviewee.

c. How regularly should you use a tool or scale?

The principal aim of this guidance is to provide information on different scales that organisations can use to measure the impact of their interventions on loneliness in older age. In order to do this, you will need to incorporate your chosen scale into any procedures for recording information about a new service user – sometimes called a baseline survey.

To see if there have been any positive or negative changes, you will then need to ask people to answer the same questions again periodically (for example, at three or six monthly intervals) and again when they stop taking part.

Comparing the results over these kinds of time periods should allow a decision to be made about whether someone's experience of loneliness has changed in the intervening period. If so, judgements can be made about whether the service that you have provided has been of benefit to individuals.

It may be difficult to ask personal questions of someone when you have only just met them. However, if your evaluation is to have any chance of showing positive change, you do need to make sure that a scale is used before someone starts using your service or taking part in your activity or group. You may want to use the words in the above section – "Introducing a survey" – to help explain why you are asking the questions at an early stage.

d. How to sample

Depending on how many people take part in your service or activity, it may be possible to ask a survey of everyone you are supporting. However, if that is not practical – or would take too much time or money – then you can survey a sample of your population instead.

Sampling is the process of selecting people to take part in your evaluation from a whole population of interest (i.e. everyone who is receiving support from you, or attending your activities). The aim is to be able to assume the results from the people in the sample are typical of the population from which they were chosen. There are three steps to creating a sample:

1. CREATE YOUR SAMPLING FRAME

This is simply a comprehensive list of everyone who is taking part in your service or activity. You may have this list already, or you may need to ask service managers to create one for you. Whether or not you have a sampling frame will influence the next stage – choosing the way that you are going to create a sample.

2. CHOOSE A SAMPLING STRATEGY

A 'random' approach to sampling is called **probability sampling**. A simple example of probability sampling would be to put everyone's names into a hat, and then pick a certain number and only approach those people to take part. The simplest type of probability sampling is **simple random sampling**, which is easy to do and it is reasonable to generalise the results from the sample back to the population. First, create your sampling frame and then randomly select the number of people you'd like to interview, e.g. 100.[29]

If you want to be sure to represent certain sub-groups within your research (for example various ages, genders, ethnicities) you may want to use **stratified sampling**. This will generally have more statistical precision than simple random sampling. To do this, you will need a bit more information about your population in your sampling frame. For example if you'd like to sample a representative number of men and women, you'll need this recorded by their name. Simply separate your sampling frame into the sub-groups of interest and then carry out simple random sampling on each group, selecting the same proportion (not number – e.g. 20%) from each group.

If you do not have a sampling frame, you may wish to use a non-probability (non-random) sampling strategy. The benefits of this are that they are much easier to assemble and can be lower cost.
The main problem is that you ***cannot*** make any claims about your whole population based on this sample – because it will not be representative.

29 Excel has a random number feature that can be used to generate a random sample. To use this, paste everyone's names into an Excel column. In the column alongside, enter the function =RAND() alongside each entry, then sort both columns by the random numbers (select "Sort and Filter" and then "Sort A to Z"). They will appear in number order and you can use the first 100 names that appear as your random sample

Two of the most common non-probability sampling strategies are convenience sampling and quota sampling. Convenience sampling is also known as accidental or haphazard sampling as you simply interview a selection of people who are easy to reach and likely to agree to answer questions. For example, when a television reporter interviews the 'person on the street' to gauge public opinion. There is no way of knowing if these samples are representative of the wider population.

Instead, we could sample with purpose to target specific groups of people. An example is **quota sampling** – selecting people non-randomly according to some fixed quota. The stricter form of quota sampling is **proportional quota sampling** which aims to represent the major characteristics of the population by sampling a comparative amount of each. For instance, if you know the population you are interested in has 40% women and 60% men, and that you want a total sample size of 100, you will continue sampling until you reach those percentages and then you will stop. The problem here is that you have to decide the specific characteristics on which you will base the quota.

The less strict form of quota sampling is non-proportional quota sampling. In this method, you specify the minimum number of people you want in each category. You may decide to sample at least 40 women, at least 40 men and let the remaining 20 respondents 'fall out naturally'. Here, you simply want to have enough respondents to be able to talk about even small groups in the population.

