Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Cofnod y Trafodion
The Record of Proceedings

Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

The Health, Social Care and Sport Committee

25/05/2017

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Others in attendance

Yr Athro / Professor Vanessa Burholt	Y Ganolfan Ymchwil Heneiddio a Dementia a'r Ganolfan Heneiddio Arloesol, Prifysgol Abertawe Centre for Ageing and Dementia Research and the Centre for Innovative Ageing, Swansea University
Emma Harris	Swyddog Polisi a Chyfathrebu, y Samariaid Policy and Communications Officer, Samaritans
Rachel Lewis	Rheolwr Polisi, Age Cymru Policy Manager, Age Cymru
Victoria Lloyd	Cyfarwyddwr Materion Allanol a Datblygwr Rhaglenni Director of External Affairs and Programme Developer, Age Cymru

Dr Deborah Morgan	Y Ganolfan Ymchwil Heneiddio a Dementia a'r Ganolfan Heneiddio Arloesol, Prifysgol Abertawe Centre for Ageing and Dementia Research and the Centre for Innovative Ageing, Swansea University
Dr Kellie Payne	Rheolwr Polisi ac Ymchwil, Campaign to End Loneliness Research and Policy Manager, Campaign to End Loneliness
Sarah Rochira	Comisiynydd Pobl Hŷn Cymru Older People's Commissioner for Wales
Sarah Stone	Cyfarwyddwr Gweithredol Cymru, y Samariaid Executive Director for Wales, Samaritans

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

Stephen Boyce	Ymchwilydd Researcher
Claire Morris	Clerc Clerk
Sian Thomas	Dirprwy Glerc Deputy Clerk

Dechreuodd y cyfarfod am 09:32.
The meeting began at 09:32.

Cyflwyniad, Ymddiheuriadau, Dirprwyon a Datgan Buddiannau
Introductions, Apologies, Substitutions and Declarations of Interest

[1] **Dai Lloyd:** Croeso i chi i gyd i'r Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yn y Cynulliad. O dan eitem 1, a allaf estyn croeso i fy nghyd-Aelodau a'n tystion y bore yma? Mwy am hynny yn y man. Yn naturiol, rydym yn cofio yn ein

Dai Lloyd: Welcome to this meeting of the Health, Social Care and Sport Committee here at the National Assembly. Under item 1, can I please welcome my fellow Members and our witnesses this morning? More about them in a moment. Naturally, of

gweddïau am ein cyd-Aelod, Julie Morgan, am resymau amlwg. Rydym wedi derbyn ymddiheuriadau oddi wrth Jayne Bryant, ac nid oes dirprwy. Rydym hefyd wedi clywed oddi wrth Caroline Jones y bydd hi yn hwyr. Gallaf yn bellach gyhoeddi y bydd yna funud o dawelwch yma ar draws y Senedd am 11 o'r gloch y bore yma i gofio digwyddiad erchyll Manceinion. Bydd y gloch yn canu i nodi yr amser penodol hwnnw.

course, we remember in our prayers our fellow Member, Julie Morgan, for obvious reasons. We have had apologies from Jayne Bryant, and we don't have a substitute. We've also heard from Caroline Jones that she will be a little late. Can I also let you know that there will be a minute's silence here across the Senedd at 11 o'clock to remember the tragedy in Manchester? The bell will ring to note the specific time.

[2] Gallaf ymhellach egluro, yn naturiol, fod y cyfarfod yma yn ddwyieithog. Gellir defnyddio clustffonau i glywed cyfieithu ar y pryd o'r Gymraeg i'r Saesneg ar sianel 1 neu i glywed cyfraniadau yn yr iaith wreiddiol yn well ar sianel 2. A allaf i atgoffa pobl i naill ai ddiffodd eu ffonau symudol ac unrhyw gyfarpar electronig arall yn gyfan gwbl, neu eu rhoi ar y dewis tawel, achos maen nhw'n amharu ar y cyfarpar sydd yn rhedeg y system sain yn y fan hyn? Ac a allaf yn bellach hysbysu pobl y dylid dilyn cyfarwyddiadau'r tywyswyr os bydd larwm tân yn canu?

Can I also explain that this meeting will run bilingually? You can use headphones to hear interpretation from Welsh to English on channel 1, and verbatim on channel 2. Can you please switch off your mobile phones or any other electronic equipment, or put them on silent, because it does interfere with the broadcasting equipment? Also, if there is a fire alarm, please follow the directions from the ushers.

09:33

Ymchwiliad i Unigrwydd ac Unigedd—Sesiwn Dystiolaeth 1—Yr Athro Vanessa Burholt a Dr Deborah Morgan
Inquiry into Loneliness and Isolation—Evidence Session 1—Professor Vanessa Burholt and Dr Deborah Morgan

[3] **Dai Lloyd**: Gyda chymaint o hynny o ragymadrodd, mi drown yn syth i eitem 2 ac ymchwiliad y

Dai Lloyd: With that much of an introduction, can I move straight to item 2, the inquiry into loneliness

pwyllgor yma i unigrwydd ac unigedd—sesiwn dystiolaeth ar lafar rhif 1. Fe fydd Aelodau'n ymwybodol ein bod wedi bod yn cynnal cyfarfodydd ar draws Cymru ers rhyw bedwar mis rŵan ar y pwnc penodol yma, ond dyma y sesiwn lafar gyntaf. Rydym wedi derbyn cryn dipyn hefyd o dystiolaeth ysgrifenedig, a diolch i bawb ymlaen llaw am ysgrifennu atom ni. Sesiwn dystiolaeth rhif 1, felly, am y tri chwarter awr nesaf, ac o'n blaenau ni mae yr Athro Vanessa Burholt, y Ganolfan Ymchwil Heneiddio a Dementia a'r Ganolfan Heneiddio Arloesol o Brifysgol Abertawe. Croeso i chi. Ac hefyd Dr Deborah Morgan, y Ganolfan Ymchwil Heneiddio a Dementia a'r Ganolfan Heneiddio Arloesol hefyd, Prifysgol Abertawe. Croeso i'r ddwy ohonoch chi. Rydym wedi derbyn eich tystiolaeth ysgrifenedig, ac felly yn ôl ein harfer fe awn yn syth fewn i gwestiynau. Mae yna nifer helaeth o gwestiynau, felly cwestiynau byr, Aelodau, gan esgor ar atebion cryno hefyd. Lynne i ddechrau.

and isolation? It's evidence session 1. Members will be aware that we have been holding meetings across Wales over the last four months on this particular topic, but this is the first oral evidence session today. We also had a lot of written evidence, and thank you to everyone for providing that for us. Evidence session 1, therefore, for the next three quarters of an hour, and before us we have Professor Vanessa Burholt from the Centre for Ageing and Dementia Research and the Centre for Innovative Ageing, Swansea University. Welcome to you. And also Dr Deborah Morgan, the Centre for Ageing and Dementia Research and the Centre for Innovative Ageing, Swansea University. Welcome to you both. We have received your written evidence, so, as is our norm, we will go straight into questions. We have many questions this morning, so can I ask Members for succinct questions, please, and maybe succinct answers also? Lynne, please.

[4] **Lynne Neagle**: Thanks, Chair, and good morning, both. I just wondered if you could tell us a bit more about the work that both of your organisations is doing on loneliness and isolation, and whether you could expand on whether there's any international evidence that might be able to inform the work the committee's doing.

[5] **Professor Burholt**: Okay, sure. We actually have a wealth of evidence in Wales that we're building our platform upon. I was part of the Bangor longitudinal study of ageing, which started back in 1979 and was one of the first studies to look at loneliness and isolation and come up with models of those. Building on the Bangor longitudinal study of ageing, there was also a cognitive function and ageing study, which started in 1995. More recently,

we've done the follow-up study for that, in 2013. In Wales, our particular focus has been on social relationships, social isolation, social networks and loneliness. So, we have a vast body of evidence, stretching right back from 1979 up to the present day, on changes in isolation and loneliness—panel changes, if you like.

[6] The cognitive function and ageing study—Deborah's PhD came out of that. So, that built on some of the quantitative data, plus our own fieldwork with qualitative date. We've run migrant studies that have looked at the status of loneliness for BME groups in England and Wales, funded by the Leverhulme Trust, but also by the National Institute for Social Care and Health Research. We've looked at supported living environments and loneliness, again funded by NISCHR, comparing the loneliness of older people receiving community care, living in residential care and living in extra care.

[7] We are part of a large, EU-funded COST action, which is a network of actions on social exclusion. I lead the management for the social resources group. Exclusion from social resources leads to social isolation, which, if judged so, would be judged as loneliness, depending on one's subjective assessment of that.

[8] You also mentioned our centre, the Centre for Ageing and Dementia Research. That is comprised of several work packages. One of those is on the psychosocial elements of ageing. Our extension bid, which is going in at the moment—that theme particularly focuses on loneliness, isolation and resilience. There are a couple of areas that we are developing that we may speak to you about later if there's some questions on that. Do you want to talk about your health service stuff?

[9] **Dr Morgan**: Yes, sure. So, my PhD was looking at transitions in loneliness. As Ness said, we looked at qualitative and quantitative data for that, and we looked at people's pathways through loneliness—so, stability and change, temporal changes in loneliness and so forth. But we also looked at the risk factors and how we could classify people into different classifications of loneliness and the risk factors that predicted each of those classifications. I'm currently working on a proposal to look at healthcare utilisation, because there's some anecdotal evidence that people who are lonely use more services, but we don't know. We can't quantify that here in Wales at the moment. The last study that did that in England was in 1992. So, it's been a long time since that's been done, so that's something we're

looking at developing at the moment.

[10] **Dai Lloyd**: Okay. Lynne.

[11] **Lynne Neagle**: Is there anything you'd like to draw to the committee's attention about the differences between loneliness and isolation and the definitions that are used?

[12] **Dr Morgan**: Yes, sure. Shall I take that one? They are distinct concepts. So, loneliness is defined as a negative unpleasant experience that results from a dissatisfaction with either the quantity or the quality of social relationships. So, effectively, that means if somebody has a large social network with lots of friends they can still feel lonely if they feel the quality of those relationships isn't as they would like—they don't feel as close to those friends. Conversely, someone can have a very small network with one or two friends but feel very close to them and then never feel lonely.

[13] Social isolation can be defined as a lack of or a paucity of social contact. We can measure that. It's an objective measure, we can measure that by counting the number of contacts somebody has within a specific time frame.

[14] **Lynne Neagle**: Okay, and have you got any comments on the way society treats older and disabled people and the impact that has on their social relationships and self-image, and any arising risk, then, of loneliness?

[15] **Professor Burholt**: So, in your packs, there is a framework that we've developed, looking at how there are societal impacts on people's experience of social isolation—so, how they're excluded from social relationships, but how that also impacts on the way in which they assess their situation. If loneliness is a subjective experience, it's also influenced by social norms. So, you can have social norms that are prejudiced or biased in the ways in which people may interact with older people, or allow them inclusion into society, but there are also norms that may be internalised. For example, we have a paper in the pack about cognitive impairment and how that internalisation of the public perception of people with dementia or cognitive impairment can then impact on what you perceive your future may hold in terms of your social interaction. You may foresee a future that sounds as if you are going to have a shrinking social world, and then feel lonely because of your perceived future trajectory, if you like.

[16] It's not a very well explored area, and one of the big bids that we are developing at the moment is a European Research Council bid, which is going to draw on some of the European Social Survey data about discrimination to see how that contributes to loneliness, but also, on a very individual level, try to understand how those personal experiences of discrimination contribute to loneliness. That may be discrimination because you are old, because you are a woman, because you are from a BME group, or because you are gay. It could be all sorts of different reasons that add to that experience of exclusion from social relations, and possibly an outcome of loneliness—but not definitely an outcome of loneliness.

[17] **Dai Lloyd**: Diolch yn fawr. Rhun sydd â'r cwestiynau nesaf. **Dai Lloyd**: Thank you very much. Rhun has the next questions.

[18] **Rhun ap Iorwerth**: A very good morning to you. You say you have lots of evidence. How easy is it—or how useful is that evidence for actually applying to planning interventions that can try to avoid the kind of loneliness and isolation that we are talking about here?

[19] **Professor Burholt**: A lot of our work has been drawing on epidemiological studies to look at the prevalence of loneliness and the associations between loneliness and risk factors. The model I describe in the paper also takes into account things like resilience, which may impact on loneliness, or the way in which you assess your personal situation. The evidence that we have for interventions and the strength of interventions is not particularly good at the moment. Some of it is quite old. There was a review on ageing and society by Cattan, which is now fairly out of date. She came up with some ideas that the most effective interventions were community group and education-type interventions. More recently there has been a systematic review by Massey, which is wildly cited—'widely' cited, not 'wildly'—that suggests that cognitive behavioural therapy is the answer for loneliness and the most effective intervention. However, I would argue that that particular review is fundamentally flawed if you want to think about loneliness holistically. They didn't draw on community studies. They drew on a very medical model of loneliness that looked at loneliness as a primary outcome, which is the term you would use if you were using a randomised controlled trial rather than looking at it in the round and saying: 'Actually, if we want to alleviate loneliness, should we be looking at something whose primary aim is perhaps to produce education or just to get a group together?' So, their conclusions were drawn primarily on a medical model of loneliness and those studies that were around depressive symptoms—so,

high levels of depressive symptoms. So, I don't think that offers us the final say in that.

[20] Then, there is another RCT that was conducted in Ireland that looked at befriending services. It showed that befriending worked; however, they didn't analyse drop-out. So, we only know that befriending works for those people who carry on in a befriending service. Between the two of us, we would argue that what we actually need is complex interventions. Now, they have started to look at these elsewhere. In the Netherlands, they've had a consortium approach to a whole range of different interventions that would map on someone's pathway through to loneliness. Deborah mentioned earlier that there are several risks for loneliness. You might be bereaved and become lonely. You may have a hearing impairment, and that impacts on loneliness. You may move to a new area, and that's what impacts on your loneliness. Or, you may cease driving. Now, befriending isn't the answer to all of those potential triggers to loneliness. There are complex pathways to loneliness, and our interventions need to match and map onto those complex pathways. So, we are looking at the ways in which we can build on some of the work in the Netherlands. Although they talked about loneliness as being complex, they didn't actually match intervention to pathway, and that's the route we think we need to take to find out what works, for whom, and under what circumstances—according to that pathway to which they have ended up being lonely.

[21] **Rhun ap Iorwerth:** Do you agree, Deborah Morgan, that there's a gap between the evidence—the quality, the quantity, all those measures—and actually how to use that? What can we, as a committee, do usefully to maybe bridge towards or nudge people into devising the interventions that we need?

09:45

[22] **Dr Morgan:** There is a gap. There is a huge gap. From the work that I've done, as Vanessa said, people's pathways are complex. Sometimes it's personal characteristics. I'm not blaming people for their loneliness at all, but sometimes, if somebody's very reserved or quiet, some of the conventional routes—interventions—are not going to be amenable to people. I've had people who've said, 'Befriending—I don't do groups'. And in a sense, that sort of exacerbates people's loneliness. So, yes, we definitely need more complex interventions, but they need to be personalised and individualised to that person. So, some of the pathways we've had were people who became lonely because they were bereaved, they moved out of loneliness but then

became lonely because their health deteriorated, and that impacted on how they saw themselves. So, we might need things like CBT for some people. Some people experience what they call a biographical disruption, so their identity—they've lost their sense of self. So, yes, we need a wide variety, and I think as a committee, you probably need to start thinking about the different sorts of interventions and the different ways that everyday life can impact on loneliness. There is a socioeconomic gradient. So, some of the economic circumstances we're in—that could potentially have a big impact. So, we need to perhaps consider it when we think of policy and developing policies.

[23] **Rhun Ap Iorwerth**: Can I dig a little bit deeper into exactly that point? These have been tough times—a decade or so for many people, and longer than that for many. Can we pinpoint whole communities or, more likely, groups of people within communities that would be more vulnerable in Wales because of socioeconomic pressures?

[24] **Dr Morgan**: Well, we didn't look at it between north and south, did we? That's something we still need to do. But when we looked at the quantitative data, there was this, like I said, socioeconomic gradient, and that's backed up by evidence from other places. So, people in very deprived communities, people living in council housing, low levels of education—they were the ones who were at greatest risk.

