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

15/06/2017

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Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir trawsgrifiad o'r cyfieithu ar y pryd. Lle y mae cyfranwyr wedi darparu cywiriadau i'w tystiolaeth, nodir y rheini yn y trawsgrifiad.

The proceedings are reported in the language in which they were spoken in the committee. In addition, a transcription of the simultaneous interpretation is included. Where contributors have supplied corrections to their evidence, these are noted in the transcript.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Rhun ap Iorwerth Bywgraffiad|Biography	Plaid Cymru The Party of Wales
Dawn Bowden Bywgraffiad|Biography	Llafur Labour
Jayne Bryant Bywgraffiad|Biography	Llafur Labour
Angela Burns Bywgraffiad|Biography	Ceidwadwyr Cymreig Welsh Conservatives
Caroline Jones Bywgraffiad|Biography	UKIP Cymru UKIP Wales
Dai Lloyd Bywgraffiad|Biography	Plaid Cymru (Cadeirydd y Pwyllgor) The Party of Wales (Committee Chair)
Julie Morgan Bywgraffiad|Biography	Llafur Labour

Eraill yn bresennol
Others in attendance

Dr Victor Aziz	Coleg Brenhinol y Seiciatryddion Royal College of Psychiatrists
Stewart Blythe	Cymdeithas Llywodraeth Leol Cymru Welsh Local Government Association
Liz Carroll	Pennaeth Nyrsio, Iechyd Meddwl ac Anableddau Dysgu, Bwrdd Iechyd Prifysgol Hywel Dda Head of Nursing, Mental Health and Learning Disabilities, Hywel Dda University Health Board
Rachel Connor	Prif Weithredwr, Gwasanaethau Gwirfoddol Morgannwg Chief Executive Officer, Glamorgan Voluntary

	Services
Julie Denley	Cyfarwyddwr Dros Dro, Iechyd Meddwl ac Anableddau Dysgu, Bwrdd Iechyd Prifysgol Hywel Dda Interim Director, Mental Health and Learning Disabilities, Hywel Dda University Health Board
Paul Gerrard	Cyfarwyddwr Polisi'r Grŵp, y Co-op Group Policy Director, the Co-op
Chris Hopkins	Cyfarwyddwr Cymru, y Groes Goch Brydeinig Wales Director, British Red Cross
Linda Pritchard	Hwylusydd Iechyd a Gofal Cymdeithasol, Gwasanaethau Gwirfoddol Morgannwg Health and Social Care Facilitator, Glamorgan Voluntary Services
Tanya Strange	Nyrs Ranbarthol, Gofal Sylfaenol a Rhwydweithiau, Bwrdd Iechyd Prifysgol Aneurin Bevan Divisional Nurse, Primary Care & Networks, Aneurin Bevan University Health Board
Dave Street	Llywydd, Cymdeithas y Cyfarwyddwyr Gwasanaethau Cymdeithasol President, Association of Directors of Social Services Cymru
Rhodri Walters	Men's Sheds Cymru
Cheryl Williams	Tîm Iechyd y Cyhoedd Lleol Caerdydd a'r Fro, Bwrdd Iechyd Prifysgol Caerdydd a'r Fro Cardiff and Vale Local Public Health Team, Cardiff and Vale University Health Board
Dave Worrall	Rheolwr Rhaglen, y Groes Goch Brydeinig Programme Manager, British Red Cross

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

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

Dechreuodd y cyfarfod am 09:30.
The meeting began at 09:30.

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

[1] **Dai Lloyd**: Croeso i bawb i gyfarfod diweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yn y Cynulliad. O dan eitem 1, o dan y cyflwyniadau, a allaf i groesawu fy nghyd-Aelodau yma? Rydym ni wedi cal ymddiheuriadau oddi wrth Lynne Neagle ac mae pawb arall yma. A allaf i bellach egluro bod y cyfarfod yn ddwyieithog? Gellir defnyddio'r clustffonau i glywed cyfieithu ar y pryd o'r Gymraeg i'r Saesneg ar sianel 1, neu i glywed cyflwyniadau yn yr iaith wreiddiol yn well ar sianel 2. A allwch chi, fy nghyd-Aelodau, nawr ddiffodd eich ffonau symudol ac unrhyw gyfarpar electronig arall neu eu rhoi ar y dewis tawel, neu fe fyddant yn amharu ar yr offer electronig sydd gerbron. A hefyd, a allaf i hysbysu pobl y dylid dilyn cyfarwyddiadau'r tywyswyr os bydd larwm tân yn canu?

Dai Lloyd: Welcome, everyone, to the latest meeting of the Health, Social Care and Sport Committee here at the National Assembly. Under item 1, the introductions, could I welcome my fellow Members here? We've had apologies from Lynne Neagle and everyone else is here. Could I just explain that the meeting is bilingual and you can use the headsets to hear the translation on channel 1, or to hear the verbatim feed on channel 2? Could my fellow Members please turn off their mobile phones and any other electronic devices, or put them on mute, because they will affect the electronic equipment that we have? Could I also tell people that they should follow the directions of the ushers if there is a fire alarm?

09:31

Ymchwiliad i Unigrwydd ac Unigedd: Sesiwn Dystiolaeth 5—Coleg Brenhinol y Seiciatryddion
Inquiry into Loneliness and Isolation: Evidence Session 5—Royal College of Psychiatrists

[2] **Dai Lloyd**: Felly, rydym ni'n symud ymlaen i eitem 2, a pharhad efo'n hymchwiliad i unigrwydd ac unigedd. Sesiwn dystiolaeth rhif 5 ydy hon heddiw yma, a'r sesiwn gyntaf yma o dan law Coleg Brenhinol y Seiciatryddion. Mae'n bleser gen i groesawu unwaith eto i'n cyfarfodydd Dr Victor Aziz o Goleg Brenhinol y Seiciatryddion. Rydym ni wedi derbyn eich tystiolaeth ysgrifenedig gerbron. Mae amser ychydig bach yn dynn ac awn ni'n syth i mewn i gwestiynau—cwestiynau byr, gan obeithio hefyd am atebion byr. I ddechrau mae Jayne Bryant.

Dai Lloyd: Therefore, we move on now to item 2, and our inquiry into loneliness and isolation. Evidence session 5—that's what we have today—and this first session is with the Royal College of Psychiatrists. It's my pleasure to welcome once again to our meetings Dr Victor Aziz from the Royal College of Psychiatrists. We've received your written evidence. Time is short, therefore we'll go straight into questions—brief questions, hopefully, and hopefully some brief answers as well. To start, we have Jayne Bryant.

[3] **Jayne Bryant**: Thank you, Chair. Good morning, Dr Aziz.

[4] **Dr Aziz**: Morning.

[5] **Jayne Bryant**: In your written evidence you stated that loneliness is more common amongst older people and particularly for the very elderly. Perhaps you could expand a little bit more on that and give us some idea of percentages, perhaps. Do you believe that the proportion of older people affected has changed over the years, or do you think that's—? Are we seeing more older people becoming lonely and socially isolated?

[6] **Dr Aziz**: Thank you for inviting me again. Yes, in the written evidence, we did actually raise that concern. I'll quote from the evidence and I'll quote another figure as well—that, actually, 5 per cent to 16 per cent of the older population is lonely. Again, that's even far higher above 80. And I'll quote a very, very simple statistic from the Office for National Statistics, who actually—the document called 'Insights into Loneliness, Older People and

Well-being, 2015'. You can have a copy.

[7] **Dai Lloyd:** Yes, that would be good. Thank you.

[8] **Dr Aziz:** And, again, they looked at older people, well-being and loneliness and there are lots of figures there, again, raising exactly the same content. It also says that 14.8 per cent of people over 80 reported feeling very bad or bad health because of loneliness as well. So, the demographic has changed: we're living longer, but also we are being faced with complex issues—that there is a culture shift, there is environment, and there are socioeconomic and individual factors. It's a complex issue, but it is on the increase, and I think, as ageing populations are on the increase, we're going to face it more and more. I think my biggest fear as an old-age psychiatrist is centralisation of services, because, on the one hand, yes, it's very important for the economy, for socioeconomic factors and for training and all of these things, but also it leaves more and more of the elderly population more isolated. There is some research about transport—lots of real research around this area that makes it more complex.

[9] **Jayne Bryant:** And do you think we're able to get to the—? Going back to the scale of the problem, do you think we're really getting close to identifying the figure, when, perhaps, a lot of people wouldn't like to identify themselves as socially isolated or lonely? Sometimes people don't think, necessarily, or want to admit to people that they are feeling lonely.

[10] **Dr Aziz:** It's really very true, and I think—. We had a bit of discussion as an old-age faculty, looking at what can be done, and I think, always, prevention is going to be better than diagnosis, but detection is very, very important. I'm not sure how much the committee is aware: there are quite a lot of isolation and loneliness questionnaires, but we have two types of questionnaire that everyone loves. There is one, for example, identifying depression, called PHQ-2, which is very, very simple—anyone can use it. There is also a three-item questionnaire for identifying loneliness and isolation. It's not really widely used. For example, I know, personally, and also I know from research, if I'm lonely, I'm going to try to phone someone for stimulation, and we know this is happening now in terms of health and social care, because we know, very often, people keep ringing the GP, keep coming to the GP. I have, personally, some patients who keep ringing the police, and we have case conferences. There is no stimulation there; they are feeling lonely. So, there is more and more practical evidence. You can identify them very, very easily. Going to A&E can identify them, going to

general hospital, going to a GP or social services can identify them. I think we need to recognise them, and that's really the work. That's the start of the work—to recognise loneliness.

[11] If I'm honest with myself, we are doing more and more work about dementia and identifying dementia, for example, but how often, now, are we talking about isolation in schools, in our education? There are lots of pension talks prior to retirement, but how often do we talk about loneliness and isolation? So, there is a lot that can be done to identify it, between employers, between education, between all sorts of things. We can say, 'Look. It's not just about retiring; it's also, "What are your plans?"' because there is definitely—. Sometimes, as you say, there is a denial, but sometimes it's a lack of knowledge, or, 'Actually, I don't know how my retirement is going to be. If I lose my partner, how is it going to be?' No-one is thinking about that planning for the future, and it's difficult. When I'm 80 or 90—. I have been seeing people 110, 106. So, it's really difficult to think ahead.

[12] **Jayne Bryant:** Thank you.

[13] **Dai Lloyd:** Caroline.

[14] **Caroline Jones:** Diolch, Chair. Good morning, Dr Aziz. The Royal College of Psychiatrists highlights the two-way relationship between poor physical and mental health and loneliness. How do we identify the most vulnerable in society regarding these health issues, and what services do you think can be used to help them?

[15] **Dr Aziz:** I can leave this document. I've got some things for you, to leave.

[16] **Dai Lloyd:** This is all very impressive.

[17] **Caroline Jones:** Excellent. Thank you.

[18] **Dr Aziz:** This was a PowerPoint. I just selected some. It was really a fantastic—. It's available on the internet from Connect2Affect. And actually, what they've done is they've looked at the social connectedness, and also looked at isolation and loneliness and looked at—. There is the three-item loneliness scale I'm talking about. It's really, really, very simple there. 'I feel left out,' 'I feel isolated,' 'I feel that I lack companionship.' So, it's really silly, simple questions that anyone can ask.

[19] The relationship between isolation and loneliness and health is two-way. For example, a very typical example: I am depressed. So, if I am depressed, I'm going to lack motivation; I'm going to lack interest; I'm going to feel tired; I don't feel like even going out; I don't feel like eating; I don't feel like shopping; and then I'm going to be going out less and less. I'm not going to see my friends, so I isolate myself, and the more I isolate myself, the more I feel lonely—I feel left out. If we take the other example of 'I'm feeling lonely and isolated, no-one is going to come and visit me, I'm not really stimulated,' you will see that, very commonly with elderly people, they are actually lying down or sleeping most of the time, because there is nothing to do. Even when you are sitting on the chair, you are dozing off. You are going to see that if I'm not mobilising, I'm going to have arthritic pains—my muscles are going to feel stiff. So, even if I walk a short distance, it's actually going to be more painful, so I prefer to sit.

[20] The typical example of that is that I look after the Cynon area and, again, it's a more deprived area, but at the same time you can see very, very well an elderly person living up the hill. So, actually, I am expecting that person to walk down the hill, which, again, has a risk of falling, to walk down the hill, to take a bus—two buses, as a matter of fact—to come and see me in Mountain Ash hospital. I'm expecting that person to wake up early, which normally they do, to go down, to feel tired, to wait for two buses, sometimes three, to just come for a clinic and do exactly the same journey to go back. This is just for a clinic. Imagine how it is for this person, if they have any arthritic pain or cardiovascular problems or anything, and they need to walk up that hill again: 'I prefer to stay where I am'. It's really a complex issue. We know from all research, again, cardiovascular disease—. Loneliness is associated with health hazards: cardiovascular; hypertension; stress; all sorts of things, and other things will make me more isolated.

[21] On completely the opposite side is what I was talking about earlier, about the impact on health, in that sometimes people are asking, phoning—phoning the police, phoning GPs—because, actually, that's the nearest—. And I know, having spoken to some carers and people, that's the fear. If, for example, I am centralising services, am I going to go there, which will make me more isolated?

[22] **Caroline Jones:** Okay, thank you. I'll go on to my next question now. Thank you very much. The evidence received states that, although 8 to 12 per cent of the general population has depression, although it's not an

inevitable situation for old age, we have the statistical information that this rises to 20 per cent in the elderly. Can you tell me, now that we have this statistical information, how this issue is being looked at and addressed in primary health and support services? My concern is doubled with the elderly people who are suffering or who have dementia.

[23] **Dr Aziz:** I was talking yesterday, I had a meeting with Dr Ruth Hussey about the integrated care work, and that's become the heart of it, in the sense that, do we really have an integrated society and integrated care that look after our elderly population from all aspects? The biggest problem for me is not someone who's moderately or severely depressed, because that's the easiest to identify, and it can be identified by anyone. You can prescribe medication, you can have more access to services if you are really more severely unwell. The biggest problem for me is people who are not identified as feeling depressed. So, again, we have the statistics about the people being diagnosed or people who have been identified, but what about all the bigger population that is not identified? Two: what about those people who have a milder degree? For example, I recently saw someone in the clinic who had been sexually abused as a child, but it had just come back now. So, it can come anytime. You cannot prescribe medication for this. It's not something you are going to follow up in secondary care, but what is there for primary care? At the moment, even with the Measure, with the primary mental health team, it's not really functioning as such, because we haven't got that sort of help to help those people who have a milder degree. Bereavement; how often are we doing any bereavement counselling or supporting those people who have lost someone?

[24] So, for me, the biggest problem is identifying those who are not identified, and also doing something about those milder degrees, that they don't need medication, for example, and they don't need constant support. But at the same time, if we tackle them there and then, we're going to avoid them becoming really severely depressed and then having an impact on health and social care, because we could avoid it.

09:45

[25] Sometimes social care is not there as well, in the sense that, if we are lacking those. Again, another concern of mine is, if you go to social services, and if you need to go to a day centre, you have to pay. What if I am unable to pay? Then I become more isolated.

[26] **Caroline Jones**: Thank you very much. Thank you.

[27] **Dai Lloyd**: Ocê, y cwestiynau nesaf gan Dawn Bowden.

Dai Lloyd: Okay, the next questions are from Dawn Bowden.

[28] **Dawn Bowden**: Thank you, Chair. To an extent, I think you've probably covered some of these points, but I notice in your evidence that you do say that depression is not inevitable in old age. So, how do you think that could then be addressed? By addressing loneliness and isolation, do you think that that in itself can address the condition of depression, or are there other factors that are at play there?

[29] **Dr Aziz**: I think it partially can do that, in the sense that, if we're talking about preventative measures, if we can identify loneliness and isolation as one of the factors, then we can do something about that. Very often, we talk to people about befriending schemes, but not everyone is going to suit a befriending scheme. Lately, last year, I was actually attending a meeting, and someone was sitting next to me, a patient, waiting for the warfarin clinic in the hospital, and he was a chair of the Silver Line. So, again, it's not very much publicised that those services are there. So, rather than, for example, phoning the GP when you need someone, or the NHS, actually, there are lots of third sector things that are not very much publicised. So, what sort of stimulation, what sort of activities, can be done to help those people? One of the examples I was talking about was pension talks. So, what can you do? What can you do as a person? What can you do as a family? Because we are seeing two types of family now. We are seeing families that are very caring and very supportive of that individual, and also we are seeing families who actually want that person to go into a care home.

[30] This weekend, I have an 82-year-old lady being admitted to hospital. Two children went for a holiday for three weeks. So what impression are you giving? She had depression. But what impression, as a family, are you giving to that person? Again, there is a society factor, because, as a society, you are not reinforcing this family and support network. Everyone is away. Everyone is looking, 'Actually, I have a family. I've got this. I've got that.' We are becoming more self-centred, rather than developing a sense of a society or a sense of family.

[31] You know from protective factors, for example, people who are religious, and, again, very often, there is research. I did publish some about it on the difference between religion and religiosity. So, we are also missing

that social factor, that social aspect of religion. We're missing that morning coffee. We're missing that trip. So, you have faith, but also there is that social aspect. We're missing a lot of the stuff that can help us. People who are active, generally, will become less depressed. Socioeconomic factors: the more I am deprived, the more I am poor, the more I am going to be isolated, and hence depression.