3. DECIDING ON YOUR SAMPLE SIZE

Your sample size is the number of people you are going to survey, within your 'population'. Choosing your sample size may be decided by the capacity of your team to conduct surveys and analyse their results. However, if you would like to generalise from your sample to your larger population you can use a Sample Size Calculator, such as the one from Survey Monkey.[30]

To calculate your sample size, simply enter the total population size, keep the confidence level at 95% and set the margin of error at 5%. (You can learn more about what these things represent via the Survey Monkey Sample Calculator – referenced above). You'll notice that a big population does not necessarily need a big sample but if your population is small, the sample may make up a large proportion of it. If you would like to learn a bit more about the principles behind sampling, we'd recommend the Research Methods Knowledge Base website.[31]

30 Survey Monkey. 2015. *Sample Size Calculator.* [online] Available at: https://www.surveymonkey.com/mp/sample-size-calculator/ [Accessed 27 April 2015]

31 Research Methods Knowledge Base. 2006. Sampling [online] Available at: http://www.socialresearchmethods.net/kb/sampling.php [Accessed 27 April 2015]

e. Gaining informed consent

The principle of informed consent is used widely in academic research. In essence, it means making sure that the people you are interviewing fully understand what you are doing, and have given permission to you to ask questions, and store and use their information.

It is therefore important that the older people you work with fully understand:

- What the evaluation is aiming to do
- How you will be using, storing and publishing any information about them
- How you will make sure their information remains confidential, and how anything they tell you will be kept anonymous if published
- How to opt-out, at any point, during the process, should they no longer want to take part

You may wish to prove this information both in writing and verbally, to make sure that people understand – and have something to refer back to later in case they have any questions about the evaluation.

f. Understanding and minimising interviewer bias

The researcher (the person asking the questions) has a key role in obtaining high quality data, which depends on their clarity, consistency and neutrality – in terms of their words spoken, tone of voice and body language. It is important to ask all questions in a completely open way, without assuming what the likely response will be. If the person has not understood the question:

- Try to slow down the delivery of the question
- Ask which parts of the question they do not understand
- Try to keep to the original wording, maybe with additional explanations if needed

The researcher's reaction to each response should acknowledge what has been said without empathising or encouraging as this can lead the user to alter their future responses to gain a certain reaction. For anyone more used to working in a supportive role, this can take some practice.

Sometimes research participants will like to digress and engage the researcher in conversation. Try to gently bring them back to the task in hand, with perhaps the promise that you can resume that conversation later, after the research questions.

Prepare and practice a brief, consistent response to typical queries you may encounter, such as:

- Queries about use of the data
- Refusal to answer certain questions or parts of questions
- Options within questions, such as the list of ethnicities or 'marital status'

g. Advice on different modes of data collection

It will be important to consider how the new user is to provide the information. There are three main ways that you could collect data about the people taking part in your service:

- Asking questions of your users, face-to-face, and recording their answers yourself
- Asking questions over the phone, and recording their answers yourself
- Asking people to complete the survey on paper by themselves (they could do this on the spot, and hand it back – or you could send them the survey by post and ask them to send it back to you)

There are pros and cons to all of these methods. It can sometimes be hard, for example, to get a good response rate on postal surveys, and people may not answer all questions - unlike in a face-to-face interview. Tests on the De Jong Gierveld Scale and the CTEL tool have both shown there can be a difference in how people answer, depending on whether they completed it themselves or had some assistance from a member of staff or volunteer. When people were helped to complete it they tended to report much lower levels of loneliness compared to those who completed it on their own. This is not that surprising. Given the stigma surrounding loneliness people can be reluctant to reveal how they truly feel in front of someone.

So, where possible, our advice is that people are encouraged to answer the questions without help. Where this is not possible the tool could still be used as a useful measure of impact as long as the same method of asking the questions is used at each subsequent application of the tool.

h. Asking open, follow-up questions

Open-ended questions can allow you to understand more about ***what*** is happening, ***how*** it is happening, ***why*** someone is, or is not, experiencing loneliness and ***who*** may be particularly affected by loneliness in your local area. Asking open questions can also help people to feel listened to and valued.

Before you write your open questions, do take a moment to consider and clarify your purpose in asking them. It may be worth bearing in mind that open-ended questions can generate a lot of data that you will need to record and analyse later on. You will need to record full responses so that you can reduce the risk of misinterpreting answers.