[25] **Rhun Ap Iorwerth**: Would you say that we have what would constitute a loneliness and isolation map for Wales now? If we don't, would that be useful?

[26] **Dr Morgan**: No.

[27] **Professor Burholt**: No. We don't have one and I don't think it would be useful. I think what would happen is you'd end up masking some of these really important differences; that it's not all about—. For some people, it will be place based. It will be that place effect that is influencing the outcome on loneliness. So, if you live in a rural area and have to give up driving because you're physically impaired or cognitively impaired, then that may well impact on your loneliness. However, that doesn't really deal with the issues—all of the other myriad of factors—that would contribute to loneliness. There are some things we do know: that if you are living in a residential care home or a supported living environment, you may be more likely to experience loneliness. But again, that's not because of those environments, it's because

of the sorts of—. Well, some of it's been about policy; suggesting, for example, that extra care was the place where you go to alleviate loneliness, and actually it increases your social interaction with other people, but it doesn't necessarily decrease your loneliness because that is your subjective experience. If you want to have relationships with your friends that you've established in your community over the last thirty years, or with your family who live much further away from that care home or supported living environment, then those are the relationships you want to maintain, not necessarily a new relationship with your neighbour.

[28] **Rhun Ap Iorwerth:** I guess by 'mapping', we don't just mean mapping geographic—. It could be mapping of patterns and societal groups, rather than—

[29] **Professor Burholt:** Well, that is the work that we've been doing in the centre: looking at those interrelationships between risk factors and outcomes and area and depression and cognitive impairment. Those are the sorts of things that we can assess from our epidemiological studies. So, the paper in there that looks at the cognitive impairment starts to unpick or unravel some of those connections that we have between those things. You have a resource in Wales, which is this two-wave longitudinal data that is robust enough to give very good estimates for the rest of Wales about those patterns associated with loneliness.

[30] **Dai Lloyd:** Mae'r cwestiynau nesaf gan Angela Burns.

Dai Lloyd: The next questions are from Angela Burns.

[31] **Angela Burns:** I've got two areas of questioning. I'll start with one that I think feeds off from Rhun's; I don't think you mentioned it when you talked earlier. I'd like to understand better the differences between collectivism and the individualistic cultures, and I'd also like to try and understand if, within that, or as a result of that, there are intergenerational markers. So, for example, are baby boomers, which will be the older people in 10 years' time, more likely to suffer from loneliness because of their life experiences and their expectations? Are there any sort of particular—? Or are we talking about loneliness and isolation as something that's particularly felt by the post-war generation? I'm trying to understand that, and I'd like to understand the difference between individualistic and collectivism.

[32] **Professor Burholt:** Okay, I'll start with the individualistic and collectivist cultures, if that's okay.

[33] **Angela Burns**: Yes, thank you.

[34] **Professor Burholt**: On the whole, the BME groups that we have ageing in Wales and in the UK as a whole have migrated from more collectivist cultures. A collectivist culture is one where either the family is more important than the individual's goals, or the community itself. So, some BME groups, you may say they are more communal. So, some of the black African groups, black Caribbean groups, may be more communal, whereas some of the south-east Asian groups are more familistic. Either way, there are collectivist cultures, so the—

[35] **Angela Burns**: Sorry, by that, though, do you mean that the families all live together, or do you mean just the mentality of being part of that?

[36] **Professor Burholt**: Okay, so normative expectations about who—. Where we would, perhaps, seek to further individual goals, within a collectivist culture it's about the goals or the purposes to support the whole family, for familistic, or the whole community, for communal cultures. Those cultures, of course, are changing, but the people who are ageing, from the BME groups that we've worked with, have on the whole come from communal or familistic cultures—more so than being individualistic.

[37] Now, those norms impact on the way that we assess our personal situations. So, in the UK, within the indigenous population, the norm is for us to have a good mix of family and friends in our social support networks, and if those deviate in some way, then we judge ourselves to be lacking in some way, so that's where we lack in the quantity or quality of our social relationships, and experience loneliness. So, for example, for older people living in the UK, if they live in what we call a family-dependent network, where they may live in a household with their family, they actually experience loneliness more than people who are living with a good mix of family and friends, because they don't have friends seeing them. Quite often, if you move into your family's house, friends stop coming to see people. If you haven't got the mix, then you experience loneliness.

[38] From a collectivist culture, the norm is different, and, from what we've seen and the way we've looked at this, it appears that having family around, and a high contact with family, is more important than having friends in the network, and, actually, it doesn't matter for the older people ageing. Having that mix of friends doesn't impact on their level of loneliness. They

experience more loneliness if they don't have family around them. That's only for this generation, because, when you were talking about generations, I know you were applying it to something else, but, in this case, these are first-wave migrants who have come from a collectivist culture to a more individualistic one. Second generation and third generation migrants have been born in an individualistic society, and so their own personal norms are going to be influenced by both their family collectivist norms, plus the society they live in. So, their way of assessing whether or not they're lonely, their social self-comparison, may be very different from their parents' comparison.

[39] And the other question was the intergenerational markers, about differences between generations in the experience of loneliness. I think, other than the macro-level stuff, which is about norms and values, it again is about personal experiences. So, we can see if you've got an increased risk of cognitive impairment, functional impairment, hearing loss, they will trigger, or could trigger, that pathway to loneliness, regardless of your generation. It may be later, if you do more about improving health, but it doesn't appear to be a period effect on loneliness. So, there isn't a set of norms—that we've observed, anyway—within the UK, because most of the age effect can be accounted for by other factors. So, the level of impairment, where you're living—those sorts of things, rather than it being a period effect.

[40] **Angela Burns:** Okay, and is that simply because you don't think it's there, that evidence, or is it because it's not something yet that has been looked at? It is really only since post war that we've had these really clear, almost linear—like rings of tree, isn't it, as we look through our generation since, at the marked sort of difference of attitude, expectation, experience, preparedness to be involved, that view?

[41] **Professor Burholt:** Well, interestingly, I have another PhD student, actually, looking at exclusion in the Valleys. It relates to this, because it relates to those cultural expectations about—. Culture was really important. The change in culture in areas is making people feel lonely and excluded. So, where language is changing and the balance between Welsh-speaking and English-speaking communities is changing, that is impacting. So, you could say that is a post-war effect because migration in those—. You could put it down to migration; it's not really—. You see, it all comes down to other things. So, it's linked to population change, which is linked to the industrial change, but that then results in a change in culture, feeling excluded from culture and a feeling of loneliness when you can't necessarily mix with

people that you don't know any more who are your neighbours, and there's a new housing development and you don't know them. So, it's very complex. This is why we say simple solutions are quite difficult to come by, because it's that complexity and down to the individual experience of that complexity, as well.

[42] **Angela Burns:** My last little set of questions—because I can feel the Chair thinking, 'Hurry up'—actually is about the relationship between loneliness and depression, and the comment that you made in your paper about people using alcohol as well to combat loneliness. So, I think my question is: what comes first? Because is it the loneliness and then the alcoholism creates the depression? Is it the loneliness, they get depressed, and they turn to alcohol, or is it actually alcohol that creates depression and, therefore, loneliness? Or is it just all mixed up?

[43] **Professor Burholt:** Okay. I think we need to deal with depression and alcohol separately, as not being synonymous. Do you want to deal with the alcohol issue?

[44] **Angela Burns:** Except that alcoholism can cause depression and the other way around, can't it? Alcoholism can be an outcome of depression.

[45] **Professor Burholt:** Yes, but we've also got a similar situation with loneliness—it can cause depression, or depression can cause loneliness. But if I let Deb talk a little bit about the alcohol and then I'll come back on depression and loneliness.

[46] **Dr Morgan:** So, I didn't look at alcohol in the quantitative data; this came out of the qualitative work that I did with a small group of older adults who had self-identified as lonely and isolated. There were a number of them who referred to using alcohol to self-medicate. So, this one gentleman in particular was drinking a bottle of wine every evening. He was a retired migrant, his wife had left him, he'd felt rejected by the local community. His only contact was to go and talk to somebody in a shop. So, he was using alcohol every evening to self-medicate. Now, this was a person who would go out, and he would go out and socialise, but he didn't feel he had that closeness with the people he was socialising with. So, he was drinking at home alone. There were other individuals who would use the pub as a way of mediating contact with other people, but then were drinking far more than they should have been, and acknowledged they were drinking more than they should have been. Then, we had individuals who spoke about feeling fearful

that if they started to use alcohol, they would be going down that slippery slope and wouldn't be able to stop. They spoke about how it was only willpower preventing them keeping alcohol in the house more than they used to. So, for these individuals, it was definitely the loneliness that was the trigger for the increased drinking or the fear that if they started drinking they wouldn't be able to stop.

[47] **Angela Burns**: Right, okay. Interesting.

[48] **Professor Burholt**: With depression and the pathway to loneliness, we've been looking at quite complex models to look at that relationship. It's a reciprocal relationship. In the model we've got in there, you'll see we've got circular feedback loops. At the moment, in a lot of statistical models, it's assumed causal pathways—so, 'This affects this', or we do an alternative model where, 'This affects this'—so, depression causes loneliness or loneliness causes depression.

10:00

[49] It is more likely that there is a cyclical effect. We did one pathway, which was looking at the way in which depression may amplify the influence of a level of social resources on your loneliness, because it disrupts your cognitive processes. It disrupts the way in which you judge the adequacy of your situation. So, if loneliness is a subjective experience and you're comparing yourself to another situation, to say, 'Is this adequate or not?', that's either comparing yourself to a social norm, comparing yourself to peers, comparing yourself to earlier in your life, or comparing yourself to the expected future, if your cognitive processes are disrupted and depression is one of those things that do that, it's an unrealistic expectation you may be comparing your present situation to. So, with depression you're more likely to experience loneliness because of the unrealistic expectations.

[50] Similarly, we've found that with cognitive impairment. Now, that goes two ways. One is it disrupts it and can be internalised as a future—. I mentioned earlier that that might be to do with those norms about, 'I can only see a future that looks pretty bleak for me'. But there is another way that cognitive impairment influences that process, and that's anosognosia—when you don't know that you are cognitively impaired. In those situations, you may be well comparing yourself, or your expectations are based on not having any impairment because you don't realise you are cognitively impaired. So, your expectation is to have the same sort of social

relationships and interactions you may have had earlier in your life. So, we've got some evidence to suggest that's the case as well. So, the ways in which things are disrupted may lead to loneliness, but also loneliness increases your risk of depression and increases your risk of cognitive impairment. So, nothing is simple. You sort of get these cyclical feedback loops that are not explained. I did put that in the evidence.

[51] **Angela Burns**: Thank you.

[52] **Dai Lloyd**: Reit. A'r cwestiynau olaf o dan law Dawn Bowden.

Dai Lloyd: Right. The last questions, then, from Dawn Bowden.

[53] **Dawn Bowden**: Thank you, Chair. I think the first question I'm going to ask you, I suspect, is going to be not an easy one to answer either. There are going to be lots of complex reasons or areas in which we can address isolation and loneliness. What is the evidence that you've been able to gather so far, telling you about how isolation and loneliness can best be addressed? A complex issue, again, I guess.

[54] **Professor Burholt**: Isolation or loneliness, or both?

[55] **Dawn Bowden**: Or both, yes.

[56] **Professor Burholt**: Okay. Do you want to start?

[57] **Dr Morgan**: Yes. As you can gather from what we've been saying, it's really complex and it's down to the individual and their individual pathway what will work best for each person. Does that make sense?

[58] **Dawn Bowden**: Yes, and I think, from what you were saying, Vanessa, it's a kind of chicken and egg, isn't it? It's what comes first, and it could be the loneliness comes before the depression, depression comes before the loneliness, et cetera, et cetera. So, you know, looking at the evidence that you've gathered, I'm assuming that what you're saying is that there isn't a simple black-and-white answer to pathways to dealing with it. But I'm just interested to know what you think about the evidence that you have gathered so far.

[59] **Professor Burholt**: There will be several areas that we would be looking at intervening, if you like, and having interventions based on someone's trajectory, if that would help. So, for example, we're even looking at genetics

and that link with cognitive impairment. So, we've got a polygenic risk score. We can work out the risk for Alzheimer's disease and how much of that risk for Alzheimer's disease is caused by loneliness. If we know that, then we can maybe decrease that risk for Alzheimer's disease by working on loneliness. But the areas then in which you think, 'Okay, then what? What would you intervene in?', well, colleagues that we work with do eye tracking and they look at the way that people with cognitive impairment either can hold eye contact, like we're doing now, to have a proper conversation. If you look away, that impacts on your social relationships. So, she's looking at how that influences with cognitive impairment, and we will have people in MRI scanners so we can see what's going on in the brain and say, 'Well, can we do something about getting joint eye attention, which improves relationships, which hopefully would impact on loneliness?'

[60] There's also environment, which we haven't really talked about here yet—the physical environment. If you can't get outside your house because the physical environment is so poor that you can't navigate, and you can't get out because you don't know where your street is if you've got dementia, or the state of the pavement's too poor for you to walk on if you've got a physical impairment, then it doesn't matter how many schemes we've got down in the centre of town to try and deal with loneliness—if you can't get there, you can't do that. So, we're working on ways of mapping local environments to find out where those are most deleterious so that you can intervene in the environment, which will then ultimately impact, we hope, on loneliness. We've got to track that to see if it does, because we've got some of the epidemiological evidence to suggest it will, but once you start intervening, you've got to check that, actually, that intervention makes a difference and who it makes a difference to, because it's not going to make a difference to the active person who can get out, who's not afraid of crime. So, it's mapping it to those people.

[61] And then there's the area of stigma and prejudice, and how you address stigma, prejudice and ageism and the influence that might have on loneliness, and that would need a big public health campaign, a public health drive, a change of attitude towards the ways in which we treat people with dementia, or treat older people themselves to change that, to decrease, if you like, social exclusion, which would help and would impact on loneliness.

[62] **Dawn Bowden**: Yes, because I think you were saying, Deborah, weren't you, earlier, on the issue of stigma, that people don't actually like to admit that they're lonely? So, presumably, in those circumstances, the first step to

be able to help someone is for them to acknowledge that they're lonely.

[63] **Dr Morgan:** Yes. Something we've got to remember as well is some people will recover from loneliness by themselves. In the work I've done, we had a small proportion of people who had recovered from loneliness, and we looked at the coping strategies they used, their attitudes towards themselves. Most of these were people who described themselves as sociable, so they were the ones who would go to befriending and they would put themselves back out there to go to those group situations. But the ones I was most concerned about were the hidden population, the ones who won't come to the attention of services because they don't want to admit they're lonely, and that's the real issue. We were trying to develop an app, weren't we, with the fire service, using that 'making every contact count', and embedding a loneliness measure within their fire safety checks that we could then use to identify people who perhaps wouldn't come to our attention?

[64] **Dawn Bowden:** I'm just wondering whether that would be—and you, again, may have done some research around that—useful tracking in terms of the number of times that people contact agencies, for instance. We talked about this before, didn't we, in terms of—? I have people coming to my surgery—you get what we call the 'frequent flyers', the people who will come in, and sometimes it's because it's just somebody to talk to, and they will do the same with a GP or with any other agency just to have somebody to talk to.

[65] **Dr Morgan:** I'm writing a bid at the moment to look at that, to use SAIL data, to look at GP records, hospital records, outpatients, accident and emergency, and to map those people using CFAS data—the people we know who are lonely and mapping them through the health records to see how frequently they've been using those services, to see if there is an increase.

[66] **Dawn Bowden:** Okay.

[67] **Professor Burholt:** Our work with the fire service was based on that premise. We had a couple of meetings at the university about two totally different, unrelated things, and it was the unscheduled care and use of emergency services, and the risk factors for the regular diallers of 999—they called them 'the social calls'—or those turning up at A&E, or turning up in surgeries or to the GP needing to talk—the same risk factors for high levels of loneliness, and so we connected the two things and said, 'Well, this is obviously an area we could tackle if we got those interventions right.' So, the

app could be used—the one we're talking about: developing the complex intervention—in any of those settings. So, in GP surgeries—.