[32] People who are fit, who drink less alcohol—because alcohol by itself we're seeing far more. I know we mentioned that it's a huge problem for us now, because we're seeing far more alcohol intake, because people are living longer and are isolated. I have a lady who we are trying hard with the family, not with the patient, who drinks a bottle of wine a day at 13 per cent. So, imagine the impact of that on her if she's not getting that wine. She's having withdrawal symptoms, she's going to have alcohol-related brain damage, she's feeling isolated, depressed, because she cannot go anywhere because of that.

[33] Sometimes, we're talking about simple things, with depression, for example. People who have some health problems, for example, those on diuretics, need to go to the toilet quite often. How often do we have public toilets? People who have stoma bags and, again, need to go. So, there are lots of factors, but it's very easy for it to be diagnosed: 'Do you feel really lonely? Do you feel depressed?' What can be done about it is we can start with simple stuff, by recognising it and directing it to services, but those services need to be available there and then.

[34] **Dawn Bowden**: And widely publicised.

[35] **Dr Aziz**: Yes.

[36] **Dawn Bowden**: So, do you think that social prescribing, because I think that was the kind of model you were talking about, that that would play a significant role in—

[37] **Dr Aziz**: Oh, definitely. Definitely. Social services do not exist. I did say this in the dementia strategy. We don't see social services.

[38] **Dawn Bowden**: So, we're relying more on the third sector now.

[39] **Dr Aziz**: We're relying more on the third sector now, but it needs to be publicised. We need to—. I did say it to the Alzheimer's Society themselves. I

said, unfortunately—. The Alzheimer's Society was fantastic with patients and carers, but now they are moving from patients and carers into more policy and strategy. And it's a shame for us, because, again, that's something—. You have a year waiting list for a befriender with the Alzheimer's Society, when, in the past, you didn't have that. So, those people, Age Connect, Age UK, Age Cymru, they are there, but I think we need to shove them back into patients and carers, rather than rely on them for policies and strategies.[1]

[40] **Dawn Bowden**: So, how does the organisation Talk to Me fit into the type of work that you're talking about there?

[41] **Dr Aziz**: I'm very disappointed with Talk to Me. The first, Talk to Me 1, no-one was aware of it. It did exist, on the shelf, for three years. No-one was aware of it. How often do you see Talk to Me 2 being publicised? You're not. It's not—. How often we advertise it in the health service, I'm not really aware.

[42] **Dawn Bowden**: But is it effective when it's used?

[43] **Dr Aziz**: If you are not aware of it, how are you going to measure effectiveness?

[44] **Dawn Bowden**: Okay, fair point. So, from your point of view, the issues that we're talking about are a significant public health issue and it needs to be addressed in that way.

[45] **Dr Aziz**: It should be. It should be. Because it's a complex issue, it should be—. On one hand, you need a whole-system approach to it, but on the other hand—. I was talking to Dr Hussey yesterday about integrated care. You can have, again, a whole system, but, actually, each valley is different. So, I will keep saying it. It's about that individual and how we can recognise that individual and what we can do to that individual, because that's what will matter. We can prevent suicide. The 82-year-old lady I was telling you about, she actually jumped out of her bedroom window. She had lots of broken—spine, ribs, back and pelvis. We want to prevent that. That's really the aim, is to identify and prevent.

[1] The Royal College of Psychiatrists wishes to note that this is Dr Azis's personal view and not the opinion of the royal college. A letter was noted by the committee on 21 September 2017.

[46] **Dawn Bowden**: Okay, thank you. Thank you, Chair.

[47] **Dai Lloyd**: Rhun nesaf. Mae yna rai o dy gwestiynau di, yn rhannol, wedi'u hateb.

Dai Lloyd: Rhun next. Some of your questions have already partly been answered.

[48] **Rhun ap Iorwerth**: Oes.

Yes.

[49] You've mentioned alcohol. Just quickly, on alcohol, what evidence is there of an increase in loneliness amongst older people turning to increased alcohol consumption? I'm especially looking at your evidence when you say that, because there are no services available in Wales to deal with the specific needs of the age group—you know, there's clearly a problem, it's very worrying. Could you just tell us a little bit more about that?

[50] **Dr Aziz**: We have given evidence, written evidence, to the alcohol policy for Wales, and we did actually say all the alcohol and substance misuse teams are directed towards adults. There are no services whatsoever, there is no specialism, in terms of old age. And, again, old age is more complex, because you are dealing not only with cognitive impairment, but alcohol will—. We are seeing far more, I know myself, in my clinics. If you want a person to talk to you about alcohol and alcohol-related brain damage in the elderly, it will Dr Robin Corkill, the consultant neurologist. He's doing research at the moment and he's collected between 200 and 400 cases of alcohol-related brain damage.

[51] **Rhun ap Iorwerth**: Is he looking at the link with isolation and loneliness?

[52] **Dr Aziz**: No. No, but it just tells you, if we are seeing more and more of alcohol-related brain damage and more and more—. I, personally, over the last two years, have been having in my clinic more people with alcohol-related problems and more people where the police themselves are complaining to us about people drinking, being disruptive, and then rather than charging them and taking them to prison—. I have two patients who've unfortunately been to prison, because we stop them but they go and drink and create problems in the local society. So, we are seeing—. There is no database, and this is one of the biggest problems. We were talking about—because you have no services, you have no database.

[53] **Rhun ap Iorwerth**: But, anecdotally, you're quite convinced that there

is a link.

[54] **Dr Aziz:** Yes, because of the amount of patients we are seeing and the amount of referrals we're having. Also, you have two categories of alcohol-related problems. You have the ones who drink who are now becoming older—that has the added cognitive impairment plus the physical health component to it. Also, we have the new ones, because, again, in relation to loneliness and isolation, you resort to alcohol.

[55] **Rhun ap Iorwerth:** That's really useful, and I think the pursuit of better data might be something that we'd be interested in. The other thing I wanted to ask you about was loneliness mapping. You highlight, as do all our witnesses, it seems, the difficulty in perhaps pinpointing those who are greatest at risk. What are your thoughts on loneliness mapping as a tool to help us in that respect?

[56] **Dr Aziz:** One of the disappointments in Wales—. We are not really a huge population. So, if we're talking about 3 million or 4 million as a population, why on earth haven't we got a database from birth to death, like the Scandinavian countries? Our NHS IT systems are still not communicating with each other. If you had that database, it would be very easy to identify all sorts of things. You could do all sorts of research, just based on the database. We haven't got that.

[57] A quick example is, for example, do you identify loneliness and isolation as an item when anyone comes to a GP surgery or is admitted to hospital? So, actually, you are saying, 'For this person, if they are to go home, we need to provide these services, if available.' But we haven't identified that this person is going to be lonely.

[58] **Rhun ap Iorwerth:** And all the information is there, really.

[59] **Dr Aziz:** All the information is there, but we haven't got that system. It shouldn't be—. With the cyber-attack, I beg you to go to any health board and try to access the internet. You cannot. It's really become—. Even the Wi-Fi has been more or less blocked. So, if we are doing this, how are we going to create that system? So, I think that we need to think about communication in a better way.

[60] **Rhun ap Iorwerth:** Thank you. Diolch.

[61] **Dai Lloyd:** Ocê. Julie, y cwestiynau nesaf.

Dai Lloyd: Okay. Julie, next questions.

[62] **Julie Morgan:** Thank you very much, Chair. I think you say in your evidence that inter-generational contact is more effective than being with people of your own age. Do you think you could say a bit more about that?

[63] **Dr Aziz:** If I give you a different example, which will give exactly the same meaning, we know music therapy is effective, but which music therapy? It's not about listening to the radio. It's not about listening to music. It's actually being interactive. It's about having live music. That's actually more meaningful and more interactive, socially. The best exercise—I always advise any elderly persons to go dancing, because it's exercise, it's social, it's music, it has all the components.

[64] So, in a way—. Coming back to the cultural shift we were talking about—the loss of family, the loss of respect, the loss of religion, the loss of real connectivity. Inter-generational is two—as an elderly person, you'll have your children, you'll have your grandchildren, you'll have all those people. But, at the same time, we are teaching them to continue contact. So, go and see that elder, they are fun, they are actually full of experience, so you will learn from them. You keep connected, not necessarily as a family—but how often do you see any project from schools saying, 'Actually, we are going to go to a care home'?

[65] **Julie Morgan:** I think that does happen, certainly in my constituency.

[66] **Dr Aziz:** Yes, but how often?

[67] **Julie Morgan:** That does happen.

[68] **Dr Aziz:** Yes, but this is why I'm saying, 'How often do you see that?' So, we are having some isolated examples, rather than—. In a way, we can do this as a normal serving-the-community programme. So, every school should really think about belonging to their community and keeping in touch. There are people at home who have no-one, so why don't we just—? Again, how often do you have a street party? How often do we connect as neighbours? We don't.

[69] So, they are isolated, but, if we really think about how we can use community resources, it will not cost us any money. It's not about money.

It's about using whatever resources we have. Very often, I have patients whose relatives are all over the country and there is no-one there: 'My daughter is in this place, my son is in that place, so I have no connections.' So, using that community sense—I want to go back to that community sense. That will prevent lots of problems.

10:00

[70] **Julie Morgan:** So, have you got any specific examples of projects that have been set up to do this?

[71] **Dr Aziz:** I haven't got any specific examples, but those are the things that, actually, we are talking more and more with the voluntary sector about. Over the past two years, we've been talking more and more to the older people's commissioner, we've been talking to different organisations, to really try to have a meaningful solution that is not about money. It's about really giving that community sense back to the people. This is why I'm saying some of those bigger organisations now are more involved in policy rather than helping people get back into their community.

[72] **Julie Morgan:** Right. My last question is: what about digital technology for older people—do you think that there's an opportunity there?

[73] **Dr Aziz:** There is an opportunity, but also there are some practical issues. Not everyone is IT-clever and not everyone likes to use IT. Also, it costs money—in terms of buying the equipment, in terms of internet connection. So, if I'm a person living on my own and only having a bit of benefit or pension, I may struggle to buy that internet.

[74] But, one solution, if we can do it, is again to create a network. Because, very often—. If I talk about myself, someone very active, how often do I go on the internet just to surf the internet? I will go on the internet to respond to my e-mails, for example. I'm going to do something specific. So, maybe one of the things we can do is—again, coming back to that sense of community—create a group. If I know there is a group of people I'm aware of, and I can continue chatting to them, that might become a more defined way of still being connected.

[75] The other thing is the availability of training. For example, computer courses or IT courses—how often are they available locally, rather than, again, being centralised somewhere? We are losing that local library that

could teach some of those people—like the mobile library, we're losing them. So, it's a way, but it just needs to serve that local community more. It needs to be focused on that local community.

[76] **Dai Lloyd**: Ocê, a'r cwestiynau olaf o dan law Angela Burns.

Dai Lloyd: Okay, and the final set of questions with Angela Burns.

[77] **Angela Burns**: Thank you. I just wondered if you could explain to us a little bit about the transactional analysis that goes on in relationship making, because one of the concerns I have about all the things we're hearing in this inquiry is that there's a huge number of people with really big hearts who want to try and solve this problem—we all do—but we all know how difficult people can be.

[78] We're spiky, we like the people we like, and we don't like the people we don't like. We have lived our lives, very often, in quite narrow parameters, and we get towards the end of our lives, perhaps, and we find ourselves without family, without friends, or in an environment where we are quite isolated.

[79] You can't just say to somebody, 'Hey, listen, chummy, I know you're on your own and you're a bit sad, so why don't you nip down to this club and join them?', because that person may not actually have that—. What are we expecting them to feel? Gratitude that they're suddenly being pulled back into society? Joy that they've suddenly got a friend? Because, actually, that person might be incredibly shy, or just not used to mixing with the kind of people who are in that club, or have a bundle of other issues.

[80] So, I just wonder if, in order to provide services, we actually have to take a little step back and have a look at what makes that transaction between one human being and another human being work. I wondered, as a psychiatrist, if you might be able to shed a light on that.

[81] **Dr Aziz**: That's the most difficult question. If you take away the individual, you've lost everything. You are absolutely right, each individual—and this is why, when I was talking about IT and these things—. Befriending doesn't suit everyone. So, I think what we tend to do, in terms of local services, is to try—. I have a patient who was—. I'm sorry, I keep trying to give examples because I think that's the best way to—.

[82] **Angela Burns**: It's great. It's really helpful.

[83] **Dr Aziz:** So, this gentleman is very, very eccentric—really, really eccentric—and suddenly came to our attention with severe dementia. He was never married, doesn't have children, really didn't have much contact with his family—the only family a brother who'd died, and a sister living in west Wales, so not much contact. How would you know about that individual?

[84] So, no-one really knows much about that individual, and he suddenly comes to you with severe dementia, so you cannot even rely on much of what he's saying. The difficulty is to take time to understand who that individual is. Because, very often, you are very quick in jumping to conclusions: 'This is a behavioural problem,' 'This is a dementia,' but actually it might be that he's an eccentric person. And we know about him, now, that he's an eccentric person, and, if I'm an eccentric person, I'm not going to live in a normal, orthodox way; I'm going to use my way. And sometimes that's the luxury we don't have, to try to identify that individual.

[85] I have a patient who's in a secure unit now, just because no care home can look after him. Again, he's severely demented, but this gentleman used to walk 10 miles a day, and he has some learning difficulties. So, in a small ward, with nothing much there, he's up and down, up and down. So, he's agitated, and we need to give him medication. Why on earth do we need to give him medication? He walked 10 miles every single day. So, it's far better to just take him out of the hospital, go for a walk, come back, and he's a lot calmer. But it took a while to understand and to know this about that gentleman, because, again, he's another loner.

[86] So, your point is very well made, and this is why, when I was talking about that individual, that community—. And also it's about respect of that individual. I like the word 'partnership', but how often do we involve them in decision making? How often do we respect their wishes? And very often we step back and then go slowly. But we have the luxury—as a specialist service, we can do that, but, very often, primary care services don't have this. If you don't engage, they will just discharge you, and the problem remains. So, I think—. Sorry. If we keep coming back to the community sense, how many people in that local community—how many neighbours—know that individual? And maybe they can guide us about what will be the best solution for that individual.

[87] There was an announcement yesterday about the Dudley model. So, it's talking about integrated care, and, in the midlands, social services now

are going to be part of primary care. So, they're moving social services from the local authority to primary care. Could that be a solution for those small communities? Rather than, 'You are a separate component', 'Actually, no, you are primary care—why can't you just go and assess those people?' For me, I've been complaining about social services so many times, because I have people who contact social services and they say, 'Have you got a diagnosis?' and will only assess you if you have got a diagnosis. That's even illegal. That's even against the law. You have a needs assessment: how often do you go and assess the needs of that individual, rather than, on the phone, 'no'. So, there are opportunities, but we are missing them because I think our mind is very much directed to targets rather than individuals.

[88] **Angela Burns**: I thank you, and I really thank you for your evidence. I thought that, for example, your analogy of the person who had to walk down the hill, take two buses to come and see you, and then the reverse—and, if you're not feeling up to it, or you're elderly or whatever, and you're on your own, it just is too difficult.

[89] **Dr Aziz**: It is.

[90] **Angela Burns**: So, there's those kinds of people. There's also the kind of people who've never been joiners, you know. There are a lot of people who meet one person in their life—that's it—and then, when that one person goes, they're suddenly on their own. There's a lot of people—. And, in my job, I have met lots of amazing, very sparky elderly people who are incredibly lonely, but they're not joiners. So, I worry slightly, because a lot of the talk that we get from the other agencies, and a lot of the evidence we read, it's all about forming group activities and making people come to them.

[91] **Dr Aziz**: It works for some, but not for the majority.

[92] **Angela Burns**: And you talk about the man with dementia and so on, but, again, they are, I would suggest to you, exceptions. I think there's an awful lot more people sitting in the middle who are quite lonely, quite isolated, they haven't really got anything hugely wrong with them, so they don't float up to anybody's attention. They don't want to join into local—

[93] **Dr Aziz**: But they don't fit any services, and therefore no-one will accept them. The analogy I gave to Dr Hussey yesterday—. I said, talking about integrated services, in Wales we have a fantastic opportunity, however we're not using it. I gave the frame of a picture. So, we have health boards

now that have secondary care, mental health, and primary care. But it's an empty frame. It's an empty frame because it has no content, because, still, everyone is separate and everyone is protecting. The opportunity is there, so, if you add social services to it, you have four components. If you have voluntary agencies, that's a fifth component. But still everyone's going to be separate. We just need those people to care. I like the term 'emotional intelligence', because that's what is really lacking in caring for older people. We really need to be emotionally intelligent about their emotional and social and psychological needs, rather than, 'We have to provide a service'. I think we need to shift our own thinking and a whole culture shift, going back to that sense of community. That would be the solution, with no money. It's just a sense of belonging. If I belong to someone and I know someone is going to check on me, I'm not going to be lonely, I'm not going to be isolated.

[94] **Angela Burns:** I can hear the Chair clearing his throat, but I actually do have probably one and a half minutes to just do one more quick question, because it picks up on something that Julie raised with you about the inter-generational issue. I just wanted a quick viewpoint. People think inter-generational means getting really old people together with really young people and, yee-hah, suddenly they're all honorary grandparents.