If you would like to attribute quotes verbatim, you can:

- Keep it anonymous – quote only, with no attribution
- Attribute the quote with a description, such as Male, aged 75
- Attribute the quote with a pseudonym – can be a useful technique for writing up a case study

If you do want to use verbatim quotes from people interviewed, make sure you ask their permission and explain or show them how you will be using the quotes. They may be interested to receive a copy of your report or case study when it is ready.

The timing for asking any open questions is important. It should take place after completing the scale so as not to influence responses to any scale questions.

Even though open questions are more conversational than survey questions, it is still good practice to ask the same questions of all your interviewees. Try to give your interviewees as much chance to talk about the positive as the negative. It can help to start with a very general question before moving on to more targeted questions.

You may want to ask questions about the context someone is in, such as existing family or friendship relationships, or their aspirations for change. Some examples of open-ended questions that you may wish to ask include:

- *Can you tell me a little bit about any contact you have with friends or family right now?*
- *What aspects of your relationships with friends or family are working well for you?*
- *Are there any changes you would like to make to those relationships with friends or family?*
- *Do you consider loneliness to be an issue for you/someone like you?*
- *What do you think could be the main factors that contribute to loneliness?*
- *Is there anything else that you'd like to add?*
- *Can you tell me about how taking part in/becoming a member of <<ORGANISATION NAME>> has made any difference to your life, if at all?*

The final question, or something like it, can be used to demonstrate just how your service has helped. You may also want to ask about any other changes that have happened since you last interviewed them. For example, changes in circumstances or use of other services – and how these too have helped or hindered.

The best strategy for obtaining full and honest answers is to leave enough time for your interviewee to respond. There may be some moments of silence as they consider their response but this does not need to feel uncomfortable for either of you.

i. Collecting demographic data

You will need to consider what level of demographic data you wish to collect as part of your evaluation. It is good practice to ask for information about some key characteristics of the people taking part in your project, e.g. age, gender, ethnicity and location.

This information can be particularly important if you would like to compare your sample to a larger population. For example, you could take a look at the demographic characteristics of your local population – the Office for National Statistics, your local council and the census[32] will be good place to start for this – and see how the people taking part in your evaluation compare to this.

If you are able to survey or interview a large enough group, it could even enable you to differentiate between different sub-groups (for example, people from different cultural backgrounds). This segmentation might offer you insights that you would have missed by only looking at the whole group. Examples of commonly used questions to collect demographic data on age, gender, marital status and ethnicity, are set out at Appendix D. To ask about location, simply ask for someone's postcode.

j. Keeping personal information confidential

Respecting and maintaining confidentiality can help build trust between you and the people you support, and encourage them to take part in your research. Personal information can be defined as anything that can be used to identify someone – be that their name, or other things like age or where they live. In smaller communities, it may be easier to identify someone from less information. There are a number of steps you can take to keep information about someone confidential.

1. Assign everyone who is taking part in your evaluation an ID number, and keep a record of this ID number and their name in a secure file that can only be accessed by staff that need to use the information (e.g. a password protected Excel file)

2. Use this number – not their name – on the questionnaire, and in any file that records responses

3. If you want to go back to the people you interviewed at baseline, refer to the identification file, get their ID number and ask the survey again using the ID number

It is important that you do not make public any information that could be used to identify someone, without their permission. For example, you may have interviewed a retired doctor, who is the only person in your group with that past occupation. Even if you do not reveal their name, writing about a retired doctor in an evaluation report could lead to them being identified, and personal information becoming accidentally public.

Using a tool with people with sensory loss

Written by Nicola Venus-Balgobin, Project Manager, Sense

There are an increasing number of older people in the UK who have sensory loss. 70% of those over 70 have hearing loss[33], one in five people aged over 75 have sight loss[34] and an estimated 250,000 have a dual sensory loss[35]. However older people's sensory loss often goes unrecognised and undiagnosed due to an assumption by staff, and older people themselves, that it is a common part of ageing.

It is therefore likely that – even if you aren't aware of it – many of the older people you support will have some kind of sensory loss and may need additional help or adaptions to be able to participate fully in an evaluation. This will also ensure the information you gather is accurate.