[68] But I don't think you have to admit you're lonely. In fact, I think the reverse is true. It's not like alcoholism—I don't think you have to do that to recover. I think, actually, what some of those early reviews suggested was that going along to something that doesn't have 'lonely' in the title, that was nothing to do with loneliness, would tackle loneliness. And that's why I think it's a fatal flaw in that Massey review—they were using interventions that only said, 'We're an intervention for loneliness and so these are the ones that work', where, in fact, I think that the earlier evidence was suggesting it's a secondary outcome, a really important secondary outcome, and people are perhaps more likely to come along to something that doesn't label them as being lonely.

[69] **Dr Morgan:** And that's come out of the work—we've run a number of events around Wales with older people, and with services, and that's come out very strongly from the events and the feedback we've had from older people. They don't want to go to something that has 'lonely' in the title. They want to do the things that they've always enjoyed doing and having the means to do that, whether that's transport—

[70] **Dawn Bowden:** It sounds like quite a miserable thing to do.

[71] **Dr Morgan:** Yes. [*Laughter.*]

[72] **Dawn Bowden:** Can I just ask you, because you did touch earlier, Vanessa, on examples from the Netherlands and that you were doing some work—? Have you got other experiences of the ways that other countries have tried to address this that you're drawing from as well?

[73] **Professor Burholt:** You have to be quite careful with how—. Because of these differences in the actual values in each culture, you could really only draw examples from cultures that may have similar values to ours, which is why one of the world-leading experts on loneliness, Jenny de Jong Gierveld, is from the Netherlands, and we work closely with Jenny, and that's why I drew on that consortium approach, because they're one of the only places to think about loneliness in terms of complexity. So, we're not going to give one solution; it's got to have a myriad of solutions. They did try a complex intervention with a consortium approach, with a lot of different services, but they didn't match those services to the individuals, other than cognitive

behavioural therapy to people with depression. And they didn't find an impact on loneliness. We suspect that the complexity needs to be addressed with the complexity of matching—. The same way you would prescribe based on the complexity of symptoms that someone presents with at a surgery, the same way you should be thinking about matching loneliness interventions—so that complexity of pathway to loneliness. So, building on that work—I think would be really useful to try that out here.

[74] **Dawn Bowden**: Okay, thank you for that. I'm just conscious of time, now. My last question, really, is about what you think the Welsh Government should be doing. You've told us an awful lot today, but if you could hone in on two or three things that you think Welsh Government could actively do to help in this area, what would they be?

[75] **Professor Burholt**: Fund CADR for another two years, so that they could focus on loneliness and isolation, which is a major theme of our work. I think we've got really good resources in Wales to deal with complexity. We've got Dewis, which is the database of service provision, so if we can map pathways to loneliness, we can map to appropriate services in local areas, which they can't do in England at the moment, or in Scotland. So, we've got a really good opportunity, I think, to do that, and to impact on prudent healthcare provision, because if we can reduce the number of emergency calls that are about loneliness, we can reduce the amount of GP time that's used up because of a social loneliness issue, then those services can be used to their full effect for their proper intent, if you like. But also, at the same time, decreasing loneliness will have an impact on the health of Wales—the public health, the cognitive health and the physical health of the older population in Wales. So, fund our research. [*Laughter*.]

[76] **Dai Lloyd**: Ar y nodyn cadarnhaol yna, mi ddown ni â'r sesiwn drafodaeth yma i ben. Diolch yn fawr iawn i chi'ch dwy am eich presenoldeb a'ch tystiolaeth y bore yma, a hefyd am y dystiolaeth ysgrifenedig ymlaen llaw. Fe allaf bellach gyhoeddi y byddwch chi'n derbyn trawsgrifiad o'r drafodaeth yma y bore yma, i gadarnhau ei fod yn ffeithiol gywir. Gyda hynny o ragymadrodd, fe allaf gyhoeddi bod y

Dai Lloyd: On that very positive note, we'll bring this discussion session to an end. Thank you very much to you both for attending today and for your evidence, and also for the written evidence beforehand. I can now announce that you will receive a transcript of the discussion this morning, to confirm that it's factually correct. So, with that introduction, I can announce that this evidence session is at an end. And I inform my

sesiwn dystiolaeth yma ar ben. A gallaf gyhoeddi i fy nghyd-Aelodau y byddwn ni'n cymryd egwyl, rŵan, am bum munud a dod yn ôl jest cyn 10.20 a.m. Diolch yn fawr iawn.

fellow Members that we'll have a five-minute break and return just before 10.20 a.m. Thank you very much.

Gohiriwyd y cyfarfod rhwng 10:14 a 10:19.
The meeting adjourned between 10:14 and 10:19.

Ymchwiliad i Unigrwydd ac Unigedd—Sesiwn Dystiolaeth 2—Comisiynydd Pobl Hŷn Cymru
Inquiry into Loneliness and Isolation—Evidence Session 2—Older People's Commissioner for Wales

[77] **Dai Lloyd**: Croeso nôl i'r cyfarfod. Gyda ni, mae hen ffrind i'r pwyllgor yma, Sarah Rochira, Comisiynydd Pobl Hŷn Cymru. Rydym ni'n diolch am ei thystiolaeth ysgrifenedig ar y pwnc yma o unigrwydd ac unigedd—diolch yn fawr iawn i chi—a hefyd mae gennym ni res o gwestiynau o'n blaenau, ac felly, gyda'ch caniatâd, fe awn ni'n syth i mewn i'r cwestiynau, ac mae Rhun ap Iorwerth yn mynd i ddechrau.

Dai Lloyd: Welcome back to the committee. With us is an old friend to the committee, Sarah Rochira, the Commissioner for Older People in Wales. We are very grateful for your written evidence on this subject of loneliness and isolation, and we also have many questions, so, if we may, we'll go straight into those questions, and Rhun ap Iorwerth is going to start.

[78] **Rhun ap Iorwerth**: Bore da. Os caf i ofyn ichi wneud ychydig o sylwadau agoriadol ynglŷn â maint y broblem o unigrwydd ac unigedd a pham eich bod chi'n credu ein bod ni'n wynebu epidemig yn hyn o beth.

Rhun ap Iorwerth: Good morning. If I may ask you to provide us with some opening comments about the size of this problem of loneliness and isolation and why you think we're facing an epidemic in this sense.

[79] **Ms Rochira**: You're absolutely right to use the phrase 'epidemic', it is the phrase I've used all along. It is a public health epidemic, and it is endemic across society, and also across age groups and generations as well. I think I first became aware of it early on as commissioner, as part of my engagement work with older people. We've been on many visits together, we

go out and we talk about issues, and I started to see something I hadn't expected to see, and that was a sense that, perhaps, people were becoming quite isolated and quite lonely. So, we started to talk more about this, and the more I spoke about it with people, the more it came up as a significant issue, and often with people you wouldn't expect to raise it. So, then I started to look a little bit more at what evidence we do have, and we do need to get more evidence behind this, but some of the figures I've looked at, particularly in relation to older older people—and I'll talk about some of the risk factors that might lead to that being the case—suggest that up to 63 per cent of those people over the age of 80, so that's around 100,000 older people, suffer from loneliness, social isolation, a combination of the two—there's a complex interrelationship between the two—but find themselves actually in the most awful of places.

[80] So, it had a scale that I hadn't expected to see, and now, of course, I look for it and I talk to people about it. It comes up all the time, everywhere I go. It is something that was off our radar, and what we've worked very hard to do is push it right up there, as one of the big issues—

[81] **Rhun ap Iorwerth:** Do people volunteer it? Do people realise, 'I am lonely, I am isolated', and want to talk about it, or is it something that you have to tease out of people, that they perhaps haven't seen that as a root of what may be more general problems in their lives?

[82] **Ms Rochira:** I think you have to, usually in my experience, tease it out of people, and if you say to somebody, 'Are you lonely or isolated?', it's a bit like being in the playground and saying, 'Hands up if you have no friends.' There is huge social stigma and shame associated with this. So, I don't really have conversations and say, 'Are you lonely?' We talk about life—'Do you go out? Where do you go? Do you do the things that matter to you? Are you still connected with the things that are important to you?' But then, increasingly, what is really interesting—and these often have to be fairly safe one-to-one conversations, not in big groups, so it might be over a cup of tea, a chat or conversation—is that actually people do start to unpack how lonely they are and the devastating impact upon their lives.

[83] One of the things that have really struck me, the more I look into this, is not just the breadth of this, so not just for older people, but across the life course as well, but also, actually, the depth of impact. We talk often about the impact on people's physical health, but the impact on their mental health, and also on their emotional health as well—. I've come to realise, in

terms of our ambition in Wales—we talk about the well-being of people—this is a huge anchor that drags down individual well-being, but also our overall aspiration and intent in policy terms here in Wales. I'm quite hard to shock, I think, but, actually, I have been really shocked and actually quite frightened by what I've seen, particularly the impact on people's emotional health.

[84] **Rhun ap Iorwerth:** What about what's causing it? We know there are many, many different factors that cause the problems of loneliness and isolation, but is there something in, even now, still, our attitudes as a nation towards people getting older?

[85] **Ms Rochira:** I think the causes are actually hugely individual. So, they're complex, I think they're often multilayered and they're often mutually reinforcing. There's a phrase, isn't there, 'The straw that breaks the camel's back'? Sometimes, it can be the smallest of things that might tip a person, for example, into being socially isolated, then they become lonely, then they start to lose some of their coping skills and it becomes a vicious cycle.

[86] But I did have a look at what some of the risk factors were, and the way I shape it, just as a way of thinking, is that there are some that are intrinsic to ourselves, such as poor health; some that are intrinsic to our lives, around our homes, so falling, for example; and some of the things that are extrinsic to the wider environment. You're absolutely right, as part of that, the wider societal norms—we're not good at saying 'hello' to people, for example, as we walk down the street. It's a world of eyes down, isn't it? Compared to some cultures, we don't all go out and congregate in the evenings together.

[87] But to share with you some of those, because I think there's an interesting point to make here, when I was looking through the things that can, directly or indirectly, so, divorce or separation; bereavement, including of course many older people's friends, because they can actually be the last person of their peer group; poverty—so that's one in six pensioners; hearing or sight loss; cognitive impairment—hugely prevalent in older people; physical ill health; mobility problems; retirement; redundancy; being the victim of crime or community safety fears; lack of transport; losing your driving licence—a huge issue for many older people; families that have moved away; support networks that are more diffuse; the rise of digital and online engagement; fewer places to go; many older people don't have children; being a carer; living alone—and so the list goes on. The point I make by sharing those is that actually very few of us are going to avoid those

as we grow older. There are joys and blessings aplenty about growing older, and you all know my view on an asset-based approach to being a nation of older people, but age brings with it some inherent risks.

[88] Now, we all have different levels of resilience, and this is the point about being so individualised, but actually, I can't imagine many people could withstand many of those hitting them, and often without any notice, as well. So, you can see how almost inbuilt into life are these risk factors. But it's hugely individual. What one person might withstand, another person might not, and often it is the interrelated nature of those.

[89] **Rhun ap Iorwerth**: And associated with that you have things that happen that can be factors. What about being part of particular groups? Carers, perhaps, you've already mentioned. What about LGBT groups? Is there evidence that there are other groups in society where we have to be particularly aware that people may be vulnerable when they become older?

[90] **Ms Rochira**: I think the point you make about groups is a really good point, because I was thinking about what 'lonely' means. So, we use it in a kind of colloquial sense, 'I'm a bit lonely', but that's not, I think, what we're really talking about here. For me, it's the impact on people's emotional health. When I read it, what I was reading was that, when people become lonely in the context that we're talking about, their sense of who they are as individuals diminishes, their sense of value diminishes, and they feel disconnected from the places that they belong to—so, the places and people that they belong to. So, I think there are some common themes, but I struggle to find a lot of research, or much research at all, to be honest, that speaks about particular characteristics. So, BME elders, for example, people from LGBT communities, are there particular issues that they face? We know there are certain assumptions that they face. So, BME elders are a key part of my engagement roadshow. There's an assumption that they all have close-knit families who are all supporting them. Actually, for many, that's an outdated assumption. It's simply not true. But the evidence base is really quite weak when you start to put some granularity behind older people, and one of the key things I think we need to focus on in the new strategy is actually working out what we do know, where are the gaps, filling those and taking what we do know and pushing that into practice across Wales.

[91] **Rhun ap Iorwerth**: It's funny, the witnesses we had in here this morning, coming at this from an academic research point of view, said there is a lot of evidence out there, but it's making that evidence applicable. Yes,

it's possible to identify the causes of loneliness, and who's lonely, but then taking that and saying, 'Right, this is what we can actually do to stop people becoming lonely' is—[*Inaudible*.]

[92] **Ms Rochira:** That's right. What do we know, how do we use that to drive what we do, and how do we measure and assess the impact that has? I found quite a few interesting academic publications that have helped grow my knowledge, and you can test those out with older people and you get a reinforcing, very rich picture. I found a few, but not many, practically useful documents. They would start off, 'A practical guide to—', probably my favourite starting title for a document, but there weren't a huge amount of those. So, there are some. I think there's enough to get us started in relation to this, but I think there are still huge research gaps, and that's got to be part of the work of the new strategy I would say.

[93] **Dai Lloyd:** Ocê. Rydym ni'n symud ymlaen i gwestiynau gan Lynne Neagle. **Dai Lloyd:** We're moving on to questions from Lynne Neagle. Lynne Neagle.

[94] **Lynne Neagle:** Thank you, Chair. Can you just tell us about the Ageing Well in Wales programme, and what you feel it has achieved in terms of, particularly, tackling loneliness and isolation?

[95] **Ms Rochira:** Yes. Thank you for asking about the programme. So, I launched the Ageing Well in Wales programme as a collaborative movement in 2014. It has, as you know, at its heart five themes, one of which is loneliness and isolation. There were opportunities for learning and employment, age-friendly communities, dementia-supportive communities, and I'm going to forget the fifth.[1] But I will send that over.

10:30

[96] I picked those because I thought they were big issues that we weren't focusing on enough, that we didn't recognise enough and that were of huge detriment to individuals and public services. And for all the reasons I've just spoken about now in terms of my early work, it seemed to me that loneliness and isolation had to feature in that programme. It's not a programme where I deliver services; it really is a social movement. It has at its heart a simple aim, which is that frailty, decline and loss of independence need not be and

[1] Ms Rochira wishes to note that the fifth is 'falls prevention'.

should not be seen as an inevitable part of ageing. There is more that individuals can do, that public services can do, the private sector can do, that everybody can do to head off some of those trials of growing older.

[97] So, we work on a number of levels. It has a European reach, where we have reference site status within Europe, and we have local authorities who have Ageing Well in Wales plans across Wales. And, of course, those were precursors of the focus of well-being here in Wales. And it has a strong focus on the grass roots as well—empowering individuals, small groups to do something. It doesn't have to be something big; there's no joining fee; there's no test or exam. It's 'Do something', and what we've been doing is sharing with people what knowledge we do have, what good practice we do have, enabling them, supporting them, encouraging them and validating them. And that's why I call it a social movement. It's different from but complementary to a top-down strategy.

[98] I was just thinking this morning about some of the things within it, and we're going to publish this year for the first time an impact and reach report, so that people can read more about it. But some of the things: we've just published a little pocket guide—I've brought it with me—to loneliness. We've done a number of pocket guides. They fly off the shelves. They're really, really popular: a bit of knowledge and power so that people can think about it, perhaps before it happens to them. We've got a huge range of networks events, and we call them 'celebrating community events' across Wales. Again, where we've been upskilling people and giving them just that little bit of knowledge to take a bit more control of their own lives and growing older. And the feedback is hugely positive. We've just launched a culture age-friendly network. Why is that relevant to loneliness and isolation? Well, you need somewhere meaningful to go and, actually, cultural events and places matter enormously to older people. And that's been a huge partnership piece of work.

[99] We have things such as the Wales Against Scams Partnership to tackle the social isolation and vulnerability that comes often with loneliness. And we've also been supporting a whole range of groups across Wales. So, it's things such as 'Ffrind i Mi', which they describe as a social movement that reconnects people with their communities. I think that's a great phrase. There's Solva Care in west Wales, there's Men's Sheds which we've been hugely supporting. We've got greater social prescribing in parts of Wales. There's a really good piece of work going on in Flintshire in relation to a heat map, for example. And we've been doing work looking at respite in terms of

time banking, and much more besides.