[95] **Dr Aziz:** There are all sorts of people.

[96] **Angela Burns:** No, and is there any research about the fact that, actually, inter-generational is literally just the decade below you or the two decades below?

[97] **Dr Aziz:** Yes. Yes, it's not clear, because I don't think anyone is doing much—. Age UK, actually—sorry, I was looking and I like to underline, but you still have a copy of all of these. Age UK has done some work into that, but, again, research is really missing into those areas. So, for example, personally, when I'm talking about inter-generational, I'm not talking about just children and grandparents; I'm talking about all our generations. This is why, when I give that example about this elderly lady coming in and the children going away for three weeks, what message—. I'm the child, so what message am I giving to services? What message am I giving? That lady who drinks a bottle of wine a day, one of the daughters who has been fighting for her is in England, but she doesn't see a bottle of wine a day as a health hazard. She thinks about it as a protective factor. So, how on earth is this going to be a protective factor for someone living on their own? They haven't got, really, much close family around. And we are giving—count it—30

bottles a month, and we can count them, because every time we go—we go twice a week—every time we can see a bottle missing. So, if she missed one bottle she's going to go into withdrawal symptoms, and then you have infections, you have all sorts of things. She likes to eat a burger a day as well, so how healthy or unhealthy is that? But this is about the transactional, understanding that individual.

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

[99] **Dai Lloyd**: Diolch yn fawr. Sesiwn bendigedig, mae'n rhaid imi ddweud. A allaf i eich llongyfarch chi ar eich cwestiynau a hefyd ar y dystiolaeth gerbron? Diolch yn fawr iawn i chi am eich cyfraniad, a gallem ni gyhoeddi y byddwch chi'n derbyn trawsgrifiad o'r drafodaeth yma er mwyn gwirio ei fod yn ffeithiol gywir. Ond, gyda hynny, gwnawn ni ddiolch, down ni â'r sesiwn yma i ben, a chawn ni egwyl am bum munud.

Dai Lloyd: Thank you very much. An excellent session, I have to say. I congratulate you on your questions and on the evidence that you've given. Thank you very much for your contribution, and we will say that you will receive a transcript of this discussion to ensure factual accuracy. But, with that, we'll thank you, and we'll bring the session to a close and we'll have a brief five-minute break.

Gohiriwyd y cyfarfod rhwng 10:14 a 10:20.
The meeting adjourned between 10:14 and 10:20.

Ymchwiliad i Unigrwydd ac Unigedd: Sesiwn Dystiolaeth 6—Conffederasiwn GIG Cymru
Inquiry into Loneliness and Isolation: Evidence Session 6—Welsh NHS Confederation

[100] **Dai Lloyd**: Croeso nôl i gyfarfod y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yng Nghynulliad Cenedlaethol Cymru. Symudwn ymlaen i eitem 3, a pharhau efo'n ymchwiliad i unigrwydd ac unigedd. O'n blaenau rŵan mae sesiwn dystiolaeth Rhif 6, ac mae tystion o Gonffederasiwn Gwasanaeth Iechyd Gwladol Cymru

Dai Lloyd: Welcome back to the meeting of the Health, Social Care and Sport Committee here at the National Assembly for Wales. Moving on to item 3, we continue with our inquiry into loneliness and isolation. Before us we have evidence session 6, and we have witnesses from the Welsh NHS Confederation. I'd then like to welcome, in turn, Julie Denley,

o'n blaenau. Gallaf felly groesawu, yn eu tro, Julie Denley, cyfarwyddwr dros dro iechyd meddwl ac anableddau dysgu, Bwrdd Iechyd Lleol Hywel Dda, Liz Carroll, pennaeth nyrsio iechyd meddwl ac anableddau dysgu, Bwrdd Iechyd Lleol Hywel Dda hefyd, Cheryl Williams, tîm iechyd y cyhoedd lleol Caerdydd a'r Fro, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro, a hefyd Tanya Strange, nyrs ranbarthol gofal sylfaenol a rhwydweithiau, Bwrdd Iechyd Lleol Aneurin Bevan. Croeso i chi i gyd. Yn ôl ein harfer, rydym ni wedi edrych ar y dystiolaeth ysgrifenedig, ac mae yna gwestiynau yn deillio wedyn. Awn yn syth fewn i'r cwestiynau hynny, ac mae'r cwestiwn cyntaf gan Jayne Bryant.

interim director, mental health and learning disabilities, Hywel Dda Local Health Board, Liz Carroll, head of nursing, mental health and learning disabilities, Hywel Dda Local Health Board as well, Cheryl Williams, Cardiff and Vale local public health team, Cardiff and Vale University Local Health Board, and Tanya Strange, divisional nurse, primary care and networks, Aneurin Bevan Local Health Board. Welcome to you all. As usual, we have looked at the written evidence, and then there are questions arising from that. We'll go straight into those questions, and the first one from Jayne Bryant.

[101] **Jayne Bryant:** Thank you, Chair. Good morning. Just looking at, starting off, the inclusion of social isolation and loneliness as a key priority for population assessments in health boards, it's only happening in some health boards. Perhaps you could talk a little bit about that. And do you think that it will help the problem?

[102] **Ms Williams:** In Cardiff and Vale, it was a question within our population needs assessment whether people felt lonely often or always, and 15 per cent of the respondents said that they did feel lonely often or always within Cardiff and Vale. So, we did include that within our needs assessment, and a recommendation, obviously, that that's going to be addressed. That was for the whole population, so it could have been a number of different ages. But when we also asked people and they belonged to a particularly vulnerable group—so, people with disabilities, or carers, or older people, or asylum seekers—if they fitted into one of those groups, that rose to 23.3 per cent that said they were lonely often or always.

[103] **Jayne Bryant:** I know that Tanya's been doing some work with Ffrind i Mi on inter-generational loneliness as well, so it's happened with younger people, in particular. But do you think that mapping loneliness and social

isolation would be a help?

[104] **Ms Strange:** It certainly would in our area. As you know, Jayne, we had an engagement event and we brought people together who were affected by loneliness, but also service providers. We spoke to a number of people and, certainly, loneliness and isolation were being identified by migrant workers, asylum seekers, children, college students, in particular, looked-after children where they had been separated from families, the lesbian, gay, bisexual and transsexual community, and I think it's probably fair to say that, locally, we haven't done enough of that mapping, but we have enough information now to certainly direct that work.

[105] I think the other issue that we've been trying to do, and we're still mapping, is the availability of support, and actually our community assets, because it isn't always about providing a service is what we've found. If we actually look at what matters to people, it could be something as simple as reading a bible to somebody, it could be something as simple as gardening—that's what is important to people. So, there is an awful lot more to do, and we know that, just from the work we've done over the last 12 months.

[106] **Dai Lloyd:** Ocê. Symud ymlaen, mae yna nifer fawr o gwestiynau, ac bydd yna ddigon o gyfle i chi ateb bob un ohonyn nhw. Caroline Jones nesaf.

Dai Lloyd: Okay. Moving on now, there are a great number of questions, and there'll be an opportunity for you to answer them. Caroline Jones next.

[107] **Caroline Jones:** Diolch, Chair. Regarding loneliness and isolation, it's important to raise awareness among health practitioners about the health and well-being of older people. How can we help raise this awareness?

[108] **Ms Denley:** I'm happy to pick that up to start with. I think it is important in older people, but it's very important in all groups. We're starting to do some work with other generation groups now and having a look at that, but I think it's something that we've got to get out there as a public conversation, because no-one wants to admit to being lonely. When you start to ask questions and survey and audit, people will be really embarrassed about saying they're lonely. So, it's about getting this out there and starting to get some dialogue about how we engage, how we keep engaged, and getting loneliness as a topic that people can talk about comfortably. Because if I look around elderly relatives, none of them would dare admit they're lonely—and they spend a large proportion of the time on their own. They

might not be lonely, but there's a fair chance they feel isolated and lonely a lot of that time. But, generationally, older people will find that harder to talk about, I think, than maybe some of the generations coming behind.

[109] **Ms Caroll:** Another thing to add to that in terms of rural communities is that oftentimes you can have very young people in farming communities who can be incredibly isolated and lonely. So, I think it's quite complex in terms of determining loneliness and pockets of loneliness in our localities.

[110] **Caroline Jones:** Okay. Thank you.

[111] **Ms Strange:** Could I add to that, please? I do agree that there is a stigma around loneliness, but, certainly, we spoke to a lot of older people during our setting up of Ffrind i Mi, and they weren't afraid to say it. And, certainly, what we're finding is, where you wouldn't expect people to be lonely—older people in care homes, for example—we've been astounded actually by the number of people who say that they are socially isolated. And I think that the societal stigma around how we label older people as burdens—that can actually impact on their willingness to tell you.

[112] **Caroline Jones:** It's having the confidence in admitting that they are lonely, isn't it? My next question is: how can GPs help identify lonely older people in a systematic but sensitive way, and can the third sector well-being co-ordinators, funded by GP clusters, help in making this work?

[113] **Ms Williams:** In Cardiff, we've got a project with well-being co-ordinators doing exactly that. So, they sit within GP practices, and their remit isn't specifically around addressing loneliness and isolation, but, inevitably, they will see a lot of people who are lonely and isolated. And we've seen, because the people who are being referred to them are identified by GPs as perhaps needing a little bit more of the social support, because they see a lot of people who aren't necessarily there because—. Obviously, they've got a medical condition, but there's other things that are under the surface as well. So, the co-ordinators will spend time with them and find out what's important to them and signpost them in the right direction if they need a community activity or a housing repair or whatever it is that they might need. So, it really does address their practical needs, but also, we're hearing from those co-ordinators that people are feeding back to them, 'It's great, I'm now in touch with this group, and I've met these friends'. They're actually expanding their social circle, as well, by getting involved in activities.

[114] So, for GPs to identify somebody, it's quite difficult, because I think, as you said, people don't always say, 'Oh, I'm lonely' but there might be something that the GP picks up on and says, 'Perhaps you'd like to see the co-ordinator to see what they can do for you really in terms of your well-being, your day-to-day living.'

[115] **Caroline Jones**: And regarding the activities and community-based centres, do you find that public transport is an issue in getting from A to B? Is that one of the things highlighted?

[116] **Ms Denley**: It is an issue. But I went to a recent GP clusters meeting in south Ceredigion, and the community co-ordinator was there, and the GPs were absolutely blown away. I was shocked how helpful they found the information, because I think we always think that GPs have all the information in their communities to hand. But what the community co-ordinator had done very cleverly was put a diagnostic label at the top, such as, 'Have you got a respiratory disease? These are things that can help.' When I took them away and had a look at them when I had some time, 80 per cent of what was on every sheet was the same, because, actually, it's about normal community activity. But it started to stretch GPs' thinking outside the traditional routes of referral, which is typically within the NHS or within social care, and they started to realise. And one of the other sheets that she attached to all of the condition ones was the transport opportunities as well, and they were, quite surprisingly, large. But again, it's hidden. So, I think the community co-ordinator has a critical role in promoting what's out there in the community as an asset, because there is quite a lot there when you start to look, but it's often not connected and not well known about, and, unfortunately, it often shifts a little bit in terms of demand and funding, because of the structure of the third sector and the community sector.

[117] **Ms Carroll**: And the challenge around that, I guess, is about having equity across a locality or across health boards, because you could have really good practice in one area and it's about how that gets replicated so that everybody's got that equal opportunity for access.

10:30

[118] **Ms Denley**: I think one of the other things about access is that GP systems usually have more data than some of our systems in the wider NHS. They're pretty good at knowing their population and will be able to tell at the touch of a button how often someone's attended, and we know there's a link

there. It's hard to say that there's a causal link around loneliness and attendance and use of services, but if you start looking at those data and say, 'Well, actually our interventions were very minimal each time they attended and they attended a lot'—there's probably something in that that's helpful. But the other thing that's helpful is a presence in GP surgeries. If the community co-ordinators, a couple of times a month, are in there with a stand, it becomes a normal part of seeking support, advice and information about what's out there, rather than a referral route for those who struggle more.

[119] **Ms Williams:** Just one thing to cover the GP appointments: one of the co-ordinator case studies that they've shared with us was a gentleman who had attended the GP practice 47 times over six months. When the co-ordinator then intervened and signposted him to all sorts of different things, that reduced dramatically and the appointments did drop a lot. So, it does have an impact.

[120] **Caroline Jones:** Thank you very much.

[121] **Dai Lloyd:** Diolch yn fawr, Caroline. Mae'r cwestiynau nesaf o dan law Dawn Bowden.

Dai Lloyd: Thank you, Caroline. The next questions are from Dawn Bowden.

[122] **Dawn Bowden:** I think you may have answered the question I was going to ask, because I was going to refer to the older people's commissioner report and research that showed that people who are lonely and isolated in particular have difficulty accessing local healthcare services. But the kind of answers that you've just been giving to the last question perhaps cover some of that in terms of the local co-ordinators. But are there any other issues that you are aware of and that you've identified as being barriers to people accessing local healthcare services?

[123] **Ms Strange:** I think the services are there, but perhaps we don't collectively know exactly what those services are. But certainly, just picking up the question about the GPs, some of the GPs have said to us, for example, that they don't have time to counsel people and there is a risk of over-medicating people. What they've said locally to us is that there needs to be a single point of referral, if you like, for people who may be lonely and isolated. We've established that through a website, as one example. But it's actually about finding out what matters to people and whether that individual actually needs a service—and this is what we tend to get a little bit hung up

on—or whether it is something that our own community assets can do to support these people.

[124] **Dawn Bowden**: This is the kind of social support that Cheryl was talking about earlier on.

[125] **Ms Strange**: Absolutely.

[126] **Dawn Bowden**: And are all of you involved in or aware of examples of social prescribing and whether it works? Are you getting any kind of feedback on that?

[127] **Ms Denley**: It's something that's very well established in mental health and has been used for many years. It started with some of the book prescribing and some of the national initiatives followed on from that very closely. There are some really good initiatives around tokens and time credits that you earn as well. A lot of people are involved in, for example—they do an activity and that activity is considered helpful to the community or individuals—

[128] **Dawn Bowden**: So you've been operating this for quite a while.

[129] **Ms Denley**: Yes, there are pockets of it. I think consistency and equity are the challenges around some of that. There's some really strong work around the Swansea and Llanelli areas around time credits and social prescribing, but it's certainly on primary care's radar a lot more in the last year and you see that it's started to come up in conversation and GPs are starting to realise that it's another route as opposed to traditional prescription.

[130] **Dawn Bowden**: Rather than prescribing the antidepressants.

[131] **Ms Denley**: Yes.

[132] **Dawn Bowden**: We've received some evidence previously from people saying that this is happening, but there hasn't really been any proper assessment of the effectiveness yet. In some areas presumably it's quite new, but you've got good examples of where it has worked.

[133] **Ms Denley**: Yes, I think it's well established—some of the mental health pathways into that—but there is the usual lack of evidence and

research about effectiveness, and that's something that we need to nail down in terms of evaluating the impact. But I think there's also a public conversation about that as well, because traditionally people still expect to go to healthcare and receive a health intervention, so I think the more we engage the public in that conversation about the different things that can help, and not just traditional things, the more likely that—

[134] **Dawn Bowden**: Is this primarily around people being lonely, or is this also helping with the diagnosis and treatment of depression as well? Because one kind of follows the other.

[135] **Ms Denley**: Yes, absolutely. Most of this is about activity and engagement—all of those things that affect self-esteem and well-being. There's lots of evidence and research around all of that. Some of those things are as effective, when you look at trials, as some traditional treatments, depending on people's reason for why they might be depressed or feeling anxious. So, it's a very, very big part of community mental health services now, and the wider community.

[136] **Dawn Bowden**: And in terms of that as well, the evidence that we've received is that this group of people tend to—well, they don't tend to, but they have a tendency to turn to alcohol as well, as a way of dealing with it. Is that something that you think the primary mental health care services are geared up to recognise and to deal with at the moment?

[137] **Ms Denley**: 'Not consistently well' would be my honest answer, I think, because it's very hidden still in some populations. I was recently talking to one of our universities, and they've been doing a piece of work with students about depression and anxiety, and 50 per cent of the students denied their alcohol impact having any relation to why they'd gone to the well-being service in the university, and we all know that alcohol can be a depressant. It can affect your sleep patterns. You know, it's great at the time, but it has consequences over a period of time. So, I think there is still, even generationally, a gap to close around alcohol and its impact on people's health and well-being. Even if it's not problematic drinking, it has an impact the next day. You know, reasonable, social night drinking leaves most of us feeling slightly less pleasant the next morning. So, you know, if you're drinking on a regular basis at high levels, that impact is only going to be intensified.

[138] **Ms Williams**: I think that the alcohol is—. In terms of our older

population, if you look at the statistics around consumption levels, it has certainly either stayed the same or has risen for age groups—from age 45 upwards, actually. So, age 65 upwards, it has either risen or stayed the same. So, there's definitely an issue around alcohol, and I'm sure that loneliness is one of the factors that will contribute to that. But I think that, in order to address it, there are lots of ways to do that, and these signposting activities—doing something else, engaging with others, having peer support—rather than directly addressing the alcohol problem itself, might have an impact.