Before you start, try and find out whether any of your participants have any sensory needs before you decide how to implement the tool. You should also people with sensory needs what adaptions they will need to be able to participate fully in the tool. You may want to ask:

- Is it better to conduct a survey in person or via post?
- If in person, does the person have any particular communication needs? Ask them how you should best to communicate (See Top Tips 1 below)
- If via post, what will make the information accessible to them? (See Top Tips 2)

TOP TIPS 1: COMMUNICATING WITH PEOPLE WITH SENSORY LOSS:

- Ask the person what works best for them
- Make sure you have the person's attention before trying to communicate with them
- Gently touching the top of a person's arm is one way to attract attention without startling them
- Identify yourself clearly
- Check that you are in the best position to communicate

33 Action on Hearing Loss. 2014. Factsheet: Caring for Older People with Hearing Loss. Action on Hearing Loss: London. Available at: http://tinyurl.com/me9mlou [Accessed 27 April 2015]

34 RNIB. 2015. Key Information and Statistics. [Online] RNIB: London. Available at: http://www.rnib.org.uk/knowledge-and-research-hub/key-information-and-statistics [Accessed 27 April 2015]

35 Emerson, E & Robertson, J. 2010, *Estimating the Number of People with Co-Occurring Vision and Hearing Impairments in the UK*. Centre for Disability Research

- Avoid noisy places and background noise
- Adapt the conditions to suit the individual
- Speak clearly and a little slower, but don't shout
- Make your lip patterns clear without over-exaggerating
- Keep your face visible – don't cover your mouth
- Use gestures and facial expressions to support what you are saying
- If necessary, repeat phrases or re-phrase the sentence
- Be aware that communicating can be hard work. Take regular communication breaks
- Try writing things down, experiment with different sizes of letters and coloured paper and pens
- For phone conversations consider using a text relay service
- Some people with sensory loss will use a particular communication method, e.g. British Sign Language, deafblind manual or Block and you may need a communication support professional.

TOP TIPS 2: MAKING INFORMATION ACCESSIBLE

- Ask people how they would like the tool provided; if they are using technology to read the document they may need it in a different format e.g. plain text, without boxes, outside of tables
- Many people will be able to read large print – usually size 14 bold or above. It is a good idea to provide information in size 14 as standard
- Some people will need the information in an accessible format such as braille, moon or audio, a good transcription service will be able to provide this

For more information on communicating with people who have a sensory impairment visit:
www.sense.org.uk/content/communicating-people-who-are-deafblind

Acknowledgements

The Campaign to End Loneliness would like to express our gratitude to a large number of people and organisations who helped us to develop and pilot our impact measurement tool, and write this guidance. In particular, we'd like to thank Guy Robertson of Positive Ageing Associates, for overseeing the development the Campaign to End Loneliness Measurement Tool and members of our Research Hub who provided advice along the way and contributed to this report:

Professor Christina Victor, Brunel University

Chris Ring, Nottingham Trent University

Dr Tracy Collins, Salford University

Dr Bernadette Bartlam, Keele University

Julie Wrigley and Kay Silversides, Qa Research

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Jason Bergen, Calouste Gulbenkian Foundation

Karl Demian, Royal Voluntary Service

Jonathan Eastwood, Big Lottery Fund

Lilias Gillies, Wandsworth Older People's Forum

Sarah Handley, Big Lottery Fund

Andrea Hare, Public Health England

Lucy Harmer, Independent Age

Heather Heathfield, OPM

Phil Rossall, Age UK

Nicola Venus-Balgobin, Sense

And, finally, thank you to the following organisations that sent staff to development workshops and webinars, piloted the tool and gave comments on this guidance:

The Abbeyfield Society

Age UK Bromley and Greenwich

Age UK Cheshire

Age UK Wiltshire

Alzheimer's Society

Anchor Trust

Archway Foundation

Beth Johnson Foundation

Brighton & Hove Neighbourhood Care Scheme

Careline

Care Network Cambridgeshire

Carers Centre Bristol

Community Network

Cotswold District Council

Cotswolds Volunteers North

Coventry University

Cruse Bristol

CSV (now Volunteering Matters)