[100] The point of the programme is that if you're a big organisation, you can show your public sector leadership. If you're a small group or an individual, you can do something too. So, it's been about enabling, empowering, promoting, validating and sometimes putting my position as commissioner behind that. One of the things that I am really pleased about, because I was looking back this morning at what we set ourselves by way of objectives in 2014, and one of them was to get loneliness and isolation recognised as a public health issue—not just me, but with partners. In a short period of time, we've done that, and that's got to be the beginning of the scale and the impact, and it's up there with those other big ticket issues.

[101] **Lynne Neagle:** Okay, thank you. In your written evidence, you've talked about the wealth of social capital and the existing skills, knowledge, experience and infrastructure that we have in Wales that can help tackle loneliness. Can you just expand on that? You seem to be saying that we seem to be very well placed to do something about it.

[102] **Ms Rochira:** I think if it's a journey that we're on to get to a position where, actually, well-being is our ultimate aim, and as part of that people are not socially isolated and lonely, then, actually, in many ways we have some of the key ingredients. So, we recognise it now as a strategic issue, not just in relation to the strategy, but in relation to our focus on well-being, and if you look through the Social Services and Well-being (Wales) Act 2014, the Regulation and Inspection of Social Care (Wales) Act 2016 and a number of other strategic things, emotional health and well-being are now starting to feature. So, that's really important.

[103] We also have, of course, a really great network of third sector organisations across Wales, many of which are already incredibly active. We also have, in many places of Wales, still really active communities that can also play a huge part, and would want to play a huge part in this. We also, of course, have older people as well, who are an asset and are absolutely part of that peer-to-peer support in terms of preventing loneliness and isolation, and also supporting people who have found themselves in that position to reconnect as well.

[104] I suppose my overall observation is we have a lot of some of the key things that we need. There are things that are missing within that, but what we haven't yet done is drawn that all together, and that, I think, is the

function of the strategy that will be published, to draw all of those together, see what is necessary, what is sufficient, what is missing, and on the front, right at the beginning of it, some very clear outcomes for what success will look like, because there are undoubtedly challenges within that. So, we have many, many fantastic third sector organisations and community groups, but they're all struggling at the moment. They tell me that, and I'm sure they tell you that as well.

[105] We also have huge challenges in terms of community services. I do a lot of work around buses, toilets, libraries, green spaces, park benches—these are a key part of tackling the loneliness and isolation agenda. Having somewhere meaningful to go—older people call them lifelines for good reason. So, I think we have a really positive start. We need to draw it together, we need to focus on those outcomes, and we need to be really clear that some of these *über* preventative services are actually at huge risk at the moment. I think that is something that we do need to be quite worried about.

[106] **Lynne Neagle:** Okay, thank you. You've already given us quite a list of organisations and initiatives that are helping in this area. Is there anything particular that you think we should be looking at by way of innovative solutions? And, just to pick up on your last point about the third sector and how they are struggling, we know that they're often the last ones to get funding after local authorities have funded everything else within the actual council. Are there any messages there then? If you're saying that people are very dependent on these third sector organisations, are there any messages we should take from that about the sustainability of these voluntary organisations?

[107] **Ms Rochira:** I think what we should be is hugely concerned about the sustainability of them. That's what they tell me. I trust and believe their judgment. I have consistently, as hard as I can, pushed the case for community services and investment in our high-impact third sector and other community based services, because there's a strange narrative, we want to focus on well-being and prevention, yet those key *über* community based preventative services are the ones that are most at risk. It's a dystopian logic. We have to bring them in from the cold. For me, the way to do that is to intrinsically link them to the achievement of those well-being outcomes.

[108] There was a phrase we coined early on, 'We need to be careful we don't become a nation of people with great hips, but nowhere to go and no

way to get there and no desire to go on', because actually that's what I see. I see us doing the difficult complex stuff actually quite well. But the buses—there's no point having the beloved bus pass if the buses don't run anymore. You know, the five ways to well-being for many older people are unachievable because, for example, there is no park bench to sit on, or if you have a prostrate problem, no public toilet, and you're worried that you might be caught. The smallest of things are often the weakest of links.

[109] Just to go back to your point about—I just want to say something about making sure that what we have is impactful. I know we live in hugely challenging financial times, but that's when public service should be at its best. Public service is there to rise to the challenge at the hardest of times, not the easiest of times. We need to make sure that we take the evidence that we do have about what works and weave that into the range of interventions we do have. I don't think one size will fit all. This is such a complex, multilayered individualised issue, but I think there are core principles.

[110] So, some of the things that I think we will find where we have really impactful outcomes are things like peer-led and co-designed, so people are an intrinsic part of developing it; local and easy to access; they instil a sense of identity; they give people a sense of purpose; are built around shared interest; they have benefit but also give back; and, really importantly, they have sustained support, but show people a way out of sustained support. What became clear to me is that there were almost two kinds of support. There were those people who it was easier and quicker, if you like, to reconnect back in, but they needed a bit of a helping hand. But there were some who'd become so far away from it that they had lost the social skills that they needed, and, actually, they needed much more specialist support to help them redevelop the confidence to just go and meet somebody new. So, I think the evidence gives us a sense, Chair, of what sits behind effective and impactful services, but that dystopian concern, I think, is hugely—. I probably talk about that more than anything else.

[111] **Lynne Neagle**: Thank you.

[112] **Dai Lloyd**: Ocê. Mae'r cwestiynau nesaf gan Dawn Bowden.

Dai Lloyd: Okay. The next questions are from Dawn Bowden.

[113] **Dawn Bowden**: I was going to ask you about Ageing Well in Wales as well, but I think you covered that in an answer to Lynne. Can you tell me how you think that provisions around isolation and loneliness could be framed in

legislation, or, I suppose, whether we already have legislation that we are perhaps not using to the greatest effect—I'm thinking of the Social Services and Well-being (Wales) Act 2014—to tackle loneliness and isolation, or whether we should be looking at framing it in completely new legislation?

[114] **Ms Rochira:** Well, as you know, I would like to have seen it in the Public Health (Wales) Bill. It would have given it the status it absolutely warrants. But, having said that, I did look earlier this week across the legislative frameworks. So, if the first thing you want is for it to be recognised, as I said, up there with those other issues, so that it has a fighting chance of becoming one of our policy drivers, well, I found it, in a sense, in a number of places. So, the Social Services and Well-being (Wales) Act—. Well, its focus on well-being, of course, is physical, mental and emotional well-being. As I said at the beginning, it was almost the emotional part that I found the most frightening: what it did to people's sense of person, identity. We have due regard to the UN principles, which in no small part are hugely correlated—things like continued participation, and connection within that.

[115] We have also, of course—and I think that these are really important—the national outcomes framework, which you've heard me speak about before. I think it's a really good document. If you go back and read it—so, these are the outcomes for individuals—you can extrapolate out the outcomes to communities' groups, and that should be all groups, regardless of diversity. It says things like, 'I can engage and participate', which goes to the heart of this agenda; 'I feel valued in society', again to the heart of it; 'I'm happy. I can do the things that matter to me. I have a social life'. And my favourite one, and this absolutely goes to the heart of the destruction wrought on people's sense of self, is: 'I belong'.

[116] So, you see it starting to be embedded in a whole range of places, and I think we shouldn't underestimate actually how unusual that is. We've also got, of course, the public services board well-being plans coming on, and I issued guidance to them, in terms of saying, 'I need you to be focusing on loneliness and isolation, because people might not tell you through your local needs assessments.' We have got stuff in the Regulation and Inspection of Social Care (Wales) Act 2016, and a whole range of other places as well.

[117] I think the bit, for me—and, again, this goes back to what I expect—. Actually, I've got a quite clear view of what I expect from the new strategy. It needs to front up with outcomes. What will success look like? When people

answer 'yes' to those outcomes in the national outcomes framework, in a sense, that's the job done, because that's what we want them to be doing. It has to start up with those outcomes. It has to identify the impact, not just to individuals but to public services, so public services can see that a price is being paid one way or another. I think what it has to do then is give status and profile to these unhypothecated and often locally based community services. So, it is a start, but a start is not the same—as I repeatedly say to public bodies—as finishing the job. And it is about finishing the job. And, for me, it starts and ends with outcomes.

[118] **Dawn Bowden**: So, going back to the point you were just making about the public services boards and their plans, are you satisfied that they are giving appropriate priority to this area of public health?

10:45

[119] **Ms Rochira**: 'I don't know yet', is the answer, because I'm currently in the process of looking at their needs assessments, and I will provide feedback to them in relation to those. I've spoken to Sophie Howe, the future generations commissioner, so that we join up in how we do that, and I will look at the formal well-being plans when they come out. I will continue to engage with them because, what I have said to all public services is, 'Do not fool yourself on the price you are paying if you do not focus on this.' So, more falls, more admissions to hospital, people enter residential care at an earlier stage, more need for emotional health support, people are the victims of crime in their own home, and so the list goes on. In no small part the interventions that we're looking at are low-cost interventions. They're local, small key. They're about connecting people. They're value-based interventions. But I saw a piece of research from the Social Care Institute for Excellence—I think that's its title; I never quite remember it, it has an abbreviation—and they said for every £80 you spend you save £300 in health and social care costs. So, there is a saving to be made and there is huge damage to people's sense of value, meaning and purpose in this world to be avoided. It is a win-win. So, in short, I think many of the enablers and drivers that we would need are potentially in place but we need to pull it together and absolutely front it. It begins and ends with outcome and ambition, and when people say 'yes' to those questions. It's not actually about the legislation or the strategy, it's about the change in people's everyday—and, you know, that's where I spend my time—people's everyday lived experiences. And I will know it's been successful when I go out and I talk to people and they stop telling me how devastatingly lonely they are and you

won't meet constituents who tell you that, and when we're older we won't find ourselves in that awful position.

[120] **Dawn Bowden:** Okay. Thank you, Sarah.

[121] **Dai Lloyd:** Mae'r cwestiynau olaf o dan ofal Angel Burns.

Dai Lloyd: The final questions are from Angela Burns.

[122] **Angela Burns:** You talk about the £80 spend to save £300, but I'd be really interested in trying to understand on that £80 if it's £80 straight to the front line, because one of the concerns I really have—and I'll be honest with you, I hold my hands up, I get very confused even in my own constituency—is there are endless boards looking at endless bits of the spectrum, and I see that the Welsh Local Government Association have suggested that perhaps they should bring forward another role, and I think they call it a 'public health improvement' role, within local government. And I'm really concerned that we are becoming so process-driven that actually all our effort, all our spend, is on endless people meeting in endless rooms without those outcomes coming. So, I'd like your view on where you think the public health improvement role should be. Should it be everyone's job? Is there a need for a defined role that says that and should it sit in local government? Should it sit in health boards? Should it sit in—? We've got these public health boards. We've got all this legislation underpinning everything from future generations all the way through to social services. Just where's your sense of where this needs to be and are we drowning in so much—

[123] **Dai Lloyd:** Boards.

[124] **Angela Burns:** Boards, thank you. Are we bored with our boards?

[125] **Ms Rochira:** Goodness, those are big and deep questions. I think I would start it by going back to the point I just made about outcomes. It's absolutely all about outcomes. I will often talk to people about issues and they'll tell me about their programme board, their strategy. Sometimes they'll send me their new information leaflet on it. That's never what I asked about. I wanted to know whether the job was done and how we defined a good job well done. For me, it's always from the perspective of the individual and you are in one sense absolutely right. I see a huge range of outputs being dressed up as outcomes and in many ways it's all about the system. Now, I like performance metrics, so do older people. The metrics I use are never about the system, they're about those everyday lives. There is always going

to be a role for system board process. I think how people go about that, that will differ in terms of local circumstances. For me it just comes back to weaving those into: are we nearer to delivering on those outcomes than we were before we did this? And, like you, I sometimes get lost within it as well. I ask what I think are the simplest of questions—well, they are the simplest of questions—and I either get no answer or the longest, most confusing of answers. There's something about, through the complexity—and it is a complex landscape, health and social care—. There is something throughout all of that about stripping it back and keeping things as simple as they are. And I'm slightly avoiding your question in a sense, because I don't know what the structure should be, because that's not my role. That's the stuff that people need to do. However, I have used a phrase more than once, which is 'industry of activity', and the point is, of course, to what good purpose and to what end?

[126] But the point I do have a view—. So, that's in terms of how many boards and—. I don't sit enough in the service to know what that structure should be like, but I do think—if this is a public health issue, I do think it should sit on the agenda of Public Health Wales. Why would it not? The clue is in the title, I think. We have public health campaigns for a whole range of things. If you're going to deliver on this, it is actually far more complex than it sounds when we're answering questions. You need a ring-holder above that. You need leadership above it, someone who is responsible for the whole landscape, always testing how effective is this, how near are we, where are the risks within it, then marshalling all of the pieces, all towards that outcome. So, I think Public Health Wales absolutely has a role, I think public services boards have a role, and I think Government has a role as well: it has to lead, it has to define outcomes, and it has to put in place those enabling mechanisms that are needed to allow people to deliver.

[127] **Angela Burns**: Do you think, though, that—? When you say Government has a role, are you talking about big or smaller government? Because a concern I have—and I would like your take on this—is whether or not local government is able to free up or be free enough with the third sector providers. And they're the guys who usually are really good at getting up and close to somebody and sorting out an issue. They tend to be agile on their feet; they tend to eschew red tape; they just kind of get on with it. But I've certainly seen it in other spaces, where the local authorities, in an effort to reinforce their own financial positions, will stop third sector organisations and suck in the services that they were providing, and make them part of their main stream, at which point they immediately start curling up around

the corners and dying.

[128] **Ms Rochira:** I think, for me, it's the point about public sector leadership. So, you're absolutely right: on a day-to-day basis, a lot of the doing takes place, because of the nature of loneliness and social isolation, in small communities, in small places, in groups. Otherwise, it can't be as personalised and, often, as intimate as it needs to be. But it's this idea about public sector leadership. So, what should Welsh Government do? Define the scale of the ambition and much of what the finished job looks like, make sure that some of those key enablers are in there. That includes being really clear in terms of things like funding streams to many of the unhypothecated services that are under risk. It's one of the reasons why I like the Ffrind i Mi initiative, because it's not core business for a health board to lead that, but what they did understand was that it is part of their public sector leadership role. But there are also mechanisms that government, national and local, have—doors, if you like, that they can open—that make it easier for others.

[129] You asked me last time, and I was thinking a lot about this, about the hard-to-reach people, because they're the ones that I would worry about as well. The reality is, though, that those hard-to-reach people touch the lives of public service staff all the time: GPs, district nurses, allied health professionals. They are not off our radars, but what we're not doing is using the mechanisms we do have to engage with them. So, the discussions that the chief exec of the NHS in Wales can be having with health boards in Wales, about their ability, at those making-every-contact-count points, to touch people, that's the enabling role for them.

[130] **Angela Burns:** This comes back, actually, to a debate we had this week on the validity of social prescribing, and actually what we need to do with social prescribing—and, you know, there could well be a case that, perhaps within the medical fraternity, we seek to enshrine a role in every GP surgery, so that if a GP picks up that somebody has got some of these issues, they will actually push them off into that direction, and that person's role is to link them into third sectors.

[131] **Ms Rochira:** I think that's one of the key issues in terms of, actually, both prevention and identifying people, so we talk about—. We talk about lots of things. We talk about making every contact count, but we don't. You're absolutely right. When people go to their GPs—. I walked past a pharmacist on the way here, and it said, 'Come on in; let's talk about your health.' I don't suppose, at this stage, that's going to be your emotional

health and whether you're lonely. It'll probably be your blood pressure, whether you smoke and exercise. That's just one—just walking in—missed opportunity. There are dozens and dozens. But, actually, whether it be health boards, local government or national government, they need to pass that instruction down, to open up those contact points and use the levers that exist there. So, when you asked me last time about hard-to-find people, I thought, 'No, they're not hard to find. They find us all the time.' What we don't do, when we say to them, 'Are you eating? Are you sleeping?' is ask them about whether they're still feeling that they have a sense of purpose or are engaged or doing the things that matter to them. I don't think it's about new costly mechanisms. It's about investing in what we've got and drawing it together more strategically. That's why I say there absolutely is a role for the Government and for public service bodies—the leadership, the enabling and sometimes the investing as well, so that those who can do are able to do it. They also need to commission that research—that we're driving that through what we do more and more.