[139] **Dai Lloyd**: Okay?

[140] **Dawn Bowden**: That's fine. Thank you.

[141] **Dai Lloyd**: Grêt. Symudwn ymlaen at Rhun nesaf.

Dai Lloyd: Okay, let's move on with Rhun.

[142] **Rhun ap Iorwerth**: Bore da i chi i gyd. Mae yna nifer o fentrau, wrth gwrs, wedi cael eu sefydlu ar hyd a lled Cymru i geisio mynd i'r afael ag unigrwydd. Un o'r rheini ydy, yn Aneurin Bevan, y rhaglen Ffrind i Mi. Beth ydy'r elfennau pwysicaf, ydych chi'n meddwl, o'r fenter honno, sydd wedi ei gwneud hi, yn eich golwg chi, yn fenter lwyddiannus?

Rhun ap Iorwerth: Good morning to you all. There are a number of initiatives, of course, that have been established across Wales to try to tackle loneliness. One of them, in Aneurin Bevan, is the Friend of Mine programme. What do you think are the most important elements of that initiative that have made it a successful one, in your opinion?

[143] **Ms Strange**: If I can just give you some very brief background, because it covers what some people have said now. This initiative started for us about two years ago, where we were talking to a number of GPs at a Royal College of General Practitioners' conference, and they'd identified a number of older people in particular who had numerous admissions—sorry, not admission; that's the wrong word. They'd attended the practice. Six of those had attended the practice over 100 times in that year. And when the GPs looked into that, they found that loneliness and isolation was at the root. And, almost in the same week, we met with a representative of the Soldiers, Sailors, Airmen and Families Association, who also told us about the lack of support for veterans. This is how it started. But, talking to the GPs, we came up with the idea of a prescription for loneliness—just what everybody's talking about today. I think the success of this service—and that's where it

started—the success has been the number of partners who have come on board to develop this social movement.

[144] **Rhun ap Iorwerth:** Was it difficult to get all the partners to buy in, or did it happen fairly naturally?

[145] **Ms Strange:** No, not at all. It wasn't difficult at all. When we started, we invited people to an engagement event, and I think it was what we called it that attracted people. So, we had 'prescription for loneliness' as the overarching banner, and then 'time to talk' and 'compassionate communities'. We had no problem engaging partners at all in that. The only concern that was raised was: 'Are you trying to develop something that's already there?' But, actually, we weren't. We do employ volunteers who are Ffrind i Mi volunteers, but they plug the gap of any sort of existing services. This was more about, and is still about, harnessing the rich community assets that we have out there and everybody giving something. So, for example, we had a 92-year-old lady referred to us for befriending. She is now a volunteer, because her stance was, 'I want to help the old people'—you know, she's 92. But being at home on her own, she found, was starting to make her feel depressed. Now, she's gone through training, she's volunteering, and she's helping the old people. We've actually brought on board—somebody mentioned inter-generational befriending—. We've had schools that are more active going into nursing homes. Nursing homes are doing a lot themselves to try and harness, really, social inclusion and community inclusion, so they're bringing other people in. We're working with the police and the police cadets, training them to have the skills to have conversations at a British Sign Language conversational level, so they can support younger people and older people with hearing problems out there. I think because we tackled this as social mobilisation rather than a development of another service, all the partners—we're really, really proud of the way the partners have taken this forward.

[146] **Rhun ap Iorwerth:** You used the word 'proud' there. I was going to say there's a clear pride in what you think you have achieved. Are you able to actually measure what you've achieved, or is it just the feeling that this is a useful addition to—?

[147] **Ms Strange:** Well, it's very early—we only launched it at the end of January. What we are using now is the Campaign to End Loneliness's quality of life indicators. I haven't brought them, but I can certainly forward them on. There are three fundamental questions that ask people about their

satisfaction with their life, really, and then you measure the intervention, whatever that may be, sort of half way through that intervention, and at the end. Currently, it's very early days, but I think it's bringing people on board that, traditionally, probably, would have had services—you know, public sector services, almost.

[148] If I look at Ada, on her own, or I look at a gentleman in his 40s we've just recruited as a volunteer, who's had a stroke—what was important to him was being able to give something back, not having services brought in. So, although it's early days, I think the impact is already demonstrated by the number of people who have joined this movement, but we do obviously need to assess the impact of that.

[149] **Rhun ap Iorwerth**: And if I can open it up to other witnesses—you wanted to come in there.

[150] **Ms Carroll**: Yes. I think the concept of befriending within mental health services isn't a new one. It's something we've done in partnership with third sector for quite some years, really, but I guess the initiative or the foundation for that wasn't so much about loneliness and isolation but more about engaging people in communities and helping them with social anxieties and those kinds of concepts. But I would imagine it certainly does have a role to play in terms of loneliness and isolation.

[151] **Rhun ap Iorwerth**: And on the issue of evaluation, again—how well these things work—the NHS Confederation, in their written evidence, suggests having a national measurement tool in order to achieve this—to have key performance indicators, or whatever it might be. Do you have thoughts on how that might work or how useful or how important it might be to have this way of assessing, in an equitable way, the kinds of initiatives that we have, which may be different in many ways, which may be similar in many ways, but aim for the same end?

[152] **Ms Denley**: I think that we're going to have to move to some measurement of this at some level, but it's probably multifaceted and multilayered. If I was involved in this and experiencing loneliness, I'd want to understand what my level of loneliness perception felt like at the start of something and at the end of something. That's a very simple measure. On the scale of nought to 10, you can do something very easily around that to see some shift. But then we'd probably need some regular societal questionnaires, once a year, to see how we're making a societal shift in

understanding loneliness as well. So, there's probably a number of layers to that. Given our ability to manage data, something quite simple and straightforward, that's very web based, will make that very easy and make those data useful, to see if there's any shift in what's going on in one area that might mean there's a bigger shift in another area.

[153] **Rhun ap Iorwerth:** Would that be a useful recommendation from this committee, if it's a theme—that we have a way of using a yardstick that's the same for all these initiatives?

[154] **Ms Strange:** There are lots of loneliness measures out there. Certainly, when we were looking to set this up, we just didn't know which one to use. We were forced, but rightly forced, I think, to say, 'Okay, what matters to our community?' So, we had three rudimentary questions: how are people affected by it; how do people currently cope; and what do they need to do? But if you're looking at GPs, for example, needing to really assess whether someone's lonely or isolated—it has to start there, I think, because how can we signpost people to services if we're not asking the right questions in the very beginning?

10:45

[155] **Rhun ap Iorwerth:** Diolch yn fawr.

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

[157] **Angela Burns:** I just wanted to come back on a comment, Liz, that you made about the fact that in mental health befriending and using third sector organisations to help to combat some of the loneliness issues—. We've just heard some evidence that says it's actually becoming harder to get the third sector to be really hands-on and that, slowly, some of these very well-known organisations are beginning to step back and be much more about policies and lobbying than actually going out there and doing the tough job on the street. And I just wanted to know if that chimes with your experience?

[158] **Ms Denley:** I can pick up a little bit—we're reviewing a lot of our commission services at the moment with our team and what we're finding we're having to do, because of exactly that now—some of our big organisations that we've relied on in terms of service delivery and the experience of people, rightly and understandably, trying to politically help us with the agenda nationally—. We're losing that direct contact. So, when we've

looked at it, we find that we're commissioning more services and using more of our budget now to buy services that we contract with and are clear on because the generic level of those organisations—. Their emphasis shifts depending on the agendas at the time. So, I was speaking to Hafal last week and they've got a policy arm and a delivery arm. We pay 80 per cent of their funding for the delivery arm. That's the reality. So, the NHS and social care actually fund an awful lot of these things. If you go back and track it through, there's often some match funding from the third sector. But the high-level organisations seem to have lost that focus on delivery, certainly in some of our areas.

[159] **Ms Strange**: Can I give an example of where it is working? It's only a small example but we've worked very closely with the Alzheimer's Society recently, and, for example, we're running meaningful engagement events for care homes. But what we've done with the Alzheimer's Society is actually set up a service—it's new, it's been launched but the people are going through training. People living with dementia and their carers will now act as peer support for people who are newly diagnosed, because the feedback that we've had from people with dementia is we need to talk to people who are living it. It's a very small example—I believe it's the first in the UK but that's what we should be doing. We should be using people in our communities who have the lived experience to support other people and I think this is one to watch—that one. They came to an engagement event as part of Dementia Awareness Week—three people who are living with dementia—and the impact that that had on the audience was phenomenal. I just think there are other things we really need to tap into.

[160] **Dai Lloyd**: Mae'r cwestiwn nesaf gan Julie.

Dai Lloyd: The next question is from Julie.

[161] **Julie Morgan**: Thank you, Chair. I just wanted to ask you about the policy and legislative framework that is here in Wales and what opportunities you think that offers to address these issues?

[162] **Ms Carroll**: Within mental health services we've got the Mental Health (Wales) Measure 2010, which obviously places statutory duties on health boards and local authorities to work and engage with people, and where loneliness is identified as an issue or proven, that's something we would work on with that individual to improve and develop networks around them within their own communities, because I think, too often, we take people out of their communities to support them, rather than look at what we can build

around that individual.

[163] **Ms Denley:** I think the domains on the care and treatment planning, even if people don't ask the question explicitly, should lead to that because it covers housing, it covers family, it covers activities and beliefs. And all of those things should, with a skilled practitioner, draw out—when they're formulating with this person what their needs are—and potentially highlight that isolation and loneliness are a factor. And we've been looking at some local data very recently and they're not robust yet, but I think what they showed us was—. We did a sample of one of our community mental health teams and that showed us that somewhere about 15 per cent of the people on our community mental health teams' books live alone. By the time we got to our wards, you're talking about 65 to 75 per cent of the people in our inpatient areas who actually live alone. So, there's something about their ability to remain in the community with their health deteriorating and living in isolation that has an impact on services. For us it was startling. I don't think we expected to see such a significant shift from our community services to our more intensive services. So, there are some questions for us to ask there in terms of impact on people's mental health and well-being and sustaining them in the community. Are there alternatives we could do to traditional community services when someone's becoming less well?

[164] **Ms Williams:** The Social Services and Well-being (Wales) Act 2014 has had a big influence, or is having a big influence at the moment in the shaping of services in the integration of health and social care. I'll just give an example from Cardiff council of what they've done to reshape what they're calling 'preventative services'. So, under the well-being Act, they've obviously got a first point of contact, so people can call the telephone centre and they can get, sort of, triage, and get advice. And either that could be the end of it, but if they need a bit more support, they have a team of visiting officers who will go to older people's homes and just go through the a sort of holistic check with them, really. So, there are a lots of different issues they can actually address through that visiting officer. It might be, again, a sort of social prescribing, I suppose, to the signposting and addressing lots of issues for that person.

[165] They also have a team of day opportunities officers, who can actually physically go with someone to a new activity, as part of the problem is if you signpost somebody, they might not have the confidence or the motivation to take that step over the threshold into that activity. So, the day opportunities team can physically go with them, and show them, perhaps, the bus routes—

that sort of thing—to actually take that step. So, they've got that whole team, and that's really focusing around prevention, and a lot of the focus is around not straight away going into a social services referral; it's trying to redirect in different ways. And they've seen that the referral statistics have dramatically dropped because of the way they've reshaped that service underneath the Act.

[166] **Ms Strange**: Well, I think the Well-being of Future Generations (Wales) Act 2015, particularly as it relates to resilient communities, is critical in this agenda, and, certainly, the health boards have built well-being goals into their neighbourhood care network plans, for example. That's a good vehicle. I think the Commissioner for Older People in Wales's Ageing Well in Wales plan, where it looks at falls and dementia, provides a really good framework to direct. I think it's for us as communities and partners to say what we need locally, but the legislation and the frameworks I think are already there. It might be the way we're interpreting it, but I think—I speak for Aneurin Bevan and I'm sure other health boards would say the same—they're live for us. They are things that we are considering as we're taking this work forward.

[167] **Julie Morgan**: So, you'd say, all of you, that we don't need any more legislation. The opportunities are there under the existing legislation.

[168] **Ms Strange**: Yes—maximise the existing legislation.

[169] **Julie Morgan**: Thank you, and the other thing I wanted to ask was in terms of the intermediate care fund. Have you got any examples of things that are happening there that are helpful?

[170] **Ms Denley**: Yes, certainly, I think it's a real good opportunity because that fund gives the opportunity to pilot and test and things. So, I know in the Hywel Dda region the fund is split into levels, and we have some regional projects that need a couple of years investment to see whether there are any benefits that pay off and we need to mainstream those. But at the other end of the fund, then, there are some community grant allocations so that people can apply to test and things, and there are a lot of community groups that are asking for very small amounts of money from that to scale up and test out some small projects that will help connect communities, and reduce isolation. So, you're talking about £1,000 applications—that's all for a year—just to get a little bit of infrastructure around what they're doing to advertise some events at their community centres, and to really get back into the heart of where people live, and for a rural community that's really, really

important. So, the ICF fund has been very helpful for that, as a flexible source to support those community groups.

[171] **Dai Lloyd:** Mae'r cwestiwn olaf gan Angela.

Dai Lloyd: The last question is from Angela.

[172] **Angela Burns:** Just actually following on from Julie—so, you've very clearly said you don't believe there's a need for any more legislation. But do you think that there's more that Public Health Wales could or should be doing, particularly in terms of getting the messaging across as to the growing increase of loneliness and isolation as a social problem?

[173] **Ms Denley:** I think it would be interesting to see what's in everyone's population assessments, and if it comes up as a consistent theme in all the population assessments, it would be useful to have Public Health Wales to do a 'once for Wales' campaign, and do some really, really helpful campaigns based on local needs—whether there are any themes coming through those needs assessments that we could do a very high-level campaign on, at all levels. Because they're the obvious organisation working across all sectors and having responsibilities at all ages and levels. So, I think it's a definite route to get this higher on people's radars.

[174] **Angela Burns:** It's been quite interesting—I thought the 'eat five healthy things a day'—I mean, that message is now sort of really embedded, isn't it, in the national consciousness? I've been very cheered, actually, by this evidence session, because you've constantly said, all four of you, about taking the service to the person rather than the person going to the service. Because some of the stuff we've been hearing has been about setting things up and making people go along to them.

[175] Tanya, your comments about how people can be very lonely in a care home setting—because of course they would be. Why, just because you're in a care home and you happen to be in the same age bracket, are you going to immediately become great friends with everybody around you? I wonder if, in the public health context, there could be any sort of—. What would you feel about—? Is there any way that we could try and get a bigger message over to the public about, as we get older, as we leave our 10-year-old and 11-year-old ages and go up, that loneliness can hit us at different stages, and that actually it's okay just to—I know it sounds so trite, doesn't it—keep an eye out on your next-door neighbour, or the person down the road, or just be a little bit kinder to the person next to you, and just try and start building

some of those social connections?

[176] **Ms Strange:** I think Public Health Wales are in a really good position to do that, but I think we need to be sure that this isn't just for Public Health Wales to do this. We all need to do it. Certainly—the work with Coleg Gwent, for example, in our area—the colleges are doing it. Yes, the overarching message is this is a public health issue, because it is. But, actually, how then can Public Health Wales ensure that everybody else is working on this agenda—you know, joins the public health message? That's the big thing. It certainly works. Even though it is really early days, Angela, we know that we're on to something here that is mobilising our community. Public Health Wales can help with that, without a doubt.

[177] **Ms Denley:** It may be an option for a conversation with the regional partnership boards as well, because those structures are early and very embryonic at this point in time, but the right people sit around the table—because you talk to the police, and an awful of the calls to them are not about crime. We had a project jointly running with the police for a while, and I sat in on a shift with that, and the amount of calls from older people surprised me—in terms of, if they've been isolated, they thought they'd heard a noise. So, I think it affects all elements of the public sector in some way, so those regional partnership boards signing up to some high-level messaging and work would be a really good way forward.

[178] **Angela Burns:** I'm sure everyone here in this room would say the same, but I've probably got 15 to 20 individuals who, ever since I became an Assembly Member, have locked onto me—they've come to the point now where they come down and have a cup of tea with my staff.

[179] **Dai Lloyd:** It's your magnetic personality.

[180] **Angela Burns:** We help them fill out their electricity bill refund applications and stuff, because actually they just don't have anyone else. That's not really my elected job, but you just do it because it's part of being there. I'm absolutely sure everyone's got those people. So, I have been cheered by this session. I do want to say that again, actually, because so much of what we've read has all been about setting up a service, and you made the comment that it wasn't about the service, it was about mobilising the community. I think that that could be a really key way forward, and, if there's anything we can do to help influence that agenda, if there's anything you'd like to see us put into our report, or anything we can lobby Public

Health Wales to do and the Welsh Government to do, we need that feedback so we can take that forward.

[181] **Ms Strange**: I think the AMs in our area have been behind us all the way with this. Jayne's been a true advocate, setting things up and actually getting the message out there. We could use—. And, hopefully, this committee is using social media more. We're getting organisations and people contacting us just through a little Twitter account that we've set up. We've been introduced to not just vulnerable groups, but people who want to support the vulnerable groups. I've probably said it too many times, but the most important thing is the social mobilisation, the community mobilisation, and all of us taking responsibility for what is a societal issue.