Dorset Partnership for Older People Programme

Family Mosaic

Friends of the Elderly

Growing Support

Halton Borough Council

Holbeck Elderly Aid

Holborn Community Association

Jigsaw Support Scheme

John Ellerman Foundation

Knowsley Council

London South Bank University

LinkAge Bristol

Link Line

Macular Society

Mentoring and Befriending Foundation

Mindings

NBFA Assisting the Elderly

New Dynamics of Ageing Older Peoples' Reference Group

NHS Warwickshire

Nottingham City Council

Oxfordshire County Council

RNIB

Rootless Garden

Rural Coffee Caravan Information Project

Salford City Council

Salford Royal NHS Foundation Trust

The Silver Line

Stafford and Surrounds Clinical Commissioning Group

Southville Centre Bristol

The Sovini Group

Staffordshire County Council

Stitchlinks CIC

Time to Talk Befriending

Together We Are Better

Tower Hamlets Borough Council

Tower Hamlets Friends and Neighbours

Toynbee Hall

Volunteer Edinburgh

West Sussex County Council

This guidance was written by Anna Goodman, Learning and Research Manager at the Campaign to End Loneliness, with contributions from Julie Wrigley and Kay Silversides (Qa Research) and Nicola Venus-Balgobin (Sense).

Appendix A: Campaign to End Loneliness Measurement Tool

We would like to ask you a few questions to enable us to measure how helpful our services are. You can choose to answer all or none of the questions, and choosing not to answer will not affect your access to any of our services in any way. When answering the questions, you could take account of the following:

- There are no right or wrong answers
- We would like you to be completely honest
- In answering the questions it is best to think of your life as it generally is now (we all have some good or bad days)

Questions

1. I am content with my friendships and relationships

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
4	3	2	1	0

2. I have enough people I feel comfortable asking for help at any time

Strongly agree	Agree	Neutral	Disagree	Strongly disagree
0	1	2	3	4

3. My relationships are as satisfying as I would want them to be

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
4	3	2	1	0

Appendix B: The De Jong Gierveld 6-Item Loneliness Scale

We would like to ask you a few questions to enable us to measure how helpful our services are. You can choose to answer all or none of the questions, and choosing not to answer will not affect your access to any of our services in any way. When answering the questions, you could take account of the following:

- There are no right or wrong answers
- We would like you to be completely honest
- In answering the questions it is best to think of your life as it generally is now (we all have some good or bad days)

Questions

1. I experience a general sense of emptiness

Yes	More or Less	No
1	1	0

2. There are plenty of people I can rely on when I have problems

Yes	More or Less	No
0	1	1

3. There are many people I can trust completely

Yes	More or Less	No
0	1	1

4. I miss having people around me

Yes	More or Less	No
1	1	0

5. There are enough people I feel close to

Yes	More or Less	No
0	1	1

6. I often feel rejected

Yes	More or Less	No
1	1	0

Appendix C: The UCLA 3-Item Loneliness Scale

We would like to ask you a few questions to enable us to measure how helpful our services are. You can choose to answer all or none of the questions, and choosing not to answer will not affect your access to any of our services in any way. When answering the questions, you could take account of the following:

- There are no right or wrong answers
- We would like you to be completely honest
- In answering the questions it is best to think of your life as it generally is now (we all have some good or bad days)

Questions

1. **How often do you feel that you lack companionship?**

Hardly ever	Some of the time	Often
1	2	3

2. **How often do you feel left out?**

Hardly ever	Some of the time	Often
1	2	3

3. **How often do you feel isolated from others?**

Hardly ever	Some of the time	Often
1	2	3

Appendix D: Demographic Data

The following text can be used to introduce the need for demographic data:

We are asking these questions in order to better understand who is taking part in our social group/ project. This information will remain confidential and will not be shared with anyone else.

Gender

What is your gender?

1. Male
2. Female
3. Other _____

Age

What was your age last birthday? OR

What is your age?

1. Under 50 years old
2. 50-59 years old
3. 60-69 years old
4. 70-79 years old
5. 80-89 years old
6. Over 90 years old
7. Rather not say

Marital Status

Are you:

1. Single, that is, never married and never registered in a same-sex civil partnership
2. Married
3. Separated, but still legally married
4. Divorced
5. Widowed
6. In a registered same-sex civil partnership
7. Separated, but still legally in a same-sex civil partnership
8. Formerly in a same-sex civil partnership which is now legally dissolved
9. Surviving partner from a same-sex civil partnership
10. Rather not say

Ethnic group

Which of the following options best describes your ethnic group or background?