[132] **Angela Burns:** You mention the NHS initiative that's being driven. Have you come across, in all your talking to older people, any sort of really good examples from local authorities? I'm not thinking about the obvious ones—you know, Men's Sheds, et cetera—they're all third sector driven. But anything where, in a local authority, you've gone, 'Wow', because they've really kind of been getting to grips with this kind of issue. Because I'm just trying to resolve in my head this challenge about whether or not we need to create yet another board, yet another public role, to drive an agenda that I think, personally, should be owned by absolutely everybody.

[133] **Ms Rochira:** Okay. So, just in terms of that, 'Do we need another infrastructure for loneliness and isolation?'—my view is 'no'. Public service boards, the legislation that we already have: what we need to do is work and use what we've got and make it work for older people, just as importantly. So, if you said to me, 'Shall we have another programme board on loneliness and isolation?', I suspect I would roll my eyes and say, 'Please no; let's use what we've already put in place.'

[134] I see so many services, and I talk to so many people. I'll just tell you about one. It was tripartite funding. So, I think there was a local authority contribution, and I think they'd set themselves up as a social enterprise as well. How would I describe it? It was a happy place, really—a sort of lunch social club in the middle of an estate. I was chatting to the chair of the committee there. It was only tiny. People went there for a cooked meal. They

were able to bathe as well, because many older people don't like to go out because they're pretty proud and worried about their appearance. They had a lovely time with peers, doing things that mattered to them. He told me about how, when he was bereaved, his life started to spiral downwards. He said, 'I became very isolated, very lonely, I started to drink and this was my lifeline'. If I had a penny for every time I hear the phrase 'And this was my lifeline', whether it be a photography class, which seems such a soft and affordable issue—

[135] **Angela Burns:** It's like the old Darby and Joan clubs. They were hugely successful in reintegrating people after the war.

[136] **Ms Rochira:** The point is it's about things that touch people's interests. The example I give is if any one of us—. We might be older and we might find ourselves socially isolated and vulnerable and somebody comes to us and says, 'Well, you're becoming a bit lonely. Would you like to come to the day centre?' I'm not sure any of us are going to vote for that. Or somebody might say to us—they might not quite put it like that; they might think that, but they might say, 'Do you know what, you don't get out much, do you? We've got a youth club down the road and I know you were really into sport. You were a professional footballer'—for example—'Some of our young lads would really like to find out more about what you did. Do you think you could come down and volunteer?' That's an asset-based, low-cost, high-impact approach, and it takes a lot of those principles behind it. But what you need is to grow that knowledge, push that into the practice and open up those enabling levers. But the big risk for me, underpinning all of this, is that those places aren't there anymore to go to.

[137] **Angela Burns:** But also, who is the person who is going to have that conversation with that older person? Who is that person—where are they going to be from—that walks into someone's house or knocks on their door and says, 'You used to be a footballer, come down and talk to the kids. We'd really like you'? That's what I can't trail back: who is going to take that sort of—? Who is going to be creative enough and lateral enough to make those kinds of connections on an individual basis?

[138] **Ms Rochira:** Well, we talk about integrated working, don't we, and that's really what it's about. Any one of us could be the touch point. What we need to know is who to go and talk to. I've seen community connectors across Wales, which aren't funded by local authorities. They seem to be incredibly impactful. So, if it was a district nurse, a chiropodist—you name

it—all they need to know is to call the community connector, and then she or he can go, 'Leave it with me'. That's really integrated. It shouldn't be 'who you know' for older people; it should be who you know within public services to call and pass on. That community connector could then say to the person, 'Come to the youth club'. What a validating approach.

[139] **Angela Burns:** Yes.

[140] **Dai Lloyd:** Okay. The bell is going to go. You can have your question afterwards. If we could stand.

11:00

Safodd y rhai a oedd yn bresennol am funud o dawelwch.
Those present stood for a minute's silence.

[141] **Dai Lloyd:** Diolch yn fawr. Lynne, you had a question to polish things off.

[142] **Lynne Neagle:** I think it's very striking what you're saying, but isn't the answer to this that this is absolutely everybody's business, and that we should be looking at something that makes sure that everybody that comes into contact with people is aware of this and knows how to ask the right questions? I'm thinking whether there are any parallels with the Dementia Friends movement, really, because that has been tremendously successful, and I think has changed a lot of people's views on how you approach people living with dementia. It's that kind of thing—would you agree—that we maybe need to be looking at.

[143] **Ms Rochira:** I completely agree. In fact, I wrote a list of all the various parts of civic society that need to play—. I've got about 15 on the list. You're absolutely right: we all have a different role to play, including neighbours and us as individuals. So, when I walk down my street, I could lift my head up and smile and say, 'Hello' to somebody. I might be the only person that's actually validated them by looking them in face and smiling, in maybe a long time. So, I think you're right, particularly because, as I said, it's endemic, it's an epidemic and it's across age groups. We do need to focus on, I think, a life course approach. We do need to focus on building resilience skills. I'm quite happy to write to you with what, for me, would make the difference between a strategy and a good strategy, because that is, of course, the real thing, isn't it? But I absolutely agree that it sits up there. We know it now; we

see it now. We should not be so negligent that actually we don't weave it through what we do. Because it is often in the smallest of places that people will share things with you.

[144] I would just close by going back to what I said at the beginning in terms of how my understanding of this has changed in terms of the impact on people's lives. Because, as a commissioner, I operate a lot of the time in the 'dark places' of growing older. There are many blessings, but there are many trials and tribulations of growing older: one of them is the risk of becoming socially isolated and lonely. The physical health issues I understand; the mental health ones I do. But I was thinking about a lady who I'd spoken to. We were talking about emotional health. People share the most intimate of things with me. We were talking about how it felt and she said, 'It felt like my soul was weeping.' I could probably weep now saying it; I could have wept then. That is not, I think, what well-being means in Wales. But ambition is not enough and having some of the structural devices is not enough; the job is done when the job is done and people say, 'Yes' to those sorts of outcomes. That's where I'm going to stay rooted as commissioner.

[145] **Dai Lloyd:** Ocê, diolch yn fawr. Tystiolaeth bwerus iawn. Diolch yn fawr iawn i chi am eich perfformiad y bore yma. Gallaf bellach gadarnhau y byddwch chi'n derbyn trawsgrifiad o'r cyfarfod yma i gadarnhau ei fod yn ffeithiol gywir. Diolch yn fawr am eich presenoldeb. Rwy'n mynd i gau'r sesiwn dystiolaeth yma rŵan. Gallaf gyhoeddi i fy nghyd-Aelodau y cawn ni egwyl am 10 munud. Bydd yr eitem nesaf yn dechrau am 11:15.

Dai Lloyd: Okay, thank you very much. Very powerful evidence. Thank you for your contribution this morning. I can now confirm that you will have a transcript of this meeting to check for factual accuracy. I'm going to close this session now. I would like to tell my fellow Members that we're going to take a 10-minute break now. The next item will begin at 11:15.

Gohiriwyd y cyfarfod rhwng 11:04 ac 11:17.
The meeting adjourned between 11:04 and 11:17.

Ymchwiliad i Unigrwydd ac Unigedd—Sesiwn Dystiolaeth 3—Age Cymru
Inquiry into Loneliness and Isolation—Evidence Session 3—Age Cymru

[146] **Dai Lloyd:** Croeso nôl i sesiwn

Dai Lloyd: Welcome back to the latest

ddiweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yng Nghynulliad Cenedlaethol Cymru. Rydym ni'n symud ymlaen i eitem 4 rŵan, a pharhad ein hymchwiliad i unigrwydd ac unigedd. Hon ydy sesiwn dystiolaeth 3, ac mae aelodau o Age Cymru o'n blaenau—mwy amdanyn nhw yn y man. Rydym ni wedi derbyn tystiolaeth eang yn ysgrifenedig ac, wrth gwrs, fel y bydd ein haelodau ni yn ymwybodol, rydym ni wedi bod yn cynnal nifer o gyfarfodydd ledled Cymru ers mis Ionawr ar y pwnc yma gyda nifer o wahanol bobl.

session of the Health, Social Care and Sport Committee here in the National Assembly. We move to item 4 to continue with our inquiry into loneliness and isolation. This is evidence session 3, and we have members of Age Cymru before us—more about them in a minute. We have received broad written evidence and, of course, our Members will be aware that we have held a number of meetings the length and breadth of Wales since January on this subject with a number of different people.

[147] Felly, o'n blaenau ni, a gaf i groesawu Rachel Lewis, rheolwr cysylltiadau allanol Age Cymru, a hefyd Victoria Lloyd, cyfarwyddwr materion allanol a datblygwr rhaglenni Age Cymru? Croeso i chi'ch dwy. Yn ôl ein harfer nawr, ar sail y dystiolaeth rydym ni wedi'i derbyn, mae yna gwestiynau yn deillio yn naturiol oddi wrth Aelodau, ac fe wnawn ni symud yn syth i mewn i gwestiynau. Mae'r cwestiynau cyntaf o dan ofal Dawn Bowden.

So, before us, may I welcome Rachel Lewis, external relations manager, Age Cymru, and also Victoria Lloyd, director of external affairs and programme developer, Age Cymru? Welcome to you both. As usual, on the basis of the evidence that we've received, there are questions that stem naturally from Members, and we'll go straight into questions. The first questions are from Dawn Bowden.

[148] **Dawn Bowden**: Thank you, Chair. Good morning, both. Can I just start by asking you what you consider to be the scale of loneliness experienced by older people, and whether there's an indication that the proportion of older people affected by loneliness and isolation has increased in Wales?

[149] **Ms Lewis**: We did a survey a couple of years ago that told us that 75,000 people across Wales felt often or sometimes lonely. Now, we've also done a smaller scale poll of 200 people, and roughly 25 per cent of those over 65 told us that they did feel lonely. So, we think it's fairly widespread. I think there's no doubt that it is an issue, and I think our concern, given the

current economic climate and cuts to public services, is that, yes, there's potential that it's going to get worse.

[150] **Dawn Bowden**: And so—you just touched on economics and public services—those are the specific areas that you think are largely responsible for that increase.

[151] **Ms Lloyd**: I'd say that, and of course the increasing numbers of older people in Wales—

[152] **Dawn Bowden**: Of course.

[153] **Ms Lloyd**: So, proportionately, the absolute numbers will grow because of the higher proportion of older people and people that are, perhaps, less mobile than they're used to. We've got more of that cohort as well, so, potentially, the problem grows with that.

[154] **Dawn Bowden**: And different family relationships and things like that.

[155] **Ms Lloyd**: I think different family relationships, people being more dispersed in their communities—. And, I think the growing digital engagement of other areas of the population can be exclusive to people who aren't digitally connected.

[156] **Dawn Bowden**: Yes, I understand that. Just thinking about barriers to overcoming loneliness and isolation—and I know the two things are quite different—but, the barriers, we've heard in evidence previously about stigma being one of them. But perhaps you could talk a bit about those barriers. The lack of information, possibly, available to people, and whether you think that the community infrastructure is adequate, or what needs to be addressed around those areas.

[157] **Ms Lewis**: I think stigma is the big issue. It was interesting, when we started our campaign, we put a public call out for older people to get in touch with us with their experiences. A lot of people did and talked about the barriers that they felt were preventing them from getting out into their communities. But what was interesting was not only did they not want to speak publicly about this, but, also, quite a few said that they didn't want to worry their friends and didn't want to worry their children, who perhaps already had busy lives and were living away, or they had siblings who perhaps were unwell. One lady had siblings who had dementia. So, they

didn't have those connections with their families and they didn't actually want to ask for help. So, I think there is definitely a stigma around loneliness that we do need to address.

[158] **Ms Lloyd:** I guess that's from people who were willing to self-identify, but stigma also means that lots of people aren't willing to do that.

[159] **Dawn Bowden:** Yes. So, therefore, you don't really know the extent of that, either.

[160] **Ms Lloyd:** Exactly.

[161] **Dawn Bowden:** What about the information available to people? They may not necessarily want to speak to you or to me or to anybody else, but they want to go somewhere to find out how they might address it. Is information readily available for people in those circumstances, do you know?

[162] **Ms Lloyd:** I think there's information out there for people who will seek it out. Our concern is that people don't seek it out, and I think one of the things, looking at the research that has been done, is that, perhaps there's a case for targeting people who we know—perhaps that we don't know are lonely, but have the risk factors associated. So, for example, local authorities will know the people who are living on their own, because of the council tax discounts that are available to those people. So, they're going to be in a higher risk group, so perhaps we should be targeting those people with information. GPs will know many of the risk factors that make people lonely and isolated, and health is the one sector that people are likely to come into contact with, even if they are very isolated. So, perhaps there's more that we could do proactively, to get information to those people.

[163] **Ms Lewis:** In terms of barriers, the people we spoke to are very confident that public toilets are an issue and they do stop people from going out. One lady told us that she liked to have a walk along the promenade, but the toilets are shut down there, so she's no longer able to do that. Also, bus cuts in local communities really do stop people from getting out and about and being able to go into town and about their daily affairs. So, barriers are—

[164] **Dawn Bowden:** So, those issues around community infrastructure, really, would be—

[165] **Ms Lewis**: Yes, exactly that.

[166] **Dawn Bowden**: Yes, I understand. That's great. Thank you very much.

[167] **Dai Lloyd**: Diolch yn fawr, Dawn. Mae'r cwestiynau nesaf o dan ofal Lynne Neagle.

Dai Lloyd: Thank you very much. The next questions are from Lynne Neagle.

[168] **Lynne Neagle**: Thanks, Chair. You undertook some research for the older people's commissioner. Can you just tell us what you thought the key messages were and if there were any particular solutions that were put forward by interviewees that they felt would tackle the issues of loneliness and isolation?

[169] **Ms Lewis**: We did some research into dementia on behalf of the older people's commissioner. So, we did a series of qualitative interviews with people and people living with dementia and their carers, and one of the key themes that did come out of that was the lack of befriending services and the lack of respite care, and also individualised solutions so that someone could go and talk to the person with dementia or the carer and find out what they needed. And, also, that access to respite care, again. That came out as a strong theme throughout the research.

[170] **Ms Lloyd**: I think the personalised approach is really important, because once we have identified the people who are lonely, because it's such a subjective issue, the solutions are going to be different for each of us. So, I think it's really important that those conversations take place in terms of what will work for that person. It's then directing those people to what might help. They're really things that they can do themselves, to help themselves, following a conversation. It may be directing them to other services or groups that exist in a community, but it's going to be very individualised.

[171] **Lynne Neagle**: Okay. And, have you had any feedback on the impact of reductions in community services because of austerity, et cetera, and the impact that that's having on older people?

[172] **Ms Lewis**: We're always having feedback on that issue, really. Public toilets, as I've mentioned, buses, but also closures of things like lunch clubs, community groups, adult learning classes—people do really value these chances to go out, and it can mean a lot to a person who's living alone to have that one lunch club a week, or perhaps even a day centre they can go

to. We're always being told that people do really value these services, and they are missed when they do go.

[173] **Ms Lloyd:** Can I just come in there in terms of things like adult community learning, particularly for men? We go back to the stigma point. A lot of people think that befriending—there's a stigma around that as well. They don't want to be seen to be done to, and I think for some people the term 'befriending' has that connotation. So, things like adult community learning groups, and things that are activity or issue based, can be a really good solution, particularly for men, who are less likely to interact with that sort of social engagement. So, I think cuts in that area are a particular issue.

[174] **Lynne Neagle:** And have you given any consideration to the ways in which solutions to loneliness and isolation can actually reduce the pressure on public services?

[175] **Ms Lloyd:** I think that's a message that we would send out very strongly, because we think that some of these things—. If we look at the impact on health of isolation and loneliness, we know that it's a risk factor for people with dementia, and it's a risk factor in terms of heart problems. So, if we can mitigate some of the impacts of isolation and loneliness, I think ultimately it will mitigate pressure on some of our public services. I think it ties in very much with the preventative agenda.