[182] **Ms Denley**: I think there's another angle to it as well, and that's about resilience and preparing people. As someone who works in the public sector, there are actually courses on pre-retirement, so that you can start to think about that. Because we all think about it as the panacea to everything, but actually it's the start of a change for people that is significant and huge in life, and we see that an awful lot. So, I think there are real opportunities to have the conversation there about preparing for transition points in life. Because the other area we see is students. We've got a couple of universities in the patch, and I met with Aberystwyth University last week, again.

11:00

[183] Sadly, we've been watching Bristol. I think one of the Bristol universities has had six suicides of young people in the last 12 months. There's a population who are really at risk in universities. We work with our university well-being service and what we identified was that referrals are high to mental health services there. They're considered a transient population. We have a duty to work with them, but actually they're only there part of the year, so engaging them is more difficult, then, as well, because actually they have responsibilities to attend university as well. So, they've got to get a pass to go out of something to go to a well-being training course.

[184] Some of the work we're doing with the well-being service is piloting something based on a therapy called 'acceptance and commitment therapy'. Fundamentally, it's about teaching you to think about your mind and how to live life well. So, we're going to pilot a course now with 400 students, proactively, as part of their intake month. So, in their first month, we're going to do it and see if there's any impact on the usual referral rates in the

university, to both their well-being service and our mental health services.

[185] Because, firstly, if people haven't got a referral, that saves us an awful lot of work, actually. They're dealing with something in a normalising way, before it happens, and that potentially reduces the flow to our services, but actually teaches them some skills for life as well. So, I think we've got to also think about resilience at transition points for young people—to student life, and adult life, and independence. Most of us are pretty settled in our 40s, 50s, and then it's hitting 60 and thinking, 'What does the last chapter—the next chapter—of my life mean?' That transition point, there, is critical as well.

[186] **Ms Strange**: Just to add, I think another group that we hadn't thought of when we started on this is people who have chosen not to have children. So, career people who had chosen not to have children then were facing retirement, and then it was, 'What next, then?' Just as an example, we've got another volunteer service in Aneurin Bevan—they're all NHS retired staff that we've employed as volunteers that go into care homes and talk to older people. So, our retiring staff, now—whether they like it or not—all get a leaflet to say, 'Come and join C.H.A.aT'. But it is a group I think that we really need to be thinking of. Particularly, because families are all moving abroad now, even if they have got children, they may not have them with them when they retire. So, I think that's something else we—it's one of our work streams, actually, to look at what we can do to support them, even if they don't recognise, at this current time, that they may be lonely in the future.

[187] **Dai Lloyd**: Ocê, cwestiwn byr olaf—Rhun.

[188] **Dai Lloyd**: Okay, a last quick question from Rhun.

[189] **Rhun ap Iorwerth**: Just a quick one to you. You mentioned the term 'compassionate communities' when you were describing the Friend of Mine programme. Was that just a general term that you used, or were you referring to the compassionate communities ideology/principle, which has its advocates and—

[190] **Ms Strange**: A bit of both, really, because, at the same time as we were launching this, we were launching Byw Nawr, on dying well in Wales, and that had the strapline 'compassionate communities'. I remember, when Byw Nawr came out, thinking that was such a really good title. So, although the engagement event was 'prescription for loneliness', the overarching theme was the compassionate communities side of it.

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

[192] **Dai Lloyd:** Wel, diolch yn fawr. Diolch yn fawr am eich presenoldeb y bore yma, a hefyd am ansawdd y dystiolaeth. Mae wedi bod yn sesiwn fendigedig. Diolch yn fawr iawn i chi. Fe allaf i bellach gyhoeddi y byddwch chi'n derbyn trawsgrifiad o'r cyfarfod yma i'w wirio ac i gadarnhau ei fod o'n ffeithiol gywir. Felly, diolch yn fawr iawn i chi. A allaf i gyhoeddi i fy nghyd-Aelodau y gwnawn ni dorri rŵan am 10 munud o egwyl cyn y sesiwn dystiolaeth nesaf? Diolch yn fawr.

[193] **Dai Lloyd:** Well, thank you very much. Thank you very much for your attendance this morning and for the quality of your evidence. It's been a great session. Thank you very much. I can tell you that you'll be receiving a transcript of this meeting to check for factual accuracy. So, thank you very much. I'd like to say to my fellow Members that we'll have a 10-minute break before the next evidence session. Thank you very much.

Gohiriwyd y cyfarfod rhwng 11:03 ac 11:14.
The meeting adjourned between 11:03 and 11:14.

Ymchwiliad i Unigrwydd ac Unigedd: Sesiwn Dystiolaeth 7—Cymdeithas Llywodraeth Leol Cymru a Chymdeithas y Cyfarwyddwyr Gwasanaethau Cymdeithasol
Inquiry into Loneliness and Isolation: Evidence Session 7—Welsh Local Government Association (WLGA) and Association of Directors of Social Services (ADSS)

[194] **Dai Lloyd:** Croeso nôl ar ôl y toriad i adran olaf y bore o'r Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yn y Cynulliad Cenedlaethol. Rydym ni'n troi rŵan at eitem 4 a pharhad ein hymchwiliad i unigrwydd ac unigedd. Hon ydy sesiwn dystiolaeth rhif 7.

Dai Lloyd: Welcome back after the break to the last session of the morning of the Health, Social Care and Sport Committee, meeting here at the National Assembly. We turn now to item 4 and continue with our inquiry into loneliness and isolation. This is evidence session No. 7.

[195] O'n blaenau mae Stewart Blythe, swyddog polisi gwasanaethau cymdeithasol ac iechyd Cymdeithas

Before us we have Stewart Blythe, policy officer, social services and health, from the Welsh Local

Llywodraeth Leol Cymru—bore da i chi. A hefyd mae Dave Street, llywydd Cymdeithas y Cyfarwyddwyr Gwasanaethau Cymdeithasol Cymru—bore da i chithau hefyd.

Government Association—good morning to you. And also Dave Street, president of the Association of Directors of Social Services Wales—good morning to you as well.

[196] Yn ôl ein harfer, rydym ni wedi gweld eich tystiolaeth ysgrifenedig ac, felly, fe awn i'n syth i mewn i'r cwestiynau sydd gerbron. Mae yna nifer o gwestiynau dros yr hanner awr nesaf ac rydw i'n siŵr y bydd yna ddigon o amser i drafod yr holl faterion y dylid eu trafod. Mae Jayne Bryant yn mynd i ddechrau.

As usual, we have seen your written evidence and, therefore, we'll go straight into the questions that we have. There are a number of questions over the next 30 minutes and I'm sure there will be plenty of time to discuss the issues that should be discussed. Jayne Bryant is going to start.

[197] **Jayne Bryant**: Thanks, Chair. Good morning. First of all, I've been looking at the evidence for the scale of loneliness and social isolation in Wales. Perhaps you could say a little bit about the challenges of maintaining and improving community facilities and infrastructure and services, like public toilets, libraries, and community centres, which really do play such an important role in helping people to maintain an active life and participate in social and community activities. Perhaps you can tell us about the challenges that you face on that.

[198] **Mr Street**: Certainly. Obviously, one of the difficulties that we've had over the last four or five years is the impact of financial austerity on the public sector, but, obviously, in our case, particularly local government. As we've moved through that, we've been able to manage that reasonably effectively by downsizing and reducing back-office costs. For a good few years, we were able to, if you like, protect front-line services. You get to a point, I think, in those challenges where the easy stuff's been done and you've really got to focus on what services you provide.

[199] I think that gives us particular challenges, in the sense that many of the services that we provide as public authorities—and, certainly, as a director of social services—they're statutory services. You've got very little room for manoeuvre. They're things you're required to do by law. But, obviously, equally, from a local government perspective, there is a range of services that are not statutory. They are services you've developed over a period of time—a time when, perhaps, the financial position for local

government and the public sector generally was far better than it is at the moment—and you have to begin to turn your attention to those non-statutory services.

[200] The difficulty that causes us on a day-to-day basis is that many of those non-statutory services are what we would call preventative services. They are services that people have used and people value—not necessarily people who need social care services as a result of assessed need, but that our wider communities value. So, things like public toilets. It is increasingly difficult to maintain those going forward, as the financial net tightens. The demand on our statutory services and the costs of our statutory services are increasing at the same time.

[201] So, it does feel, in that way, we've got a little bit of a—it's coming at us from all directions. We do our best to sustain the non-statutory services, but, inevitably, in order to balance the budgets each year, some of those services are having to go, or be delivered in different ways.

[202] **Mr Blythe**: Dave's pointed towards the austere times and the challenges that that brings. I think it points to, I suppose, the importance of building that community capacity. How do we support third sector organisations to be able to support communities? How do we support people themselves to be able to support themselves in their own communities and get those community connections built up?

[203] **Jayne Bryant**: Do you have any examples around Wales of best practice, really—of looking at innovative approaches due to the challenges of austerity, as you suggested? Are there any good examples around Wales where you've had to adapt services?

[204] **Mr Blythe**: Yes. I think we've used, I suppose, opportunities that have been made available. I'm thinking in particular around aspects like the intermediate care fund, which has freed up some resource to be able to look at working together in partnership with other colleagues, like housing, health, third sector, and looking at potentially testing out new ways of delivering services and providing some ability to have some flexibility in approaches.

[205] I'm thinking in particular—there are a number of approaches that have been taken forward. I know, in Conwy, they use some of the funding to support third sector organisations. One example is that they ran a

watercolours class with a small bit of funding to get things up and running. That group then bonded as a group and connected, and so took it forward themselves, and, with a little bit of funding to keep going, to provide things like materials, they've managed to sustain as a group, provide connectivity within the community, but also welcome in new members at little cost to those people then, because there's still that little bit of money that's coming in to support them. But I think those pools of money have helped areas to test things, and I know areas like befriending, as well, have been piloted as a result. So, I think it's allowed people to test out new ideas, find out what works, but also to be able to connect with other funding resources as well.

[206] **Jayne Bryant**: Are there ways of sharing that information? Do you collate that information and share it with other local authorities to make sure local authorities have it or—?

[207] **Mr Blythe**: I think it's probably something we can do better. We do share good-practice examples. I think it's probably something that we need to look at better in terms of having a better catalogue of what we're doing. I know certainly it was an element that we were looking at, particularly in relation to the intermediate care fund—good-practice examples. I know some of that work has already started, but, yes, I think we can do that.

[208] **Jayne Bryant**: I think we all know here about the importance of public transport for our older communities in particular so that people can actually leave their homes to get to where they want to go and to engage with the wider community. Are there any examples around Wales of good practice on this, about how community transport or public transport are used to connect communities?

[209] **Mr Blythe**: I think we picked up a couple of areas in our response, particularly in Carmarthenshire and south Ceredigion with Bwcabus. I know that's had some EU funding to support it, but I think that there are some really good case studies that have come out of that about how it's enabled some people to be able to access, in particular, health facilities where public transport was limited as a starting point. So, it's about enabling people to be able to access GP appointments and hospital appointments. I think, to give credit to health, as well, they've also been flexible when they know that someone's arriving through community transport—they're seen more quickly and are able to catch their transport back out. I know Monmouthshire, as well, run their own community transport, which has enabled some of the rural, outlying areas to be better connected with some of the larger areas.

[210] **Jayne Bryant:** Finally, we all know, again, that housing is another crucial point for the future about how we want to live and where we want to live, especially with an older population. Can you explain a little bit more about your vision on housing and also how that can help to reduce loneliness and social isolation?

[211] **Mr Street:** I think one of the challenges we face there, particularly in Valleys communities, is the very type of properties that we've got—the historical properties: terraced houses on hills with 10, 15 or 20 steps to get to your front door. Once you start to lose your independence and your mobility, they become quite challenging, and there are lots and lots of examples of people almost caught in their own homes, because they physically can't get out. I think we need to start engaging with people far earlier in terms of their possible future housing needs, at a time when there are other properties of which there is a dearth of provision—one and two-bedroomed properties.

[212] The conversations that we're having on an ongoing basis with things like registered social landlords, in terms of making sure that as we develop accommodation, moving forward, it's developed particularly with older people in mind—perhaps that hasn't been the case historically; it's been built for other reasons. But we have to understand that, with the sort of demographic challenges we're facing, going forward, we really have to have older people in mind as we construct our housing estates and our accommodation models, moving forward. Historically, what we've seen is people living in their own homes for as long as they can, and when they face those problems, they then end up in community warden or sheltered housing complexes and residential care homes. We know that most people don't want to end up in those facilities. We know we don't want them to end up within those facilities unless it's absolutely necessary, but there are examples where, actually, people end up in those facilities because of a lack of appropriate accommodation elsewhere in our communities.

[213] **Mr Blythe:** We know from research that if someone's suffering from loneliness and isolation, they've got a far greater chance of entering residential care at a much earlier stage, so I think it points to that importance of having those support services that are available to be able to support people to live independently within their own homes.

[214] **Jayne Bryant:** Thank you.

[215] **Dai Lloyd**: Caroline Jones.

[216] **Caroline Jones**: Diolch, Chair. Good morning. Can I please ask how aware you are of the loneliness framework developed by the Campaign to End Loneliness and Age UK? Do you believe that it is a useful tool in enabling public bodies to plan intervention to address loneliness and isolation?

[217] **Mr Street**: I'm certainly aware of it. It is a useful document. I think it's actually one of many useful documents on loneliness and isolation that's around to support public bodies at the moment. There's little doubt that, as an issue, this is heading somewhere near the top of our priority listing. Yes, it is a useful framework, but I think it's one of many useful frameworks. What I wouldn't want to do is perhaps focus on one document almost at the exclusion of a number of other significant pieces of work. Tackle the same issue, but perhaps from a slightly different angle.

[218] **Mr Blythe**: I think certainly there's been a whole range of research around loneliness and isolation. We're challenged in having a conclusive picture of what works and what doesn't work. I think the tools that have been developed are always welcome and are helpful. You don't want to be spread across too many tools. I know that, certainly, at least in England, the Local Government Association have supported it. So, any tools are welcomed, I guess.

[219] **Caroline Jones**: Thank you. My next question is: what impact do community enablers have on reducing the effects of loneliness and isolation? Is there any evidence to demonstrate the reduction in the demand for other services, for example hospital admissions?

[220] **Mr Street**: I think there are some examples. I think hard data is more challenging. I think that is something that we have to consider moving forward just now. How do you measure a reduction in loneliness or isolation? It's quite challenging in the context of performance. As I said, I think this whole loneliness and isolation agenda is heading to the top of our agenda moving forward anyway. I think the recent legislation—the well-being of future generations Act and the social services and well-being Act—has really given a focus to the sort of challenges that we face in this area. I think one of the real difficulties we've got moving forward is actually getting people to recognise there's an issue in the first place, and getting them to recognise that they've got an issue. There is a stigma, whether we like it or not,

attached to someone saying, 'Actually, I'm lonely'. I'm not sure that, as a society, we consistently take that seriously. It's not like going and saying, 'I am ill. I have an impairment. I have another difficulty'. 'I'm lonely' can often be a perception, can't it—a feeling rather than a hard fact?

[221] So, the issue for me—and Stewart touched on this a little earlier—it's about that community resilience. It's how can we develop our communities in Wales to actually identify that there is a problem around loneliness in Wales. It will in the main be those communities that have to resolve those problems, as opposed to statutory services.

[222] **Mr Blythe**: Certainly, under the social services Act and under the well-being of future generations Act, they're having population assessments that are being completed to help inform the picture across Wales. I guess one of the challenges that's been highlighted by a couple of regions in particular is actually identifying how many people suffer from loneliness and isolation. I think we've had national research that gives you an indication of the numbers and the percentages, but I suppose when you're out there working with individuals it's that challenge of actually identifying someone who's actually suffering from loneliness and isolation as that starting point. So, knowing the impact, then, and how it has been reduced, and the impact on other services—it's challenging to find out at the moment, because I think we haven't got that kind of baseline at the starting point.

[223] **Caroline Jones**: Right. Okay, thank you.

[224] **Dai Lloyd**: Ocê. Rydym yn symud ymlaen nawr at gwestiynau gan Rhun ap Iorwerth.

Dai Lloyd: Okay. Moving on now to questions from Rhun ap Iorwerth.

[225] **Rhun ap Iorwerth**: Diolch yn fawr iawn. Mi ydych chi wedi crybwyll yn barod y Ddeddf Gwasanaethau Cymdeithasol a Llesiant (Cymru) 2014, ac wedi sôn yn benodol am yr elfen o fapio poblogaeth. Rhan arall o'r Ddeddf honno ydy gofyn i'r awdurdodau lleol ddarparu gwybodaeth, cyngor a chymorth i'r boblogaeth. Sut all hynny fod yn ddefnyddiol yng nghyd-destun yr

Rhun ap Iorwerth: Thank you very much. You have already mentioned the Social Services and Well-being (Wales) Act 2014, and you specifically mentioned the element of population mapping. Another part of that Act is requiring local authorities to provide information, advice and assistance to the population. How can that be useful in terms of this loneliness agenda that we're talking about

agenda unigrwydd rydym ni'n sôn today?
amdano heddiw?