White

1. English/Welsh/Scottish/Northern Irish/British
2. Irish
3. Gypsy or Irish Traveller
4. Any other White background, please describe

Mixed/Multiple ethnic groups

5. White and Black Caribbean
6. White and Black African
7. White and Asian
8. Any other Mixed/Multiple ethnic background, please describe

Asian/Asian British

9. Indian
10. Pakistani
11. Bangladeshi
12. Chinese
13. Any other Asian background, please describe

Black/African/Caribbean/Black British

14. African
15. Caribbean
16. Any other Black/African/Caribbean background, please describe
17. Arab
18. Any other ethnic group, please describe
19. Rather not say

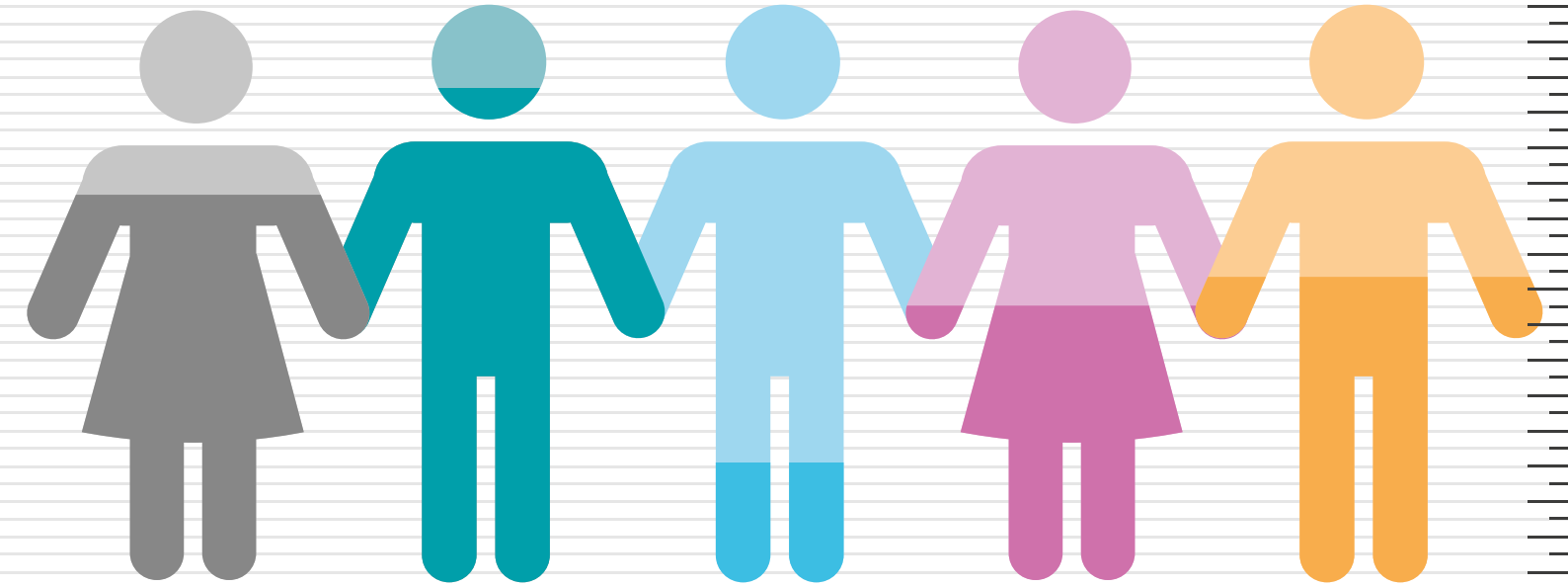
If you would like additional standardised questions on demographic data, for example on disability and impairment, we recommend the Office for National Statistics webpage on harmonised concepts and questions.[36]

Sexual orientation

What is your sexual orientation?

1. Lesbian
2. Gay
3. Bisexual
4. Heterosexual
5. Other _____

36 Primary set of harmonised concepts and questions. Available at: http://www.ons.gov.uk/ons/guide-method/harmonisation/primary-set-of-harmonised-concepts-and-questions/index.html [Accessed 30 April 2015]



About the Campaign

The Campaign to End Loneliness inspires thousands of people and organisations to do more to tackle loneliness in older age. We are a network of national, regional and local organisations and people working through community action, good practice, research and policy to create the right conditions to reduce loneliness in later life. We were launched in 2011, are led by five partner organisations, Age UK Oxfordshire, Independent Age, Manchester City Council, Royal Voluntary Service and Sense, and work alongside more than 2,000 supporters, all tackling loneliness in older age. Our work is funded by the Calouste Gulbenkian Foundation, the Tudor Trust, the Esmée Fairbairn Foundation and the John Ellerman Foundation.