[176] **Lynne Neagle:** Okay, thank you.

[177] **Dai Lloyd:** A allaf i jest holi, ymhellach i beth rydych chi wedi ei ddweud eisoes ynglŷn â beth gellid ei wneud i ymdrin â'r broblem yma o unigrwydd ac unigedd, am unrhyw fanylion o waith Age UK yn datblygu ac arbrofi dulliau addawol o ymdrin ag unigrwydd a gwersi yn sgil hynny ar gyfer datblygu atebion yng Nghymru? Beth ydych chi'n ei wneud fel Age UK er mwyn helpu efo'r atebion, ymhellach i beth rydych chi wedi ei ddweud eisoes?

Dai Lloyd: Can I just ask, further to what you've said already about what can be done to deal with this problem of loneliness and isolation, about any details on the work that Age UK is doing in developing and looking at methods of dealing with it, and lessons learned, perhaps, from that? What are you doing as Age UK to help find some solutions, further to what you've already said?

[178] **Ms Lloyd:** Age UK have been doing a really wide piece of work on this

issue in different sections. So, to start off, in terms of helping to identify people who are isolated and lonely, they've done some work in terms of developing what they call loneliness heat maps. They've done a piece of work with the Office for National Statistics to help service providers and service commissioners to identify where people were isolated and lonely, and to be able to target services. It's a really interesting piece of work, picking up factors from the English longitudinal study on ageing, marrying those data with information from the census, and then looking at specific areas of England where support should be targeted. Obviously, we don't have the equivalent to ELSA here, but, actually, if we could look to see whether there are proxy measures for those key areas where they say the risk factors are, potentially we could have for Wales that data marriage with the census information for Wales so that information could be targeted, and we could actually find out where we have those wards where people are most concentrated.

[179] So, they're doing a whole piece of work around identification. Data is one method. Obviously, feet on the ground is the other. So, it's about people in the community identifying people who are isolated and lonely, and then going through with those people to find out what the responses should be. So, they're doing a whole piece of work around identification. Then, with local Age Cymru partners and local Age UK, they're looking at various different solutions. So, individual and group-based solutions, befriending approaches, in terms of one-to-one, group approaches, and then also some community-based approaches, and then evaluating those programme by programme. I think what has been found is that community-based approaches can be really successful. Programmes have been evaluated one by one, and Age UK are in the process of bringing that all together, but they found that things like age-friendly community approaches and dementia-friendly communities provide a framework for the communities then to use their assets to identify and support people who are isolated and lonely. So, there's a whole range of different things. Environmental factors they also look at, and they've got case studies and evaluations against each of those. So, it's a really important piece of work and there's a lot that we could learn from in developing strategies here in Wales.

11:30

[180] **Dai Lloyd:** A oes gyda chi enghreifftiau o fentrau eraill yma yng Nghymru sy'n ymdrin ag unigrwydd

Dai Lloyd: Do you have examples of any other initiatives here in Wales dealing with loneliness and isolation

ac unigedd ymysg pobl hŷn yn uniongyrchol neu'n anuniongyrchol? A oes unrhyw fentrau eraill nad ydym ni wedi sôn amdanyn nhw eto, sy'n digwydd yma yng Nghymru, sy'n mynd i'r afael efo'r agenda yma?

amongst older people, directly or indirectly? Are there any other initiatives we haven't talked about yet, which are happening here in Wales, which tackle this issue?

[181] **Ms Lewis**: I can talk you through some of the initiatives that Age Cymru Swansea bay have shared with us that they are doing within the community to limit loneliness. So, they've had local authority funding for 12 years for a befriending project, but that has actually been withdrawn now. So, they are carrying on a smaller scheme with the restricted money that they have, but that is not sustainable, so they're very concerned about that. They have been looking at other ways of keeping befriending or initiatives that tackle loneliness going. So, they've been working with Tesco and Sainsbury's to develop a mobile befriending service, which is quite an interesting one. They have use of the premises and then they will take people there to meet and make connections within the community.

[182] They're putting in bids to private trusts and also they're working—. One which I think is becoming more and more popular is using transport from the local authorities that is not used at weekends. So, they're using the vans of social services to take them out at a minimal charge, to take people out for social occasions. But, talking to them, they are very concerned about the sustainability of all of these initiatives. The short-term funding, of course, can mean that some people are left vulnerable when a service is withdrawn.

[183] Also, the befriending project is volunteer led, and so it's engaging a lot of different people. Those that don't necessarily want befriending can be a volunteer and get involved that way, and that can also combat loneliness. But I think the problem is that there are not the finances there to sustain the volunteer-led service. It needs training. There are certain safeguarding measures that have to be put in the process. We are hearing this again and again in the third sector—this concern about the sustainability of the services and the short-termism of funding, which makes their services quite vulnerable to ending, which is a big shame.

[184] **Ms Lloyd**: This was reinforced to me yesterday. I was with the Welsh Senate of Older People yesterday and they were talking about the loneliness issue and they were talking about the success of some of the projects that

have been funded through the Big Lottery's advantage scheme. Obviously, that's come to an end now, and whilst many of those projects were successful when they were funded, the end of the funding has meant that some of them have shrunk and are managing to survive on a smaller level, but it has meant that lots of them have disappeared.

[185] **Ms Lewis**: One point that Swansea bay has made to me is that the idea is that these befriending projects will become self-sustainable, but you have to note that not all friendships are long-term friendships, not everybody is going to make a friend that they then carry on for life, and some people might need a bit more input than that on a regular basis.

[186] **Ms Lloyd**: The other examples that we've got are through some of the work we do around healthy ageing. So, they're not friendship projects per se, but it's back to what I was talking about earlier in terms of other activities that are there for older people that actually help with that isolation and loneliness. So, we run a range of physical activity programmes. We do Nordic walking that's funded by Welsh Government and we've got groups taking place across Wales. So, that brings in some social connection for older people, but also it's really valuable exercise for the volunteers and they get a lot out of it in terms of both the physical and the social side of things. Then, the Welsh Government fund our Gwanwyn programme, which is an arts and creativity festival for older people, and there are grant schemes under that that fund lots of local arts-based activity. Again, whilst it's not specifically about befriending, it does provide a focus in the community for people to come together and share.

[187] **Dai Lloyd**: Okay. Angela, on this point.

[188] **Angela Burns**: I mean, they're great and they sound absolutely fantastic, all those initiatives, and we've read a whole wodge of evidence today from different organisations, but one of the concerns I have is about the people who are not mobile, because all of these things are where—. Your 90-year-old may not be able to do Nordic walking, may not even be able to leave their home, and, with care packages being under such pressure, I just wondered if there was any thoughts about how we might get to those kinds of people. I think it was the older people's commissioner, or it could have been the academics at the very beginning, but they said that something like 17 per cent of older people will feel lonely or isolated, but, of the 80 to 90 group, something like 63 per cent of them will feel lonely and/or isolated, and so you think that is probably because of the lack of mobility, they

probably don't have their car anymore, friends will have died, partners might have died, et cetera. So, I just wonder what your view is on how we might get to those people, because they're not able, even if you went and chatted to them, to necessarily come out.

[189] **Ms Lloyd**: One thing that Age UK have been doing over the last few years is running a telephone befriending scheme, which won't necessarily work for everybody, but it's been hugely successful and what that does is it takes referrals from agencies about people that are lonely in their own home and would like a daily good morning call—or a good day call rather than good morning; so, a good day call. So, they spend a period of time getting to know the person with a daily call, finding out how they are, and, then, ultimately, they match them with a volunteer who does a weekly call, and that's proved hugely successful and they've got some fantastic case studies. It's all done through a call centre to avoid safeguarding issues. Lots of corporate organisations get involved in terms of allowing people to take an hour out of their day once a week to make those calls. So, it's quite light-touch in terms of the volunteering side of things, but it can provide a real boost to some of those older people. So, that's one method that is looking to work very well and recently I think Age UK now are looking at doing that in terms of older veterans, matching people based on interest.

[190] **Angela Burns**: Can I throw an idea out? We obviously have our carers who go out into people's homes to help particularly those who are infirm or perhaps disabled people, and they will have anything from 15 minutes, which I think is atrociously short, all the way through to whatever it might take. What would be your view if we were to try and get a system in place where actually emotional well-being is also seen as one of the ticks in the box for having a carer? So, you might actually have a carer who comes out once or twice a day who just sits down and makes you a cup of tea and chats to you, because you can't come out but you don't actually need someone to get you dressed, make your tea for you or whatever, but you do need that company, and I just wondered—

[191] **Ms Lloyd**: I think that's a thing that would make a huge difference for an awful lot of people because I think—we hear it about meals on wheels services, don't we—when somebody gets their meals on wheels delivered, that might be the only personal contact that they have, and that's why so many people are supportive of those deliveries taking place daily rather than the weekly ones. So, I think that would be beneficial to lots and lots of people, and perhaps take pressures off services in other areas.

[192] **Angela Burns**: Yes. I had one constituent who was always phoning the ambulance service up—always. And then they put a carer in, but she was an 18-year-old kid—nice kid, but you know—so the ambulance calls kept coming and then they got somebody who called around who was in her 60s, much closer, and it all stopped. It all went away.

[193] **Ms Lloyd**: And it's that sort of instance I was thinking of, because we do hear that so often, that people would phone the ambulance or they'd phone the GP, but actually the sorts of intervention you talk about, somebody going in just for a quick cup of tea and a chat, I think that would make a huge difference.

[194] **Dai Lloyd**: Ar gefn hynny, cawsom ni ddadl yn y Cynulliad yr wythnos yma ynglŷn â rhagnodi cymdeithasol ac wrth gwrs dyna'r math o bethau roeddem ni'n sôn amdanyn nhw. Felly, mae yna gwestiwn yn y fan hyn yn gofyn a fuasech chi'n cytuno—neu beth yw eich barn chi ynglŷn â rôl rhagnodi cymdeithasol i fynd i'r afael â'r holl agenda yma o unigrwydd ac unigedd?

Dai Lloyd: On the back of that, we had a debate in the Assembly this week about social prescribing and of course those are the types of issues we were discussing. So, can I ask what your opinion might be on the role of social prescribing in dealing with this agenda of isolation?

[195] **Ms Lewis**: We would say social prescribing could have a huge impact on levels of loneliness and I think that's going back to our point around identifying people that are lonely, people that call the ambulance a lot, people that visit the GP a lot. I think there have been studies that have shown GPs can identify people within their surgeries who are lonely and would benefit from that initiative. So, I think working with the health boards, local authorities, integrated working, again, is key to this. There has to be more responsibility for recognising these people and perhaps looking beyond the issue, talking about what the problems could be and talking to them about their own individual solutions as well. We have the 'what matters' conversations supposed to be coming through within the Social Services and Well-being (Wales) Act 2014 and those really should be drilling down about what a person really thinks can be done to support their situation, their health needs, but also their emotional well-being—'what matters to me'. So, I think that social prescribing can be really successful in rolling out that approach.

[196] **Dai Lloyd:** Da iawn. A'r cwestiynau olaf o dan law Angela.

Dai Lloyd: Very good. And the final questions, Angela.

[197] **Angela Burns:** Yes. I wanted to, actually, talk about current policy solutions, because—. Sorry, I've got my fingers in all different bits of your evidence here. In your evidence, you feel that the Social Services and Well-being Act (Wales) 2014 and the Well-being of Future Generations (Wales) Act 2015, if implemented, would be able to reduce loneliness and isolation. And I just wanted to explore that a little bit, because you talk about the drive towards a person-centred approach, including the facilitation of 'what matters' conversations. But it's back to my original question—it's how do you get to those difficult people, because this Act isn't going to help that at all, is it? What would you see it being able to achieve?

[198] **Ms Lewis:** I think the way that we're looking is that the social services Act has, again, more focus on an individual's well-being as opposed to just the medical problem, but looking at them in a holistic way. The issue around finding people that are lonely, of course, is a separate one—I would accept that—but I think that social services, local authorities, all have a role to play in making sure that people's eyes and ears are open and looking for people who are at risk of loneliness. We know from what we are being told that bereavement is a big trigger. We know, as you've said, that loss of mobility is a big trigger. It's going back to Vicky's earlier point that local authorities and health boards do have a way of seeing people that have these risk factors, and identifying them and making sure that perhaps they are then allowed to have a needs assessment that's around their whole personal well-being, and not just making sure that they have the wheelchair to get them around better, and everything.

[199] **Angela Burns:** Rachel, can you give us any best practice that you've spotted from any particular local authority in terms of how they've been able to identify, to assess, either using the legislation or just as part of their general public health improvement sort of match?

[200] **Ms Lewis:** Unfortunately, I can't think of any individual—

[201] **Ms Lloyd:** I was going to mention about the Community Connectors project. I was talking to one of the connectors from Swansea yesterday, and the approach that they have in their community I think is a really positive one, as long as they've got things to connect people to. But actually having

those posts in place is, as Rachel says, the eyes, the ears, on the ground. They're able to help with that identification process, because I think we'd accept that, unless we've identified those people, the preventative elements of the Act aren't going to help unless people are in the right place. But I think if we get better at that identification then those things will flow behind.

[202] **Angela Burns:** Yes. There was one other thing I wanted to talk about on your—. When the Age UK study, which used guided conversation and motivational assessment to understand older people's circumstances—. Can you just give me a bit of detail about that? Did that happen in their homes? Did they go somewhere for it?

[203] **Ms Lloyd:** It was a piece of work that was done down in Cornwall around integrated care, and the people were identified through a risk stratification tool within the GP surgery, and then the volunteers then went out to the person's home and had that guided conversation. And, actually, the evaluation of that piece of work was hugely impressive in terms of the results, and I think it's something then that Age UK have sought to replicate in other areas. So, there's some quite good information around that, which we can share.

[204] **Angela Burns:** But that was driven by the GPs.

[205] **Ms Lloyd:** It was a partnership approach. It was, I think, part of the partnership funding that was available, and I think it was the third sector health partnership.

[206] **Ms Lewis:** There are quite a few examples now of co-location of premises where the GP might co-locate with social services. Care and Repair are doing a social prescribing project, so it's about the different sectors coming together. And I think there are different ways in which people are working, so they realise that, if they co-locate premises, that sort of interface between the services that have historically been separate can be achieved more easily.

[207] **Ms Lloyd:** And, in terms of the risk stratification, I know our colleagues in Age Cymru Gwent are working with GP practices in Newport to do some of that work, and then to help be proactive in contacting people that might benefit from the services.

[208] **Angela Burns:** Is that a tool or is that a methodology, this

stratification, or is it something that's just ingrained in—

[209] **Dai Lloyd**: Well, it's ingrained, but there's a pro forma as well.

[210] **Angela Burns**: Oh, okay.

[211] **Ms Lloyd**: Yes, and they can stratify on different factors. I think the one in Cornwall, and potentially the one being used in Gwent, is about likely admission to hospital.

11:45

[212] **Angela Burns**: So, if I was to put my waving wand hat on and say to you, 'What would be your couple of key things that you would most like Welsh Government to do to tackle this issue?', what would they be?

[213] **Ms Lewis**: We discussed this earlier and I think our two key asks are around addressing the stigma and getting people talking about the issue with health professionals, the people within their own neighbourhoods, and then looking at how the infrastructure and how the removal of services is affecting older people, and what can be done to really make sure that people are not falling through the gaps. Somebody who's recently bereaved is looking for somewhere to go, but perhaps a bus service has been cut back, the community centre has been shut down, and the library has gone: what is happening to those people? So, I think a real look at investment and how communities can support these people who might become victims to loneliness.

[214] **Angela Burns**: Thank you.

[215] **Dai Lloyd**: Lynne, you had a question.

[216] **Lynne Neagle**: I'm particularly interested in—[*Inaudible*.]—implications of the social services Act on this, really, and we all know how we want the legislation to work, but I think that there is a risk that proportionate assessments, which are becoming more popular, plus the tightening of eligibility criteria, could lead to actually more people slipping through the net. Is that something that you've seen happening anywhere, and is that something that you're concerned about?