[226] **Mr Street:** I think the information, advice and assistance concept is actually now very well embedded across Wales. I think for social care particularly, but also health, we have those initiatives. In the context of loneliness and isolation, there are specific bits of work that have been undertaken. I think within the evidence you've received in advance we referenced Dewis Cymru, which is an initiative that's been pulled together by all 22 local authorities in Wales specifically to help people to address any issues they've got around loneliness and isolation. So, you go into Dewis Cymru, you log in, you put your postcode in, and what will jump up immediately is a range of services around your immediate locality. Some of those are public services—they're libraries, leisure centres, et cetera—but increasingly now, that information is being populated with community and voluntary groups, so things like reading groups. I was looking at one yesterday that had a knitting group on it—Scrabble groups. So, people actually can begin to have a better understanding of what's in their immediate community. They don't need to jump on a bus or a car. They're not dependent on that. But again, it does begin to take people down the road where actually there are initiatives out there to help people help themselves, and I think that is going to be key moving forward. We've got a big piece of work to publicise it, to get it in the public consciousness. In addition to that, we're working to align the principles of Dewis Cymru with the 111 service of the NHS. So, over a period of time, we should have a very thorough database of what resources are actually in our communities, and not just communities as a county borough council, but as we break them down into our towns and villages. Hopefully people will see that as a resource that they can access for themselves and their families moving forward.

11:30

[227] **Rhun ap Iorwerth:** Ac mae hynny'n bwysig. Ond sôn yn y fan yna ydym ni, wrth gwrs, am y mewnbwn—yr hyn sy'n cael ei wneud gan awdurdodau lleol. Pa mor effeithiol ydym ni, wedyn, ar y gallu mesur yr allbynnau, yr *outcomes*? Pa mor llwyddiannus ydy'r ddarpariaeth yna o wybodaeth a chyngor o ran

Rhun ap Iorwerth: And that is important. But we're talking there about the input, and what is done by local authorities. How effective are we, then, in measuring those outcomes? How successful is that provision of information and advice in terms of tackling loneliness? That is, is there evidence of what is

taclo unigrwydd? Hynny ydy, a oes yna dystiolaeth eto bod yr hyn sy'n cael ei gynnig yn arwain at ostyngiad—neu ffyrdd o leihau mewn unrhyw ffordd yr elfennau o unigrwydd sydd yna allan yn y gymdeithas?

offered leading to a reduction—or ways of mitigating those elements of loneliness in society?

[228] **Mr Street:** I think, as I touched on earlier, hard evidence is difficult to come by. Certainly, there is anecdotal evidence. There are experiences that we have of talking to individuals. I think it's something that we have to get better at—actually measuring people's feelings around whether things have improved isn't particularly tricky. It can be done quite crudely in some cases. You can ask people to score themselves out of 100 or out of 10 when they first approach you, and how they feel after six months or a year. I think having those data in terms of how they then impact on statutory services—are people in GP surgeries as often, are people going into care homes sooner than they would have needed to—that is proving more difficult, and we're probably not as fast as we need to be in that context.

[229] **Rhun ap Iorwerth:** And in terms of the role that could be developed for local government in having a public health improvement role—statutory, whatever—do you think that's a direction that we could be, should be or are moving in?

[230] **Mr Blythe:** You've probably seen from our evidence that it's, I suppose, I direction that local government would support. If you look at the social determinants of well-being, a lot of them are under the control—well, not the control, but the ambit—of local authorities. You look at those wider community services—housing, education, social services and community education as well—and I think we've moved public health from the direction of treating illness to actually supporting well-being. So there's an opportunity, I guess, to be able to make those connections between the work that public health do around improvement and the work that local government is involved with. We've got a number of examples where we are working closely together to support improving well-being outcomes for people, but that opportunity to actually make that bigger leap is, I suppose, following the example that's happened in England, where they've taken that opportunity following on from the Marmot review in 2010, which I think recognised the roles and responsibilities that local authorities have, and the opportunities that that provides.

[231] **Rhun ap Iorwerth**: And again, it's about outcomes. It's like the difference between providing a leisure centre and taking responsibility for wanting to make the population healthier. You can provide the information for people on things that can be done to help them address loneliness, but it's then taking that responsibility for tackling loneliness, and making people less lonely and isolated.

[232] **Mr Street**: I think one of the key issues for me is not being dependent on people coming to us. It's how do we get that information into people. How do we eke out of people that, actually, they do fundamentally have an issue where they feel lonely or isolated? Because they might not tell you that the first time they meet you, and they're very unlikely to tell you it over the phone. So, actually, where are those engagements where we can tell people what is available to them, and almost in some issues, take some of the solutions to people, as opposed to simply waiting for the people to come to us? I think we've got a challenge as a public sector in Wales that we've got to put loneliness and isolation on the same footing in the public consciousness as some of the other challenges we face. I think there would be very few people you could walk up to and talk to in the centre of Cardiff today who couldn't tell you about the issues that we've got around childhood obesity, for example, around the challenges of smoking—those other public health issues that we face. I'm not sure loneliness and isolation are as well in the public consciousness yet as some of those other challenges that we face.

[233] **Rhun ap Iorwerth**: I was going to squeeze another one in on the financial side of it, but I think that's the next block of questions anyway, so I would have been told off for stepping on somebody's toes.

[234] **Dai Lloyd**: Yn rhyfeddol, mae yna gwestiwn atodol gan Jayne ta beth. Jayne.

Dai Lloyd: Astonishingly, Jayne has a supplementary question anyway. Jayne.

[235] **Jayne Bryant**: Thank you, Chair. It was just a really quick one, just back on Dewis Cymru, actually. It was something that came up at the committee's event in Newport when we had a stakeholder event there a couple of months ago. I think there's so much going on, there are lots of things happening in our communities—lots of knitting groups or 'Come and have a chat here'—and I know Newport council, for example, have done a good job in trying to put that onto the website, but it was still clear that lots of people didn't know about it, and it's okay having the website, but I think we have got a huge

amount of work to do, as you said, about putting it in people's consciousness. But I think we're doing ourselves and other people a disservice if we think, just because we're putting it on a website—that that means people have access to it—

[236] **Mr Street:** Absolutely.

[237] **Jayne Bryant:** It has to be clear, it has to be—I'd quite like to see it on the front page of every council's website, for example, of what's going on. But there are so many activities, and I really don't think that people know enough about what is happening and what they can access. I know there were some people that would like—they do a coffee morning with one group, but they were quite happy to go to another coffee morning, but if they don't know about the other group's coffee morning it's—. So, I think, it's just a plea, really, that just having the website and putting the information on there—it needs to be a lot more than that.

[238] **Mr Blythe:** And I think that points to the fact that Dewis is one tool of many that enables that opportunity to bring a whole host of information together that's, hopefully, easily accessible that people can access, and it's been designed in a way so that GPs can access it and provide information to patients, in the same way that social workers can take out copies to people as well. And it's certainly not, I suppose, being done in isolation. I'm just conscious that—. We've got community connectors, local area co-ordinators, as well, being employed by a whole raft of different local authorities and regions, and one of their roles is around that provision of information and advice about accessing or finding out what's happening within their local areas and communities, and being able to signpost people to those activities as well. So, it's a really helpful tool that helps us to enable that provision of information, advice and assistance, and one that we're building on as well. I should stress that it's early days for Dewis as well, and I suppose we haven't seen it reach its full potential yet and I think, because we're still building information into it, it hasn't had as much advertising yet as it will do once it's fully operational.

[239] **Dai Lloyd:** Reit, mae'r cwestiynau nesaf o dan ofal Julie Morgan.

Dai Lloyd: Right, the next questions are with Julie Morgan.

[240] **Julie Morgan:** Diolch, Chair. I want to go back, really, to the question that Jayne raised right at the beginning, and that's the financial issues, and

you've obviously touched on that and the difficult position that local authorities are in. Are you able to make a case for doing the sort of preventative work that results in much less money being spent in the long term? Do you have a forum to make that case? Are you able to convince the decision makers on this?

[241] **Mr Street:** Well, obviously, from a local government's perspective, there are 22 authorities, and a lot of those dialogues will go on internally in terms of where their priorities are. Certainly, there have been examples of cases being made on a national level. So, Stewart's already touched on some of the progress we've been able to make as a result of the integrated care fund. We're also using some of the delivering transformation grant money as ADSS Cymru for this year to build on our resilient communities work, which I think is absolutely fundamental to where we're going. However, there is a reality to this and there is a financial reality out there. Like everyone else, I suppose, we don't quite know what the future holds in terms of public sector budget settlements. Our understanding, as it is at the moment, is the position is only going to get more difficult, and I think that's where that—I'm sorry, I apologise, I keep coming back to community resilience, but that is going to be absolutely key, moving forward. We're not going to be in a position where statutory services can maintain some of those preventative services, moving forward. So, how, actually, can we have those honest conversations with communities of, 'Actually, in order to maintain some of the services, you're going to have to find a way of running them yourselves'? There are some very good examples of that in Wales. Unfortunately, they only tend to come to the forefront when a facility is due to be closed. So, there are lots of examples of community groups running public toilets and running libraries, for example, and I think those sorts of conversations are going to need to take place more and more often.

[242] We can't lose the focus on preventative, because if we do, down the line, we have a much bigger problem in the context of the costs of our statutory services, but balancing the two off is a real challenge.

[243] **Mr Blythe:** There's also, I should say, an opportunity. The WLGA, as an organisation, for a number of years now, has been calling for that need to invest in preventative services. We've got the legislation that is pointing in the direction that prevention is the way forward, and I think we've been arguing the case for that need for investment to come into local governments to be able to support some of that work. I think there are still some opportunities: we've mentioned the intermediate care fund, there's also the

primary care fund, which has been, I suppose, health-led funding to support primary care services. I think there's probably been a mixed picture across Wales about how local authorities or local government have been able to access or influence some of that funding. So, there are still some opportunities as well within existing funding streams to better integrate towards that direction of investing in preventative services.

[244] **Julie Morgan**: What about the struggle that voluntary bodies have got with their funding, because that, presumably, does affect a lot of the initiatives that are taken in this field? Have you got any overview on how that's affecting things?

[245] **Mr Street**: There certainly has been an impact. I would say, in most areas, there have been examples of reductions in some voluntary sector funding. I think, in the main, that's really come about from a detailed analysis of exactly what are you paying for in terms of funding the voluntary sector. There have been some examples of duplication that we've been able to move away. Certainly, I know from my own experience, currently, the five local authorities across Gwent and Aneurin Bevan health board are looking at how they use their voluntary sector funding, to see if we can use that more efficiently and sustain those voluntary sector services that are of particular value and make a real difference. But there are certainly examples where the pressures that local government have faced have also been faced in the same way by some of our voluntary sector partners.

[246] **Julie Morgan**: Thank you.

[247] **Dai Lloyd**: Hapus? Angela i orffen. **Dai Lloyd**: Content? Angela to finish.

[248] **Angela Burns**: I'd just like to continue exploring the financial issue for a moment, because we've heard two sides of the story. We've seen examples in other inquiries we've done of where local authorities have taken third sector money away from other organisations in order to use it within their own authorities in order to shore up—so they've taken on board the services, but the reality is it's to shore up the, if you like, traction that they need to maintain an entire area. We've also heard that a lot of third sector organisations are now beginning to step away from being really hands-on and they want to do much more policy and political engagement and strategic planning. So, there aren't those third sector bodies out there to aid local authorities and health boards and to be given the various tasks to do.

So, I'd be quite interested in your view on that.

[249] I also wonder if the WLGA has an idea in its head of, roughly, what percentage of the budget that it gets from Welsh Government is spent on statutory services and what percentage of its budget does it have left available for discretionary spend across the entire piece.

[250] My third question on the financial element of this is: is there no longer any recognition that when central Government puts upon you an onus to be responsible for, say, 'You've got to help tackle the obesity agenda, so try and keep the playing fields open or the sports club open', there's no funding? Because there used to be what was called the Sue Essex convention, where if that onus was put on the WLGA or the local authority, then there would be an element of funding coming across. Has that all stopped now? You're looking blank, so it looks like it has stopped.

11:45

[251] **Mr Blythe:** In terms of the statutory and discretionary split, I don't have those figures with me, I'm afraid. I can certainly report back to my finance colleagues to find that out.

[252] **Angela Burns:** It's not the detail that I'm after, it's just this general, you know—. What I'd like to know is: do local authorities, with their money, end up having to spend most of it on statutory? Because I am really conscious that we ask local authorities—you know, we ask planning to take part in helping to combat the obesity agenda, by ensuring, whenever they build houses or enable housing to be built somewhere, there's an element of cycleway, or there's an element for playgrounds. So, we're asking for lots of these sort of preventative areas to come into local authority remit. We're asking schools to look at increasing physical education, but they need playing fields to be able to do that. Or we're asking old people's homes under local authority control to do much more about cognitive therapies, but, of course, where does that money come from? So, that's why I'm quite interested to know whether local authorities feel that they are being asked to take on too much responsibility for a general well-being message without having that funding to back it up, and if you've got any sort of idea within your heads as to what that shortfall might be—just in terms of percentages, not actuals.

[253] **Mr Blythe:** I'm hesitant to put a percentage on it, but, certainly, there

has been a distinct shift in, I suppose, local authorities' ability to be able to spend on preventative services. The focus has become on statutory services, which I guess is understandable within the austere times that we're having. There is, I suppose, a challenge even with new legislation, as well, coming in: the new burdens that are coming alongside those, the expectations that are being placed—the cost-neutral social services Act, which I think we've supported in principle, but it has a challenge in how you actually implement it. And, again, building that community capacity is great, but actually having the resources to be able to do some of that. I suppose some of the aspects, like the population assessments themselves, having the skills and the ability to be able to actually undertake those assessments, to be able to inform some of those discussions and future direction, as well, are a challenge. So, I think there certainly is a challenge around, I suppose, the responsibilities that get placed on authorities, without necessarily having appropriate planning or support on top.

[254] **Angela Burns:** Third sector: do you see them falling away from supporting you in your work?

[255] **Mr Street:** I think there are certainly examples of that. It's a slight generalisation, but I think with some of the big national organisations, certainly, that's the case. They seem to be moving more as almost pressure groups and lobbying groups. I think there is still a significant resource at a local level, and that's really where our energy has to go. As I said, my day job is I'm the director of social services for Caerphilly County Borough Council, but increasingly what we're seeing is us working on a much smaller community base. We've got 12 neighbourhood care networks. We're looking at how we actually facilitate services from the voluntary sector and the community-based sector in those areas as well. So, I think you will see a shift in terms of that provision, from, perhaps, the big, large, national organisations to more local-based organisations.

[256] **Angela Burns:** Do the local authorities have the capacity within themselves to drive forward these partnership workings with these smaller community organisations?

[257] **Mr Street:** It's a challenge. Life's a lot easier when you're dealing with three or four large organisations—of course it is—but I think it goes back to Stewart's point. I think we have to do that, because in the main, certainly to start with, we have to nurture those groups. We have to persuade people to set those up; we may have to assist them, there may be a little bit of funding,

and we've got to get people to actually get themselves up and under way, but we simply can't sit back and do nothing, for the reasons we touched on earlier on. These are going to be key partners, moving forward, as times get tougher. Quite frankly, we have to find the capacity. It's very challenging.

[258] **Angela Burns:** So, my final question, then, is if—. We're asking the Welsh Government—we're going to put forward a report and say, 'These are our recommendations and our thoughts.' Is money the key, then? If you had one thing you could put on your wish list, is it simply about the money or is it more about the integration, the tying together of local authority work with local health board work and the third sector? Is it the collaboration agenda? What is the most important thing that you would see to help facilitate a real delivery of preventative measures that would encourage greater well-being, particularly in this area of isolation and loneliness?

[259] **Mr Blythe:** We certainly wouldn't say no to more money—

[260] **Angela Burns:** People never do say no to more money.

[261] **Mr Blythe:** Whilst I suppose investment in preventative services or the ability to be able to invest in preventative services is welcomed, I think we've seen examples, again to touch on the ICF, where additional funding for a specific area to enable some of that free working has been beneficial. But at the same time, I don't want to say that extra funding is the be-all and end-all. It's important what you do with that money. We touched upon that building capacity within communities, and a key part of that is being able to work together with all those organisations and bodies that are in that community so that you have that awareness of who's there doing what and that you're able to support each other, that you're all working in the same direction. I think that's a key element of it, and if there is additional funding that's able to support some of that work as well, then that can only be a good thing.

[262] **Mr Street:** I would agree. I think that community capacity is key, and that awareness. We really have to get the message out there of what the challenges—the loneliness and isolation—are going to mean for our communities moving forward. This isn't something that might happen in the future; it's something that happens now. The awful scenes we saw in London yesterday, where you saw a community coming together to deal with a horrific event—there are lots and lots of examples. It never ceases to amaze me that we get community resilience, but it normally requires four inches of

snow before it starts to happen. As soon as that happens we all take an interest in the older people in our communities. We all make sure they're okay, we make sure that they've got the stuff they need from the shop and we keep an eye out for the people that live next door or the door up from one. However, when that melts away, then that goodwill melts away with it. I think the real challenge for us is getting our communities to understand that we need to change behaviours, and they have a responsibility to do that as much as statutory services do.

[263] **Angela Burns**: I wouldn't disagree with that at all. Thank you.