Campaign to End Loneliness
3 Rufus Street
London
N1 6PE

For general queries, email us at
info@campaigntoendloneliness.org.uk
or call us on 020 7012 1409.

@EndLonelinessUK

www.campaigntoendloneliness.org.uk

Campaign to EndLoneliness
CONNECTIONS IN OLDER AGE

Esmée Fairbairn FOUNDATION

Design by i_do_creative www.i-do-creative.com

Agenda Item 3.2

Cynulliad Cenedlaethol Cymru
Y Pwyllgor Cyllid

National Assembly for Wales
Finance Committee

Health, Social Care and Sport Committee

15 June 2017

Dear Dai Lloyd AM

Scrutiny of the draft Budget

I am writing following the Business Committee's consideration of their draft report on changes to Standing Orders in relation to scrutiny of the draft Budget, prior to the Standing Order changes and the Budget Process Protocol being considered in Plenary next week.

The changes to the Budget process are the culmination of a piece of work started by the Finance Committee in the Fourth Assembly; the devolution of fiscal powers in the Wales Act 2014 have meant that the Assembly's scrutiny now has to consider not just Welsh Government spending plans, but how these plans will be financed, through taxation and borrowing.

The main changes which are being proposed are that the budget scrutiny becomes a two stage process, whereby the higher level information which would be scrutinised by the Finance Committee is published prior to the detail needed by the policy committees, and more time is allowed for scrutiny. Specifically, it is hoped this additional time will allow the policy committees to undertake more detailed scrutiny of the spending in your portfolios, and you will no longer be required to report to the Finance Committee, you are able to report in your own right should you so wish.

Cynulliad Cenedlaethol Cymru
Bae Caerdydd, Caerdydd, CF99 1NA
SeneddCyllid@cynulliad.cymru
www.cynulliad.cymru/SeneddCyllid
0300 200 6565

National Assembly for Wales
Cardiff Bay, Cardiff, CF99 1NA
SeneddFinance@assembly.wales
www.assembly.wales/SeneddFinance
0300 200 6565

I have requested a discussion on these changes at the next Chairs' forum, to enable us to talk through the changes in more detail and we can consider how:

- the Committee scrutiny will work in practice,
- the Finance Committee can maintain an oversight role,
- we can work together to maximise public engagement,
- any training and development needs for committees can be met

Prior to consideration in Plenary the proposed changes to Standing Orders have been tabled, as has the revised protocol.

Should you have any queries on this please do not hesitate to let me know, and I look forward to discussing these changes further at the Chairs' Forum meeting on 12 July 2017.

Yours sincerely

Simon Thomas AM

Chair of the Finance Committee

Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Health, Social Care and Sport Committee
HSCS(5)-20-17 Papur 5 / Paper 5

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon
Cabinet Secretary for Health, Well-being and Sport

Llywodraeth Cymru
Welsh Government

Dr. Dai Lloyd AM
Chair, Health, Social Care and Sport Committee
National Assembly for Wales
CF99 1NA

Sent via: SeneddHealth@Assembly.Wales

22nd June 2017

Dear Dai,

Further to the action point recorded at my attendance at the Health, Well-being and Sport's Committee meeting on 7 June, please see links below to the cluster plans as requested.

Abertawe Bro Morgannwg University Health Board:

http://www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=89064

Aneurin Bevan University Health Board:

http://www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=89065

Betsi Cadwaladr University Health Board:

http://www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=89066

Cardiff and Vale University Health Board:

http://www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=89067

Cwm Taf University Health Board:

http://www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=89068

Hywel Dda University Health Board:

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1NA

Canolfan Cyswllt Cyntaf / First Point of Contact Centre:
0300 0604400
Gohebiaeth.Vaughan.Gething@llyw.cymru
Correspondence.Vaughan.Gething@gov.wales

http://www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=89070

Powys Teaching Health Board:

http://www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=89071

Yours sincerely

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon
Cabinet Secretary for Health, Well-being and Sport