[217] **Ms Lewis**: It certainly is something that we are concerned about. We

have been looking at levels of assessments, and it seems to be—shall we say, it's not uniform across the whole of Wales. So, we are concerned about what levels of criteria people are using. So, that's something that we do want to look at in a bit more detail, and we are actually planning to look at that needs assessment and how it's been rolled out across Wales, because, of course, that is a concern for us, that too many people are slipping through the net, and just being given a bit of information and advice, and then just left.

[218] **Lynne Neagle**: And sent on their way, yes.

[219] **Ms Lewis**: It should really be properly monitored to make sure that people are achieving their personal outcomes.

[220] **Ms Lloyd**: I think our concern is that people are being screened out of the system too early.

[221] **Lynne Neagle**: Yes, yes. Exactly.

[222] **Ms Lloyd**: And so it's something that we're very alive to, and keeping an eye on at the moment.

[223] **Lynne Neagle**: Okay, thank you.

[224] **Dai Lloyd**: Diolch yn fawr. Wel, dyna ddiwedd y cwestiynau a diwedd y sesiwn dystiolaeth yma. Diolch yn fawr iawn i chi am eich presenoldeb a safon eich tystiolaeth y bore yma, a hefyd am y dystiolaeth ysgrifenedig gerllaw. A allaf i gyhoeddi y byddwch chi'n derbyn trawsgrifiad o'r drafodaeth yma i gadarnhau ei fod e'n ffeithiol gywir hefyd? Ond gyda hynny, diolch yn fawr iawn i chi am eich presenoldeb. A allaf i gyhoeddi i'm cyd-Aelodau fe gawn ni egwyl fer nawr am 10 munud, a dechrau nôl am hanner dydd? Diolch yn fawr.

Dai Lloyd: Thank you very much, and that's the end of our list of questions and the end of this evidence session. Thank you very much for being here today, and for the standard of your evidence today, and also for the written evidence you've already given us. Can I let you know that you will receive a transcript of this discussion to check for accuracy? Thank you very much for being here today. Can I tell my fellow Members also that we're going to take a short break for 10 minutes, and we'll be back at midday? Thank you very much.

[225] **Ms Lloyd**: Thank you.

[226] **Ms Lewis:** Thank you.

Gohiriwyd y cyfarfod rhwng 11:48 a 11:58.
The meeting adjourned between 11:48 and 11:58.

Ymchwiliad i Unigrwydd ac Unigedd—Sesiwn Dystiolaeth 4—Y Samariaid a'r Ymgyrch Atal Unigrwydd
Inquiry into Loneliness and Isolation—Evidence session 4—Samaritans and Campaign to End Loneliness

[227] **Dai Lloyd:** Croeso nôl, bawb, i sesiwn ddiweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yng Nghynulliad Cenedlaethol Cymru. Rydym yn symud ymlaen i eitem 5 ar yr agenda y prynhawn yma, sef parhad efo'n hymchwiliad i unigrwydd ac unigedd. Hon fydd sesiwn dystiolaeth rhif 4 o'r bore.

Dai Lloyd: Welcome back, everyone, to the latest session of the Health, Social Care and Sport Committee here at the National Assembly for Wales. We now move on to item 5 on the agenda this afternoon, which is continuation of the inquiry into loneliness and isolation. This will be evidence session No. 4 of the morning.

[228] Rhaid i ni ddweud ein bod ni wedi derbyn toreth o dystiolaeth ysgrifenedig ymlaen llaw, a hefyd mae'r pwyllgor hwn ac aelodau ohono wedi bod yn cyfarfod â phobl ledled Cymru ers tua phedwar mis nawr, fel rhan o'r cefndir i'r ymchwiliad yma.

We have to say that we've received a great amount of written evidence beforehand, and also the committee and members of the committee have met with people the length and breadth of Wales for about four months now, as part of the background to this inquiry.

[229] Ond, o'n blaenau ni nawr, fe allaf groesawu Emma Harris, swyddog polisi a chyfathrebu y Samariaid, Sarah Stone, cyfarwyddwr gweithredol dros Gymru y Samariaid, a hefyd Dr Kellie Payne, rheolwr ymchwil a pholisi yr ymgyrch i roi diwedd ar unigrwydd. Croeso i'r tair ohonoch chi.

But, in front of us now, I can welcome Emma Harris, policy and communications officer from the Samaritans, Sarah Stone, executive director for Wales at the Samaritans, and also Dr Kellie Payne, research and policy manager at the Campaign to End Loneliness. Welcome to the three of you.

[230] Rydym wedi derbyn eich tystiolaeth fendigedig ymlaen llaw ac, yn seiliedig ar hynny, mae yna gwestiynau yn dod oddi wrth Aelodau. Felly, yn ôl ein traddodiad erbyn nawr, fe awn yn syth i mewn i gwestiynau, ac Angela sydd yn arwain.

We have received your wonderful evidence beforehand and, based on that, Members have questions. So, according to our tradition by now, we'll go straight into questioning, and Angela is leading on this.

[231] **Angela Burns**: Thank you, and good morning. Thank you both for your sets of evidence. They were without a doubt, for me, the most interesting that I read in this session. I'm going to stray very slightly from the reason you're here, which is to talk about loneliness and isolation in older people, because I do want to pick up on young people as well, in passing. But if I could just start with whether or not you would agree with the older people's commissioner that this is a public health epidemic in the making in terms of loneliness and isolation in the elderly.

12:00

[232] **Ms Stone**: I would agree that it's a major issue and the evidence is that it's increasing as an issue. So, yes, it's something that we need to look at really seriously, and the detriment to health is really significant. One of the things that we at Samaritans want to make is that connection between loneliness, isolation and suicide. So, it is a very serious issue. What we want to do is to move the actions that need to be taken to tackle loneliness into a much more serious space, if you like. We've got a campaign that is called Local Action Saves Lives. It's all about how acting locally on suicide—which is a highly complex issue, multifactorial, lots of things involved—but to bring all those things together, you need local action, and one of those local actions is around mitigating loneliness and social infrastructure.

[233] **Dr Payne**: I would agree. I think with loneliness, we've sort of come to a crossroads in a similar way that, say, we did with smoking many years ago, where there's now such a great body of evidence that really shows the link between loneliness and many health effects—so, increased risk of stroke, heart disease, mental health issues as well, risk of suicide. There are just so many links. Some of the more profound evidence shows that its risk to morbidity is equal to that of smoking 15 cigarettes a day. It's the same risk as things like obesity. So, I think we're really at this point now where we

acknowledge that it's a really severe health issue, and it should be tackled in the terms of a public health issue. But I think what we need to really move on to now is finding that evidence that shows what we can do to tackle it. I think, unfortunately, we've got a lot of what we call 'promising approaches': things that seem to be working. But I think we're definitely calling for there to be more evidence around what does work and what interventions are working.

[234] **Angela Burns**: We've—. Sorry, Emma, did you want to say anything?

[235] **Ms Harris**: No.

[236] **Angela Burns**: We've listened, actually, quite a lot this morning to all the debate about taking away services. You know, when people can't go out, they haven't got benches to sit on, loos to go to et cetera. So, I think in terms of your evidence, and from my part, what I would really like to try to really highlight—and this is your opportunity to highlight—is where social isolation and loneliness will take people. In your paper I think it says—. Sorry, I've got fingers on everything here. Both of your papers were excellent. I must admit, Kellie, that the way that you describe loneliness as the social equivalent of thirst or hunger, and how it's been defined there—I think that's absolutely excellent. I think it brings it home enormously. And the Samaritans, you've talked about the areas or the groups who are most vulnerable: elderly people, men, young people, people from ethnic groups et cetera; different types. So, will you please just talk a little bit to us about if somebody gets to the point where they are lonely, where they feel socially isolated? We talked a little bit with the academics who came in right at the very beginning about people turning to alcoholism—people will become depressed. I would really like to explore that a little bit more and find out how likely you think it is that that is the direction of travel for people, and then how much more likely it is for them to take the ultimate step and then move on to suicide, and the prevalence in any particular group.

[237] **Ms Harris**: I think one of the main problems with loneliness and isolation is that it's not necessarily known to the individual that they are lonely or isolated until they reach crisis point, especially in men. So, in men—moving over to them as a high-risk group for a moment—one of the reasons they are more likely to take their own lives is because they may not seek support until they're at crisis point, because they're not taught to open up in the same way that women are. So, by the time someone might realise they're lonely or isolated, it may be past the point of taking that first step and

joining a community group, which is why it's so important that local authorities take action, and that's why programmes like Communities First are so vital and such a lifeline to so many. The closure of them is of real danger to people to become more lonely or isolated. So, I think that would be one of the main things I would highlight.

[238] **Angela Burns:** That's really useful. Does anybody else want—?

[239] **Dr Payne:** One of the things that has really struck me in learning more and more about loneliness is really that it's a very person-centred problem, but it's something that can only be solved by having the whole community—. You can't solve it only individually. People will be lonely for so many different reasons. We particularly focus on older people, and it's often these transition points that happen in life. So, things like going into retirement and losing those people that you see on a daily basis, or bereavement—that happens very often. So, there are many points at which people are much more at risk of becoming lonely. It's really this sort of chronic loneliness that we're talking about, and that's when people say things like they don't speak to anyone—you know, that they hardly speak to anyone in a given month. Maybe the only people they'll see are the people at the shops. I think this is another thing: that it's quite difficult to know how to identify lonely people. I think that's one thing that we've worked very hard on. We've put a guide together called, 'The Missing Million', which looks at how you can work with things like the local fire service to identify it. So, thinking about all the people on the ground that might have access to lonely people. So, I think that's one of the key elements as well. But I do think it is very difficult, because each person is going to be lonely for their particular reason, but there are, of course, risks.

[240] **Ms Harris:** I think, as well, if a person is chronically lonely, then it makes it that much harder to relate to other people because of a lack of socialisation; so it makes it more difficult to reach out and gain the support they need, which is why, in terms of addressing loneliness and isolation—you know, a public health approach—I think early intervention and prevention before it gets to that point is much more important.

[241] **Angela Burns:** That's why I found some of your evidence so surprising, because, looking back at other evidence we received earlier today, there was some statistic—and I'm probably not quoting quite accurately—that came out, which was that something along the lines of 17 per cent or 18 per cent of all people 60-plus, or whatever it was, will feel lonely or isolated at a

point, but that increases to something like 63 per cent of anybody who is 80 to 90. You kind of get that, in a way, don't you, because they might be housebound, they've probably lost the use of a car, the transportation services aren't so hot, and so on and so forth. So, you can see how they could be trapped. Friends will have been older like them and have probably died et cetera. They're probably on their own, which is why, in your evidence, when you talked about young people—. You actually make the comment here that a study throughout the UK found that the 18 to 34-year-olds were more likely to feel lonely than the over-55s. I found that absolutely staggering, and I just wondered if you could expand on that. And also, could you say whether there are any studies that talk about pre 18? I represent, sadly, a constituency that's had a significant number of suicides in the last few years, from young people, and we're still trying to get an understanding of why this is happening.

[242] **Ms Harris:** There's certainly limited evidence on young adults, young people and children under 18 experiencing loneliness, but there's mounting evidence to show the link between social media and mental health and the fact that excessive—or not even excessive—. I think it was a study by the University of Pittsburgh found that more than two hours of social media use a day doubled the chances of you being socially isolated. Considering that, I think, 95 per cent of young people 14-plus have social media—it's that initial risk. So, the chances of a young person becoming lonely because of their online socialisation—a world that we don't understand because we weren't born into it in the way that they were, and they live their lives online—. A study came out by the—I can't think who it was now. There was a study that came out a couple of weeks ago that found that social media increases the risk of depression, anxiety and loneliness in young people, and I think that's what we focus on in terms of that being a precursor for loneliness plus 18.

[243] **Angela Burns:** So, do you think that if we can tackle those senses of loneliness, we can build resilience through, so that when somebody travels from being an 18-year-old through to being a 70-year-old, that—. Because the older people's commissioner spoke about building resilience in older people. Do you think that we can build resilience along the way, and teach people from an early age about friendship and the importance of feeling connected?

[244] **Ms Harris:** Yes. So, one of the things we call for in Samaritans Cymru is emotional health on the school curriculum. We think it should be mandatory,

we've run a Cardiff DEAL pilot, which has implemented Samaritans' DEAL programme into the curriculum of six schools, and it teaches many different components of emotional health, but one of them is connecting with others. So, it teaches children how to identify their support network, how to ask for help, but more importantly in terms of this inquiry, what human connection really is, and it explains that social media isn't a substitute for human connection, it's not the same as having a conversation. And, it seems quite obvious to a lot of us that that's the case, but to young people I don't think they do know that and they think that scrolling through Facebook for hours is the same as being sociable. So, yes, the same report, which I can send on after this, or—

[245] **Angela Burns**: That'd be great, thank you.

[246] **Ms Harris**: —I can signpost people to, that calls for safe social media use on the school curriculum as well. So, teaching young people how to use it appropriately and responsibly and put better support networks in place.

[247] **Angela Burns**: But to bring it back to older people now, do you think we could usefully use social media? Is it a useful tool at all to help connect older people? I mean, in your view—we talk about loneliness and isolation—how can we reconnect with these people and how can we find them?

[248] **Dr Payne**: I think, we show in our evidence some evidence taken from a report that we did called 'Promising approaches', which shows we've created a loneliness framework. And one of those key pillars of the framework is called structural enablers, where we look at things like travel, transportation, but also technology, saying that these are really things that can connect people. I know there's evidence that shows, in young people, that screen time doesn't replace face-to-face time, but I think what technology really has the ability to do is connect people. One of the things that we often hear from people is they don't know what's going on in their area, they would like to know more about what's going on. Often, this type of information is available on the internet, so if you can get people connected a little bit more. And one of the great programmes that often happens is there's—I think a number of Age UKs do this, where they mix older people with younger people in technology classes, so that's a great intergenerational way of bringing together older people and younger people and sharing those skills. Often when I talk about technology, I give the personal example that I met my husband on internet dating, and we have so much in common, but we wouldn't have met otherwise, unless we'd been connected through that

quite impersonal means. But, it's really that face-to-face connection that really matters, and technology really does enable those things. So, I think, in terms of the evidence, perhaps the jury is still out about what it can do, but I'm a strong believer in the possibilities of it to connect people, as long as you are moving away from, not merely that your interactions are solely on a screen, but if you're moving to face-to-face connections made through the links that you can have through technology, I think it's a great resource.

[249] **Ms Stone**: Just to pick up on the question that you asked earlier about what it is about loneliness that is so significant. When we were preparing for this, we were talking about this, and our own service is about that. Samaritans' service in terms of listening is about the critical importance of human connection.

12:15

[250] One of the best ways of mitigating suicidal feelings is human connection. So, in our case, obviously, it manifests itself in a service that is actually about human empathy; it's about listening without judging; it's about that empathetic connection with another real human being. So, if you don't have that, people don't have that sense of connectedness. We've produced a report on socioeconomic deprivation and it looks at different aspects of this.

[251] Rumination is one of the things that can lead people towards suicidal ideation and completed suicide, so, the same thoughts running round and round your mind, over and over, but without being interrupted by the connection with another person. So, isolation can support that happening. People need a sense of belonging and we talk about a thwarted sense of belongingness and that can be created by isolation, and that's why we talk about programmes that mitigate the impact of recession, for example, of hard economic times, which keep people connected to the workforce in some way, can really mitigate suicide. So, belongingness, connectedness, disrupting really negative patterns of thinking, all those things are connected with contact with other people.

[252] **Angela Burns**: Thank you.

[253] **Dai Lloyd**: Lynne.

[254] **Lynne Neagle**: Thank you. Can I just say that I just wanted to start by

paying tribute to the work that you do, really, especially the preventative work that you're doing, which I think is absolutely first class? I wanted to ask about Talk to Me 2, which you've highlighted in your evidence, and you've said that there needs to be an implementation plan, and also that there need to be local plans. So, I guess the fact that you've highlighted that in your evidence suggests that there is no implementation plan, so I'd like you to comment on that, really, because we are very good in Wales, I think, at having excellent policies, but then not having a road map to implement them. I wanted to ask if you could outline a bit more, really, about what kind of discussions have happened with Welsh Government about the need for every local authority to have that kind of local action plan.