[264] **Dai Lloyd**: Jest i orffen, a allaf i jest ofyn—? Rydym ni wedi cael tystiolaeth ymlaen llaw, yn naturiol, fod, yn ôl gweithgareddau'r sector wirfoddol a'r cwestiynau roeddech chi'n eu hateb i Angela, adrannau o'r sector wirfoddol wedi, efallai, gadael y gymdeithas leol ar ôl ac wedi mynd i wneud pethau eraill fel ymgyrchu a datblygu polisïau ac ati, ac yn tueddu i beidio â gweithredu'n gymunedol ddim rhagor. Wrth gwrs, yn y cyd-destun yna, pan rydym ni'n sôn am unigrwydd ac unigedd ac ati, mae hynny'n bwysig, achos i raddau mae'r sector statudol yn dibynnu ar y sector wirfoddol go iawn i fod yn darparu gwasanaethau. Wrth gwrs, beth rydym ni wedi ei weld hefyd ydy crebachu, fel roeddech chi'n awgrymu ar y dechrau, a cholli'r gweithredoedd statudol. A'r enghraifft roeddem ni'n ei chael oedd bod gwasanaethau cymdeithasol wedi diflannu o'r maes, megis. Nid ydw i'n gwybod a fuasech chi'n licio ymateb i'r sylw yna am y dystiolaeth flaenorol. Rydym ni'n deall y cyfyngiadau ariannol ac ati, ac rydym ni'n deall beth sy'n digwydd ar y

Dai Lloyd: Just to finish, could I just ask you—? We've had evidence beforehand that, according to voluntary sector activities and the questions that you answered to Angela, parts of the voluntary sector have left the local society behind and gone on to policy development and campaigning and so forth, and tend not to operate on a community level any more. In that context, when we talk about loneliness and isolation and so forth, that's important, because to an extent, the statutory sector does depend on the voluntary sector to provide services. Of course, what we've also seen is that we've contracted, as you suggested at the outset, and lost some of the statutory services. And the example we had was that social services have disappeared from the field. I don't know whether you'd like to respond to that comment about the previous evidence. We understand the financial limitations and so forth, and what's happening on the ground and what's happening, naturally, in a society that faces a crisis, such as that in London, but at the end of the

llawr a beth sy'n digwydd yn naturiol mewn cymdeithas sydd yn wynebu argyfwng, fel yn Llundain, ond ar ddiwedd y dydd, dylai yna fod ymateb statudol hefyd.

day, there should be a statutory response as well.

[265] **Mr Street:** Absolutely. I certainly wouldn't recognise a situation where social services has disappeared from the field. I think what we are looking at now is different types of solutions to those problems. Historically, yes, there have been arrangements for the large voluntary organisations. They have been principally driven by service contracts, so actually they're commissioned services in the main that have followed a formal process. I think what we're moving to is a much softer approach, moving forward, where we are going to need relationships with community-based groups that we're not going to procure and we're not going to commission in the same way as we have historically. We will have to have very different relationships where we encourage, we cajole, we persuade, we support these organisations to actually not necessarily replicate what went before it, but actually to do different things to perhaps what we've enjoyed from the voluntary sector, moving forward, and that is going to be challenging. It isn't something that can happen overnight. You're not going to engender that kind of response from people. How do we actually get people to come forward and volunteer? I think one of the real untapped resources for me is actually: how do we almost reverse engineer this, so we actually get people who are lonely to be volunteers in their own right, as well? Because for me you've got a double whammy; they stop becoming lonely, and then they actually contribute more to the broader agenda as well. They're not things that happen overnight; they're things that you have to build over a period of time whilst trying to sustain some kind of presence while those changes begin to happen.

[266] **Dai Lloyd:** Grêt, diolch yn fawr. Dyna ddiwedd y cwestiynau, rydw i'n credu. Diolch yn fawr am eich presenoldeb a hefyd am ateb y cwestiynau y bore yma. Gallaf bellach gyhoeddi y byddwch chi'n derbyn trawsgrifiad o'r drafodaeth y bore yma i gadarnhau ei fod yn ffeithiol gywir. Ond diolch yn fawr ichi am eich presenoldeb y bore yma. Gallaf bellach gyhoeddi i fy nghyd-Aelodau

Dai Lloyd: Great, thank you very much. That's the end of the questions, I think. Thank you very much for you attendance and also for answering the questions this morning. You will receive a transcript of this morning's discussion to confirm that it is factually accurate. But thank you very much for your attendance this morning. And I will now announce to my fellow Members

y cawn ni egwyl byr am ginio nawr a byddwn yn ôl am 12:45. Diolch yn fawr iawn i chi.

that we will have a brief break for lunch and we will be back at 12:45. Thank you very much.

Gohiriwyd y cyfarfod rhwng 11:56 a 12:47.
The meeting adjourned between 11:56 and 12:47.

Ymchwiliad i Unigrwydd ac Unigedd: Sesiwn Dystiolaeth 8—Y Groes Goch Brydeinig yng Nghymru
Inquiry into Loneliness and Isolation: Evidence Session 8—British Red Cross in Wales

[267] **Dai Lloyd:** Croeso i bawb yn ôl i sesiwn nesaf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yn y Cynulliad Cenedlaethol. Rydym yn symud ymlaen i eitem 5, parhad efo'n hymchwiliad i unigrwydd ac unigedd. Hon ydy sesiwn dystiolaeth rhif 8 ac o'n blaenau y mae cynrychiolwyr o'r Groes Goch Brydeinig yma yng Nghymru. Felly, a allaf groesawu Chris Hopkins, cyfarwyddwr Cymru y Groes Goch Brydeinig—croeso—ac hefyd Dave Worrall, rheolwr rhaglenni y Groes Goch Brydeinig, a hefyd Paul Gerrard, cyfarwyddwr polisi grŵp Co-op? Rydym wedi derbyn eich papur ysgrifenedig sydd gerbron, a diolch yn fawr am hwnnw. Yn ôl ein harfer—hanner awr sydd gennym—fe awn ni mewn yn syth i gwestiynau sy'n seiliedig ar eich papur. Felly, mae Jayne Bryant yn mynd i ddechrau. Jayne.

Dai Lloyd: Welcome back, everyone, to the next session of the Health, Social Care and Sport Committee here at the National Assembly. We move on to item 5, continuing with our inquiry into loneliness and isolation. This is the eighth evidence session and before us we have representatives from the British Red Cross here in Wales. So, I'd like to welcome Chris Hopkins, Wales director of the British Red Cross—welcome—and also Dave Worrall, programme manager, British Red Cross and also Paul Gerrard, group policy director with the Co-op. We've received your written paper that's before us—thank you for that. As usual—we have half an hour—we'll go straight into questions based on your evidence. So, Jayne Bryant will start. Jayne.

[268] **Jayne Bryant:** Diolch, Chair. Good afternoon. I'll just start on the issue around the evidence and the scale of the problem that we're facing. Perhaps you could outline some of the findings of your report 'Trapped in a bubble'

so that the committee could delve into that a little bit more.

[269] **Mr Gerrard:** Certainly. We carried out research last year, and we published it in December. I think a couple of things I would pull out—and you'll appreciate it's a pretty big research package—but a couple of things I'd pull out: 80 per cent of people in the UK have experienced loneliness. So, if you look around this room that's probably at least—only a couple of people haven't. But I think the thing that I would really pull out is that 18 per cent of people in the UK—and there's no differentiation between region or, indeed, between urban or rural locations—18 per cent of people felt lonely always or very often. So, in Wales that equates to about 480,000 adults, which is a city bigger than Cardiff. I guess the other—and I'm sure we'll get into this in a second—. There are some quite surprising findings from the research about the kinds of people that are lonely. But I'm sure we'll get to that in a minute. So, I think the scale for me, when it's one in five of us—so, you look around this room and probably a couple of us feel lonely often or always—that's a pretty significant problem.

[270] **Jayne Bryant:** It is. So, do you want to go into a bit more about older people, in particular?

[271] **Mr Gerrard:** I can do. The research looked at and identified six groups, not just the older, actually. But I will run through them. They were: young new mums, who were actually the most likely—the most likely—to feel often or always lonely; recently divorced or separated, which isn't age specific; those who have got mobility issues, often the elderly, but not alone; those who've got health issues; those who are recently bereaved; and also those who are over 55, either because they're empty nesters, i.e., the kids have left home, or because they've just retired—so, those six groups.

[272] Within that, actually, the ones that are specifically the older group—although the recently bereaved, divorced, can be throughout—the over 55s are less likely to feel lonely often or always, in the research. But I think, with the research there, we're pulling out a specific group when actually the demographics are more crosscutting than that.

[273] **Jayne Bryant:** That's really, really helpful, thank you. Perhaps you could go into a little bit more the causes of loneliness and social isolation that 'Trapped in a bubble' identified.

[274] **Mr Gerrard:** Certainly, and my colleagues from the British Red Cross

will, I'm certain, be able to give a lot more colour than just the data. I think there's three things, I'd say. The first thing is that what came out in the research very strongly was loneliness is often caused by transition. Transitions increase the risk of people being lonely. So, it could be a change—often a change in role, be it a job, or retiring, or becoming a mother, or becoming a widow or a widower rather than a husband or a wife.

[275] So, those transitions often increase the risk of loneliness. I think that involves loss of identity, but it also, I think—the easy connections that the previous role had are lost. So, there's a great story in the research about a gentleman who's retired. He talks about, throughout his day, he had any number of small social interactions with people, and when he retired they all went. So, I think transitions in life increase risk.

[276] There's then three factors that are interdependent that cause loneliness. One is individual—it could be identity, income is an issue, health is an issue, and changed habits. So, I think there's a set of individual causes. I think there are a set of community causes—the reduction in social spaces, reduction in social groups, reduction in safe neighbourhoods. And I think there's then some societal issues, some of which are political, some of which are cultural.

[277] I remember going on buses in Lancashire with my grandma who'd happily talk to whoever was on the bus, and it wasn't because she was weird, it was because that's what people did of that age. That's gone now. I think that relates to neighbourhood safety. So, I think there's three causes there: individual causes, community causes, and societal causes.

[278] **Jayne Bryant:** Did you want to come in?

[279] **Mr Worrall:** I was going to say, my experience is very much centred around north Wales, and that's an area I've been working in for a long time now. We started working with loneliness and isolation about five or six years ago. For that particular area, the retirement of people from big areas like Manchester, Liverpool, and Birmingham into north Wales has been a massive issue. There are lots and lots of locations where people have moved away from the social structure they had and the family that they've had. They're moving into an area they don't know particularly well and are struggling to find that local connection. So, for me, a big issue is about the location for retirement.

[280] But it can also be things like a breakdown in family relationships, which is really sad—at a stage in your life where you want support from people, what you're finding is that that relationship is potentially breaking down. So, the causes are very, very different, but the key thing is there tends to be a trigger, something that happens, when individuals maybe get a diagnosis of a condition, they take on caring responsibilities, or there is a bereavement, as Paul said. So, it's recognising what those key triggers are that start the whole process of loneliness and isolation off.

[281] **Dai Lloyd:** Okay—

[282] **Jayne Bryant:** Sorry, Chair, I was just finally going to say that we heard from some witnesses this morning about some of the work that's going on to tackle this huge issue. Can you identify a few aspects that you think—? What sort of response is needed to this?

[283] **Mr Gerrard:** I'll let my colleagues talk about the specific things that I think organisations like the Red Cross can do. The Co-op is a large business. We've got 200 sites and 4,500 employees in Wales, and 400,000 members in Wales. I think businesses have got a role to play here, both as businesses that employ people—so, as an employer, we can provide, and do provide, support to our staff, and I'm very happy that the people who provide our employee assistance also provide the same services around loneliness to all their clients now, not just us. So, there are things you can do as an employer, but I think that, as a business, businesses can do more to recognise and address this. So, just one of the things, perhaps, that is specific to the Co-op is that we're the biggest funeral provider in the country, and one of the things we do is to run bereavement clubs. I think the interesting thing about bereavement—and, obviously, as a funeral provider, we understand this—is that there's a lot of support for people in the immediate aftermath of a bereavement, but, as people get on with their lives, those who are bereaved are often left behind. And what we've found with bereavement clubs is that they provide those contacts that mean that those disconnections don't continue. And so I think businesses can look at ways in which their core businesses can also play into this space, if that makes sense.

[284] **Mr Worrall:** For me, as an organisation like the Red Cross, it's the power of volunteers who are actually part of their own local community, and it's what they can do to bring that local knowledge of what is going on. I firmly believe that the solution to a lot of these things lies within our own communities and the local communities and what they have, but it's

recognising and finding out what the strengths are and how we can build on that. And I think that volunteers are really good at identifying those links—you know, 'What can we find in the community that will help that individual?' And so often they were really small things—it's a local crochet club—but they exist within the community, and I think it's this concept of connecting. And something that we're doing with Paul is this notion of community connectors, where we link people back in.

[285] Sometimes, it is anxiety about going back out that stops people engaging with these things, and that in itself is quite a trigger to loneliness, that people are anxious. It's a fear of going outside, and it's just giving them the confidence to do that. Quite often, that's by supporting them to do that type of thing.

[286] **Jayne Bryant:** Thank you.

[287] **Dai Lloyd:** Thank you very much. Do you want to ask your question about community connectors now, because we've just referred to—?

[288] **Jayne Bryant:** Yes, thank you, Chair. Yes, if you could just sort of—. I'm aware of community connectors, particularly in my area, and I'm struck by the fact that I think it was the Red Cross that has come out and identified Newport—unfortunately, it's something that I don't want us to be known as, but as one of the loneliest places, I think, in Britain; if not, certainly in Wales, along with my colleague Lynne Neagle, in Torfaen. Perhaps you could talk about the ways community connectors can help to change that and have an impact on that.

[289] **Mr Worrall:** One of the things we've picked up on is the 'what matters' conversation, which has come out of the social services and well-being Act. I think everything we do with individuals has got to be person-centred. It's got to be about what they're looking for. So, we try and use a number of soft outcome tools to find out what matters to that individual. We also have a thing called top three goals, where we ask the individual, 'What is most important for you in this relationship?' And it's in that conversation with them that we find out what it is that they most want. And our role, really, is to facilitate that, and it's to find ways that are sustainable. We can't carry on doing it forever. What we need to do is enable them to do it for themselves. When we work with our volunteers and staff, that's a key part of the process—it's how do we enable the individual. Because, if we take them, if we do things for them, as soon as we move out it will disappear, and it has to

be something where they will carry on with it after we've gone. So, it's key what that individual needs, but it's also key the sustainability of it.

[290] **Jayne Bryant:** So, it doesn't matter in terms of ages or—. That covers all ages and—.

[291] **Mr Hopkins:** The community connectors programme that we shall be developing in Newport and Torfaen, and in Conwy and in Carmarthenshire, they are focused on people from 18 up to 99, whereas a lot of our other projects are focused on older people. The connectors—we're just starting the programme now. So, they're just starting, and their first job is to get connected themselves with the local community. We've appointed people who are of the community, and they will be bringing in volunteers who are also of the community, rather than just parachuting in.

13:00

[292] And we'll be supporting people for up to 12 weeks to make those connections that are important to them and are meaningful to them, to reattach themselves to hobbies and interests that they've had in the past, to connect to local organisations, and even to start some things themselves to bring people together who share this challenge of loneliness, so that we'll be working with them and be thinking in terms of preventing loneliness from happening for people in the future and responding to people who've had that challenging transitional event. There are people who we will come across, I'm sure, who will suffer from more chronic loneliness, who are trapped in that bubble and who we, because we can devote time and individual support and care, can hopefully start to bring those people into an environment where the loneliness becomes less acute and less of a challenge.

[293] **Mr Gerrard:** Just very, very briefly, I think one of the key things for the connectors will be helping people access help. Probably the most frightening thing for me about the research we did was that 75 per cent of those people who are most or often lonely don't know where to get help. And I think that's the—if there's anything I would take from that research, it's that.

[294] **Mr Worrall:** I think that's resulted in the fact that a lot of people, because they don't know, tend to go to their doctors and that's a key point—and the pressure that we're putting on the health service, because a lot of the time, the visits are inappropriate and are not health-related, but that's their route to try and find a way out of this. So, we have worked in lots of

cases in doctors surgeries to try and stop that unnecessary non-health-related intervention. But we also talked earlier about Dewis Cymru, which I think is a really important development. I'd like to see more people take and use Dewis Cymru as an information portal.

[295] **Dai Lloyd**: Good. A step change in questioning now. Caroline.

[296] **Caroline Jones**: Diolch, Chair. Good afternoon. I'd like to ask a couple of questions, please, based on the impact of loneliness and isolation on the health and well-being of older people and the use of services. My first question is: the British Red Cross review of more than 100 published studies found that a lack of social connections is linked with increased death rates and other health risks such as cardiovascular disease. Therefore, how many of these health risks would you consider are linked with loneliness and isolation? What sort of proportion?

[297] **Mr Worrall**: It is difficult to say because it kicks things off. I have heard it said that the impact of loneliness is equivalent to smoking 15 cigarettes a day. I think that's something that's been talked about quite a lot. It's where it takes people—it's that whole loss of self-worth and in lots of cases we do see suicidal ideation that comes about out of that loneliness thing. I think I would find it hard to specify, but what we do know is that it kicks people into a downward spiral in their health and it's really looking at that, for me, prevention agenda.