[255] **Ms Stone:** Talk to Me 2 is a really good suicide and self-harm prevention strategy. Priority people, priority places and the actions that it pushes for around training front-line staff, all those things are really important. The local implementation, it's not that nothing is happening—there are forums meeting in different parts of Wales—however, there is a patchiness about that and that reflects the challenges of bringing people together on the ground, of resources, of commitment and all of those things. There are good examples, and there are example where things are lagging behind a bit.

[256] There will be guidance on who should be on those forums, how they should conduct what they do and the sorts of things you'd expect to see in a local suicide and self-harm prevention plan, coming out shortly from the Welsh Government, which is really welcome and, hopefully, that will galvanise things to be happening more consistently locally. So, that's where the difference is going to be made in many, many ways. It is a work in progress. My understanding is that, now, Public Health Wales will have a lead role, not in doing all the doing, but in ensuring that there are those sorts of local forums meeting consistently across Wales. I think we've got a way to go to really have that energised, to have all the people around the table who should be around the table. So, that's one area where we need to see progress happening.

[257] **Dr Payne:** Can I just say something from the campaign's perspective? We've worked quite closely with a number of local authorities in England to develop our local authority guidance, but going forward, we are having a campaigns manager, who will be based in Wales, working with Ageing Well in Wales. Similarly, the Scottish Government is doing a similar inquiry, and I've spoken with one of their representatives and we're planning to take our local

authority guidance that was specifically designed in England, to translate that into a Scottish context, and I'm suggesting that we do that in Wales as well, so we can make sure that—. It's essentially quite a detailed plan of how you can strategically address loneliness from a local authority's perspective. So, if we can get that translated and made into a more friendly version for Welsh local government as well, I think that's something that the campaign would like to do.

[258] **Lynne Neagle:** I wanted to ask about social deprivation as well, because Emma you picked up on that. You highlighted the impact of the loss of Communities First. You've done a lot of work on the links between social deprivation and the extreme end of loneliness, really, which I suppose is suicide. Is that something that is being followed up—what impact these kinds of changes to things like Communities First will have on a local level in terms of increasing loneliness and isolation?

[259] **Ms Harris:** We've just responded to the inquiry into Communities First lessons learned to highlight our concern over the closure of groups. Anecdotally, where we've spoken to organisations that are involved with community groups, they are very concerned because of the amount of residents who've said that they're going to lose a lifeline, they're not going to have anyone to communicate with. We've heard of some examples where people are so isolated that the groups they involve themselves with, the leader of those groups is the only one who knows they're there. They've got no family or friends and so if it wasn't for that person—. So, we've really put forward very strongly that, in terms of the 70 per cent reduction in funding and local authorities deciding which projects should continue, we think that any that achieve the outcome of social connectedness—and it doesn't have to be a specific social group, it can be anything: a digital inclusion class or a coffee morning, anything like that—they should be considered not just in terms of their effect on being a social outing, but much higher than that: it should be seen as a preventative measure. It reduces the strain on health services. It's highly important, so we've called for that very strongly.

[260] **Lynne Neagle:** Okay, thank you. And Kellie, can I ask about the loneliness framework that you've referred to in your written evidence? Can you tell us a bit more about that? You've referred to having local action plans. Is that how you see that kind of thing going forward?

[261] **Dr Payne:** It was initially created for a report called 'Promising approaches', but our local authority guidance is also based on the

framework. So, as I've described in the evidence, it breaks it down into different ways to approach loneliness, from things like direct interventions to more community-based things. What was your second question?

[262] **Lynne Neagle:** I was just really looking for more information on it, and how you would see that working in practice in Wales.

[263] **Dr Payne:** I think, because the current guidance online, which is the local authority guidance, was created in an English context, I think it does need to be translated to the local government structure in Wales. But it really provides a framework for creating local strategies and then implementing. It sort of walks through the various stages—so, things like, within a local area, ensuring—. I'm afraid I'm not sure how it's structured in Wales, but in England we've got health and well-being boards, and making sure that all of the different players within a local authority are working together on that strategy and mapping what assets are available. It's really taking that asset-based community development approach, but really understanding what assets exist, and then also what things are missing. I think that's really one of the things that's come out strongly through the evidence, that all of these approaches really need to be tailored to the specific area, because different areas will have different assets. I've been working in particular with a programme in Worcestershire called Reconnections, and there are various implementation partners for this project, and one of the examples, for instance, has a really excellent building, a community centre, where they're able to deliver all of their different loneliness programmes. It is, by and large, within that area, the most successful project, simply because they have that local asset of a building and also they've got a van that can take people to and from the building. So, really understanding what those local assets are, and what gaps there are within a local area. So, that's largely why we've taken a very local approach to much of our campaigning.

[264] **Lynne Neagle:** Okay. And finally, do any of you have any information on any work that's been done on the costs and benefits of interventions to tackle loneliness and isolation?

[265] **Dr Payne:** We currently have contracted to the London School of Economics, and David McDaid, who was mentioned in the evidence, is a health economist—they're currently working on a project that looks across—. It's doing, first, a literature review to see all of the examples of any interventions that have done a cost-benefit analysis of the economic benefit to providing an intervention, and then it's going to be—. In addition to

showing the various ways that you can do that, we hope to create a tool as well to help both local authorities, but also people providing services to make their own calculations to be able to show commissioners what benefits there are.

[266] So, they're currently—. They've done work already—some of the work that's mentioned in the evidence—looking at the costs to the health and social care system of loneliness. That has been very research based and based on different academic papers that have illustrated the various costs. But they are currently doing some other work in Worcestershire. It's part of this Reconnections programme, where they're actually going to tie the use of interventions, and they're going to have access to the NHS records of the people who are taking part in the interventions. So, they will be able to actually show over some time what savings those people who have undertaken the Reconnections intervention—.

[267] So, it's very much an area where we are very invested in getting the results around, first, the cost of loneliness, and also the cost-effectiveness of interventions being able to really show that that's something that both interventions can show, but also what type of information commissioners can ask for. They're things that we're very aware of, and we're working very hard to get as much evidence as possible but, unfortunately, the evidence as it is currently is just so indicative; it's not very solid yet.

[268] **Lynne Neagle**: And that research will cover Wales as well as England.

[269] **Dr Payne:** Yes. It covers the whole of the UK, yes.

[270] **Ms Stone:** Lynne, just on the cost of suicide, we can get you some figures on that after this, if that would be helpful, but I would just say in general that the cost of every suicide is immense. There is a financial aspect to that. There's also the effect on friends, family and community, which is—. There's an enormous ripple effect, so it's extremely costly both in finances and in the health and well-being of the people around; it's a very costly thing.

[271] **Dai Lloyd**: Diolch. Mae'r ddau gwestiwn nesaf o dan ofal Rhun ap Iorwerth.

Dai Lloyd: Thank you. The next questions are from Rhun ap Iorwerth.

[272] **Rhun ap Iorwerth:** Just to go back to loneliness mapping, do you have

some more information on where loneliness mapping in communities has been effective?

[273] **Dr Payne:** So, in our 'The Missing Million' guide, we—. Unfortunately, the case at the moment is that a lot of risk mapping has been done in England by Age UK, so basically what they've done is they've taken Office of National Statistics data and linked them to the English Longitudinal Study of Ageing data that show what the risk factors for loneliness are. And they've mapped those risk factors on to the ONS data, and they've been able to show that in local areas, you can go on and you can type in the postcode and it will show you what the likely risk of loneliness is in that area. In our 'The Missing Million' report, we show various examples of what other local Age UKs have then gone on to do with those data, so once the risk map is created then they will often have to sense-check it to make sure it's indicative of the amount of risk there is, but it's not an on-the-ground view of what's actually happening. But we would recommend that, in any way possible in Wales, you could adopt a similar model of the risk mapping.

[274] Essentially, in our 'The Missing Million' guide, what we say is there are many data-driven approaches that you can take to funding where lonely people are, and it's something that you have to work from the top down and then the bottom up to get to where you actually understand what the true risk is, because the data will show you an overall view and give you an indication of how many lonely people there are, but then you really need to sense-check it to see, on the ground, if that is actually the case.

12:30

[275] **Rhun ap Iorwerth:** And is that a part of the work that you're doing in west Wales at the moment as well?

[276] **Dr Payne:** So, I'm not sure—. The person is only starting on the 1 June, so we haven't developed very extensively what will happen, but—

[277] **Rhun ap Iorwerth:** But it may.

[278] **Dr Payne:** —I think calling for the risk maps to be extended to Wales is one of the key recommendations that we would make, and I think they would be working—. Obviously, if the person who is working in west Wales had access to that sort of information, it would immensely help her, where she decides to seek to develop the assets that are there.

[279] **Rhun ap Iorwerth:** And would the Samaritans agree that developing this risk mapping should be one of the recommendations—the key recommendations, even—that we make as a committee?

[280] **Ms Stone:** We support the idea of loneliness mapping. Suicide risk is a complex thing, though, because you can look at it in terms of groups but it's not predicting individual risks. It's important to say that. In the work we've done on social and economic deprivation, there is a chapter that is about place and living in a socially economically deprived area there is an increased suicide risk there. So, place has a role to play in looking at suicide risk and there's a link between that and the isolating effects of deprivation, for example. So, with the qualifications that you mentioned, of needing to then look at it in a commonsensical way and draw up more, that sort of mapping approach seems to have some real merits.

[281] **Ms Harris:** I think, as well, because the mapping approach can be seen as preventative and early intervention, I think it could certainly have a place with public service boards and local well-being plans, and that kind of sustainable development principal, protecting future generations—I think it could definitely be slotted in there somehow as a form of prevention.

[282] **Rhun ap Iorwerth:** Is it resource intensive, developing that kind of risk mapping that you think is at a level where is could be useful?

[283] **Dr Payne:** I think it really depends on the data that are available. In the English case, because the risk factors from the ELSA data could probably be transferred—it's just whether it would be similar, like the CFAS data, which I think you would have available. But I'd have to check on that about how—. I know very well that our colleagues at Age UK have been working on that, so we do have contacts in to the people who created the risk maps. I'm sure they could explain the ways that they could go about creating those for Wales.

[284] **Rhun ap Iorwerth:** Okay, thank you.

[285] **Dai Lloyd:** So, you're convinced that risk mapping works. Is that—?

[286] **Dr Payne:** I think a really good example of it working is in our 'The Missing Million' report, where—I don't remember the exact area, but it was a place in England, essentially, where there was a lot of work going on around

loneliness in a particular area—I think it was Merseyside—and they then looked at the risk maps and they noticed that there tended to be a higher risk in a particular area, and when they had then mapped on what sort of coffee mornings and activities were going on, that area that had a really high risk didn't have many activities. So, they were then able to match the activities with the risk. So, it's really that marrying of sort of practical things alongside the indication that it can give in terms of where lonely people might be. I think it does work, yes.

[287] **Dai Lloyd**: Fine. Final questions—Caroline Jones.

[288] **Caroline Jones**: Thank you very much. I'd also like to thank you for the work that you do, and I was directly involved with the Samaritans, as I worked in the prison service running my own department on suicide prevention, anti-bullying and cultural diversity. So, I would like to thank you for the work that you do there. I have a couple of questions here for you, and key actions that you think the Welsh Government should take to address the problem of loneliness and isolation in older people. Could you state what you think those key actions should be? Thank you.

[289] **Dr Payne**: We made recommendations in our report, and one of the first things that we talk about across all nations in the UK is really the desire for there to be a target to reduce loneliness. So, I think in Wales, you've already got a good measure, with older people, of the number of people who are lonely. So, I think setting a target in terms of reduction is really important. We tend to think of it a little bit like with climate change—that need to set out a goal in terms of what reduction we would like to make and really it's a top headline thing that says, 'We're really committed to this and we're making this pledge to attempt to reduce loneliness by a certain amount.'

[290] We also think that there really needs to be more effort put into creating a stronger evidence base around what works. We feel like there are a lot of really good examples, but the actual—you will see in my evidence, on the last page, I go through any of the meta analyses that have looked at loneliness interventions. They say, time and again, 'We don't have enough evidence about what actually works.' So, really putting effort and budget towards that type of evidence, I think, is really important.

[291] We also think that Government departments, as employers, should really take a leadership role. I think it's really important to acknowledge,

particularly as employers, that loneliness can happen. In particular, there's a lot of work around transitions, so people who are transitioning into retirement having courses available to explain to them how critical it is, once they do make that move into retirement, that they should not be lonely.

[292] Then our final request is, really, that we move the rhetoric around loneliness to something a little bit more positive. So, I think the use of 'loneliness and social isolation' has been really critical in understanding it and getting it to this point where you've got this inquiry that's looking into creating a strategy. I think this is a great point, and I think we've really been able to highlight the public health issue that loneliness is, but we also need to move on to embracing a little bit more positive language around social connections, community building and social capital, and those correlates to loneliness that are a little bit more positive, and really using an asset-based approach when we're thinking about the community, to really see what assets exist.

[293] One of the things I was really struck by was the evidence from the older people's commissioner in Wales saying how she felt we needed to ensure that those local assets that do exist, such as the library, just local places that—we can't continue to cut funding and not expect that that's not going to have an impact on local assets. So, we really feel that we would echo that recommendation that you really continue to ensure that those local areas for people to come together and socialise are not taken away.

[294] **Caroline Jones**: Thank you. Could you tell me how you think the proposed Welsh Government strategy should address the problems of loneliness and isolation experienced by older people?

[295] **Ms Stone**: I think looking at it in terms of tackling things on a societal level, on a community level and an individual level is a helpful way of segmenting it out, because we are talking about highly complex interactions here. So, having some kind of theming around that—so, in terms of older people, it's a question of looking in terms of suicide prevention. I think that gives an extra impetus to the general work to produce a more community-based approach to tackle loneliness and to support just the kind of things that you were talking about, things that might seem a bit soft, the teas that people have, the community centres, the lunches—things that aren't badged as something that is about loneliness, but are just badged as going along to do some drawing, going along to engage with people in some way. Those are actually really important preventative things, so I think there's that

community action that is really, really important.

[296] There are also the health messages that are given to people. So, I think, there is a public mental health question about trying to increase public understanding of what builds their own resilience, that there is something that they can do, that they should and can seek help, and that preventative work can have an immense effect. Re-engaging with your world—. We know that things happen as people grow through their lives. They get knocks, they get knocked back, and being able to get back into social networks is incredibly important in helping people through those crises and getting out of them and reconnecting is really, really important.

[297] **Dai Lloyd:** Excellent. Diolch yn fawr. Excellent evidence this morning.

[298] Diolch yn fawr i'r tair ohonoch chi. A gaf i hefyd ddiolch i chi am ansawdd eich tystiolaeth ysgrifenedig y gwnaethom ni ei derbyn o flaen llaw? Roedd hi'n fendigedig, fel y mae eraill wedi sôn eisoes. Gallaf i hefyd ddweud y byddwch chi'n derbyn trawsgrifiad o'r cyfarfod yma i gadarnhau ei fod yn ffeithiol gywir. Ond, gyda hynny o eiriau, a allaf ddiolch i chi unwaith eto am eich presenoldeb a'ch tystiolaeth? Diolch yn fawr iawn i chi.

Thank you to the three of you. Can I also thank you for the quality of your written evidence that we received in advance? It was excellent, as others have already said. I can also say that you will receive a transcript of this meeting to check for factual accuracy. But, with those few words, can I thank you again for coming and for your evidence? Thank you very much.

12:41

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o Weddill y Cyfarfod
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Remainder of the Meeting

Cynnig:

bod y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod yn unol â Rheol Sefydlog

Motion:

that the committee resolves to exclude the public from the remainder of the meeting in

17.42(vi).

accordance with Standing Order 17.42(vi).

Cynigiwyd y cynnig.
Motion moved.

[299] **Dai Lloyd:** Rydym yn symud ymlaen i eitem 6 a chynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o weddill y cyfarfod er mwyn symud i sesiwn breifat. A ydy pawb yn cytuno? Mae pawb yn cytuno. Diolch yn fawr iawn i chi.

Dai Lloyd: We're going to move on now to item 6 and a motion under Standing Order 17.42 to resolve to exclude the public from the remainder of the meeting. We're moving into private session, therefore, if everyone is in agreement. Thank you very much.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 12:41.
The public part of the meeting ended at 12:41.