[298] **Caroline Jones**: Yes, that's right.

[299] **Mr Gerrard**: I absolutely agree that it's difficult to put a number on it, but there's some research that we did with the New Economics Foundation that put an economic number on it and the cost of loneliness to business is about £2.5 billion a year. That's a significant sum.

[300] **Caroline Jones**: Okay. My next question is concerned with cost. Again, the British Red Cross's written evidence also states that £12,000 could be the cost of a person experiencing loneliness over the next 15 years. So, how can we look at prevention before the situation escalates and needs a cure?

[301] **Mr Worrall**: I think that one of the key things for me is identifying those triggers that tip people into loneliness and isolation. I think there's a lot of work that needs to be done with health and social care professionals—they quite often see those triggers, but there's not necessarily a link to

putting them into services that specifically are looking at helping people in that case. So, if we can have a stronger link with health services and social services, which can recognise those triggers and then, rather than just leave it for the thing to decline, refer them on to us, I think that would be a non-cost thing that we could do quite easily. But it's joining up the services, and if we could, and we have done it in a number of pilot cases, embedding people from the third sector within doctors' surgeries, so that they can show the range of services that are out there that can help prevent these things happening.

[302] **Caroline Jones:** Thank you.

[303] **Dai Lloyd:** Rhun.

[304] **Rhun ap Iorwerth:** Yn adeiladu, mewn ffordd, ar beth o'r dystiolaeth rydym ni wedi'i chlywed yn barod gennych chi, ac edrych ar beth rydych chi wedi'i ddysgu oddi wrth ymchwil ynglŷn â darparu gwasanaethau, rydych chi wedi cyfeirio'n barod at y broblem cyfeirio, *signposting*, ac rwy'n meddwl eich bod chi wedi ateb yn eithaf da pam rydych chi'n meddwl bod yna broblem yn y fan yna. Os gallaf i droi at bwynt 13, rwy'n meddwl, yn eich tystiolaeth ysgrifenedig:

Rhun ap Iorwerth: Building, in a way, on some of the evidence that we've heard from you already, and looking at what you've learned from the research on providing services, you've already referred to the problem of signposting, and I think that you've answered quite well why there is a problem there. If I can turn to point 13 in your written evidence:

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

[306] Could you perhaps expand on that?

[307] **Mr Worrall:** Yes, I remember that one. It's how you structure the intervention with people. I think, from the outset, it's got to be an enabling process. If you go in there thinking that you're just going to do things on their behalf, then they never resolve their own issues. So, I think the idea of one-off, it seems to be, 'Here we are, that's the solution, now I'm going away.' It needs to be more structured than that.

[308] **Rhun ap Iorwerth:** Can you give us examples of things that don't work—one-off interventions that perhaps you've seen through research?

[309] **Mr Worrall:** I think one of the common ones is, if we take the examples of Alzheimer's and Cruse, where they offer very specific services, one of the key things I've found with them is that you have to go to them. So, if, as an individual, I give you a leaflet and say, 'I think the people who can help you most are going to be Alzheimer's', the issue for that individual is, 'Yes, it can; how do I get to it?', and part of the process is then that question of transport. And, to do that will take quite a while of organising, because they need to be in charge of that process themselves. So, it's, 'How do I get there? Are there local taxis that can do it? Do I have the finances to do it?' So, there's never a single answer to these things, and the solution is often quite complex until you can put all the pieces in places. So, for me, that means that there needs to be a period—in our case, we're looking at 12 weeks—where we build up how that individual accesses development services.

[310] **Mr Hopkins:** And loneliness isn't a one-off thing. So, it's about recognising that solutions have to be much more holistic and they have to engage with the wider community, not just that organisation or this organisation. And we need, I think, to be less scared of the term 'loneliness' and of outing loneliness, if that's the right term—that we don't stigmatise it, that we all are open about it, and that we recognise that we're all susceptible to it at different times of our lives, potentially. That, I think, would be one step. And I'm sure Welsh Government can help with this as we move forward with the strategy around this, that we're having conversations about it, and that we're talking about it, on pre-retirement courses, for example, that, 'This might happen, and these are some of the things that you might want to think about, should it happen, that might support you in that in the future.' In antenatal classes, talking about the fact that, 'Actually, if you're going to be a mum, your life might change to the point where you're not actually having those social connections that you've currently got, and these are some of the things that you might be able to do to stop that.' So, I think it's about broadening the dialogue and the conversation about loneliness.

[311] **Rhun ap Iorwerth:** One more point. You mentioned, just as an example, Alzheimer's. If I could just quickly explore that. Are there particular ways of dealing with loneliness and isolation among those with dementia, and their carers, that you have been able to identify, any of you?

[312] **Mr Worrall:** Alzheimer's have got a lot of good schemes, but they're only one organisation, and we know how much pressure they are under. But there are things like Singing for the Brain and that sort of thing. They have some great, great services. I think one of the things for Alzheimer's, though, is people accessing those services and how you get to them, and it brings, for me, this key issue around transport and how you get to them. But it's supporting people to go to that as well, because individuals may be anxious about attending things like that, and we can help in those cases with supporting, going along with them for the first couple of trips, and, as we said, then stepping back and allowing them to do it for themselves. But organisations like Alzheimer's are so key, because, for every individual, we don't actually know what it is that they're trying to resolve, and that's why we do the top three goals—'What is it that's important to you?'—and for each of them it will be different, but it will be the way to get out of loneliness.

[313] **Rhun ap Iorwerth:** And, in a way, that fits into the idea of having bespoke strategies for particular groups of people, people with dementia and their carers being just one of them. Yes, okay. Thanks.

[314] **Dai Lloyd:** Mae Angela yn mynd i ofyn y cwestiynau olaf.

Dai Lloyd: Angela will ask the last questions.

[315] **Angela Burns:** Yes, thank you. Hello. I was listening with interest to your answer just then, because one of the areas that really concerns me is that an awful lot of people are unable to take that first step out of the door, either because they're quite tricky individuals who've not been good at making friends throughout their lives, don't have family around them or have fallen out with their family. They're not going to suddenly become joiner-inners of any group or other. And, of course, the other thing is that we know that a significant number of the very elderly are saying that they are lonely and, of course, they have mobility problems, they perhaps haven't got a car or are rural living. So, have you got any words of wisdom as to how we might be able to get alongside the lonely who are, if you like, trapped through either circumstance or their own psyche and personality in their homes, and how we might help them?

[316] **Mr Worrall:** I think, sometimes, we've got to realise that not everybody wants to join a club, and that's one of the things you've got to avoid—they might not necessarily want to join in something big, but it's actually finding what's key to them. There are times when we've used technology to resolve issues like that, because it's showing them how to use something like

Facebook, and that's been on occasions quite useful, but also FaceTime and they can connect with relatives who are perhaps a long way away. So, the solutions will present in lots of different ways. I've talked about transport, but, for me, also, IT is a gateway and it's a way of resolving the issue. So, for some of those who are most lonely, it could also be a telephone call, and it's anything that starts that process of reconnection. I don't really mind how it's done, but it's specific to that individual.

[317] **Angela Burns**: Do you have any examples of where telephone befriending has worked successfully, because I should think that anybody who is walking towards old age and are now in their 40s are going to be IT literate—in their 50s, marginally less, and in their 80s, probably not. So, IT isn't necessarily a way for them, but I'm interested in the telephone befriending aspect.

[318] **Mr Worrall**: I did run a scheme in north Wales for quite a while, but we also had the Silver Line that came along—that's from Esther Rantzen—and that was specifically for older people who were lonely and isolated. So, I always feel that, if there are other options, we should point people at what there is out there. I've heard of some great schemes. I think there was a community in the north-east of England where they held church services over the phone, and you can almost do things like teleconferences where people can join in and take part in a church service. So, there are a lot of innovative ideas that really don't cost very much, but it's just establishing them and then linking people to them.

[319] **Angela Burns**: So, we're talking about these innovative ideas, and I'm with you on that; I think there are a lot of small organisations who are just getting to grips with a particular area. Do you think that they are getting support from the larger third sector organisations? One of the things that's come up quite a lot in our discussions today is that some of the larger third sector organisations who used to provide services—feet on the ground—are now withdrawing from the front line because, actually, they're concentrating on policy and fundraising, and all the rest of it, rather than the feet on the ground. And I'd like to have that comment from you on the general perspective, and also on what your organisations' direction of travel is in this matter.

[320] **Mr Hopkins**: I think there are two or three things there. In terms of feet on the ground, British Red Cross's direction of travel is to continue to deliver services through volunteers, through paid staff, but predominantly

through volunteers, and to do that in partnership with other parts of the sector. And I think you make a very good point about the smaller organisations who find it difficult sometimes just to get that traction. We live in an environment in the third sector more and more these days, actually, where it's short-term funding, and that doesn't allow particularly smaller organisations that haven't got the infrastructure that the red cross have to (a) deliver what they set to deliver, and (b) demonstrate the efficacy of the work that they're doing.

13:15

[321] I think there are opportunities for organisations like the red cross and other larger organisations, if you like, to work in partnership with some of the smaller organisations. And, certainly, that's part of the ambition around the Community Connectors programme, namely that we will identify and work with some of those smaller community-focused organisations that do so much tangible good that we can help them, maybe, to harness some of the efficiencies and effectiveness stuff, and help translate some of their work and effort into evidence that future funders would find attractive.

[322] So, certainly from a British Red Cross perspective, being more of the community means attracting—sorry, 'attracting' is the wrong word—connecting directly with those smaller organisations who have the absolute best ideas very often, and the simplest ideas—the ideas that make that difference. Certainly, focusing on the community and the individuals within that community in a transformative way is something that both big and large can contribute to effectively.

[323] **Mr Gerrard:** Just two further points to build on that, I think. We aimed when we set out in our partnership with the British Red Cross to raise £3.5 million, and we ended up raising £6.1 million, which is great. The conversations we're having with our British Red Cross colleagues are about how we spend the extra with them, and that is very much, as Chris says, about using other partners to do that, and perhaps smaller partners. So, that's one thing.

[324] The second thing is that a key part of the Co-op is that for every £1 our members spend, we give 1 per cent back to local causes. Here in Wales, we've given £580,000 back to 300 causes over the last six months. And many of those causes—local causes, small causes, feet-on-the-ground causes—are addressing isolation and loneliness. So, I think, for us,

absolutely, we will partner with the British Red Cross, a phenomenally admirable organisation, to campaign about this, but we'll also, through our community fund—our 1 per cent—fund smaller organisations. As I said, we gave £580,000 in Wales to 300 causes, and we gave £9 million across the UK to 4,000 causes, but very much in that space—smaller causes that perhaps are really in need of funding as funding gets restricted.

[325] **Angela Burns**: I absolutely commend you on that. I'm sure we've all seen fantastic small organisations. It's about the passion and the dedication of a few individuals that come up with a great idea, they make it happen and they find it so difficult to fight for air and money. You know, they've come to me and said, 'We want to apply for a grant', and they want to apply for a grant this big and the paperwork's that big, and you think, 'This is ridiculous—it can't be that difficult.' So, I really do commend the Co-op.

[326] **Mr Gerrard**: Ask them to look at the Co-op.

[327] **Angela Burns**: Hey, listen, look, now you've had three mentions. [*Laughter.*] I might have to mention alternative stores soon.

[328] **Mr Gerrard**: It's free money, so what's not to like?

[329] **Angela Burns**: Yes, and I'm very grateful. My last question to you is on a wish list. What would you like to see most in the Welsh Government's isolation and loneliness strategy? What would you like us to lobby for on your behalf?

[330] **Mr Gerrard**: I'll start, but my colleagues will have probably more sensible things to say or more useful things. I think having a strategy that raises the issue—you and your colleagues in Scotland—is a massive step forward, because it is an issue that people think about, but nothing is being done. So, I think, having that strategy, you should be commended hugely for that.

[331] **Mr Worrall**: I guess, for me, it's trying to develop the gateway services for people, and transport is something that I come across time and time again, and how can we facilitate people getting to these things. But, also, I think it's about delivering services in the right places. A lot of organisations have this insistence that you come to them, and I think we need to be delivering services into communities. That's not a cost thing; that's actually just strategic in how you do it. All too often with social services, you have to

go to them. And I know a lot of councils are running single points of access and information points, but I want them to put those more into the community and understand that that's where we deliver. I think, if we have them there, people who have issues around loneliness and isolation will be more tempted to go to them. So, that's key. But certainly gateway, and if we can do things around IT and transport.

[332] **Mr Hopkins:** Having the strategy, as colleagues say, is fantastic. What I hope it does is bring the loneliness and isolation agenda much closer to the surface, and allow us to talk about it collectively and start to act about it collectively. I also think we do lots of stuff—lots of the third sector does lots of stuff. What we'd like to be able to do is evidence that that stuff works and makes a difference. I feel, with the weight of a Government strategy behind it, that we can go out and publish that evidence, and do the stuff that works, and encourage people to do different stuff that makes a difference.

[333] **Dai Lloyd:** Diolch yn fawr. Rydym ni wedi rhedeg allan o amser. Diolch yn fawr iawn i chi'ch tri am eich presenoldeb a hefyd am ateb y cwestiynau mewn ffordd mor raenus. Gallaf yn bellach gyhoeddi y byddwn ni'n danfon trawsgrifiad o'r cyfarfod yma atoch chi er mwyn i chi allu cadarnhau bod yr holl beth yn ffeithiol gywir. Ond, gyda hynny, diolch yn fawr iawn i chi. Fe gawn ni doriad byr tra ein bod ni'n cael y tystion nesaf i mewn. Diolch yn fawr iawn i chi.

Dai Lloyd: Thank you very much. We've run out of time. I'd like to thank the three of you for your attendance and for answering the questions in such a polished way. I'd like to say that we'll be sending you a transcript of the meeting for you to confirm the factual accuracy. But, with that, thank you very much. We'll have a quick break while we bring in the next witnesses. Thank you.

Gohiriwyd y cyfarfod rhwng 13:21 ac 13:23.
The meeting adjourned between 13:21 and 13:23.

Ymchwiliad i Unigrwydd ac Unigedd: Sesiwn Dystiolaeth 9—Gwasanaethau Gwirfoddol Morgannwg (GVS)
Inquiry into Loneliness and Isolation: Evidence Session 9—Glamorgan Voluntary Services (GVS)

[334] **Dai Lloyd:** Croeso nôl, felly, i'r **Jayne Bryant:** Welcome back to this

adran ddiweddaraf o'r Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yn y Cynulliad Cenedlaethol. Rydym ni'n symud ymlaen rŵan i eitem 6, parhad efo ein hymchwiliad i unigrwydd ac unigedd. Sesiwn dystiolaeth rhif 9 nawr, ac o'n blaenau ni mae tystion o Wasanaethau Gwirfoddol Morgannwg. Felly, mae'n bleser croesawu Rachel Connor, prif weithredwr Gwasanaethau Gwirfoddol Morgannwg; a hefyd Linda Pritchard, hwylusydd iechyd a gofal cymdeithasol, Gwasanaethau Gwirfoddol Morgannwg. Rydym ni wedi derbyn eich adroddiad ysgrifenedig. Diolch yn fawr am hynny. Mae ein cwestiynau ni yn deillio o'ch adroddiad chi a hefyd materion sydd wedi cael eu codi gan weddill y dystiolaeth yr ydym ni wedi ei derbyn. Felly, gyda hynny o ragymadrodd, fe awn ni'n syth i mewn i'r cwestiwn cyntaf, ac mae Jayne Bryant yn mynd i'w ofyn. Jayne.

latest section of the Health, Social Care and Sport Committee here at the National Assembly. We move on now to item 6, continuing with our inquiry into loneliness and isolation. This is evidence session 9, and before us we have witnesses from Glamorgan Voluntary Services. So, it's a pleasure to welcome Rachel Connor, chief executive of Glamorgan Voluntary Services; and also Linda Pritchard, health and social care facilitator, Glamorgan Voluntary Services. We've received your written evidence. Thank you very much for that. Our questions stem from your report, and also issues that have been raised in the other evidence that we've received. So, with that preamble we'll go straight into the first question, and Jayne Bryant is going to ask it. Jayne.

[335] **Jayne Bryant:** Diolch, Chair. Good afternoon. We've just heard from some witnesses—the last witness, actually—who talked about the importance of embedding third sector organisations into GP surgeries. Perhaps you could say how you'd feel about that, and perhaps look at how GP surgeries would be able to help and support people who are socially isolated and lonely.

[336] **Ms Connor:** I think we do actually have a really good example of that, and I think Linda is probably the best person to give details on that particular project.

[337] **Ms Pritchard:** There are two aspects to that. One of them is with the work we do in Barry. Within all the surgeries in Barry, there is a third sector champion, who will either be a practice manager or will be a receptionist, and that was set up with the help of the lead GP in Barry. They put themselves

forward for this role, it's obviously a voluntary role, and they are my link person. So, I maintain contact with them, I send them information about the third sector, but I also organise third sector stands in the surgeries and that's worked really well. We'd like to roll that out to other areas, but it's really good, because I'm their point of contact in the third sector, and they're my points of contact.

[338] But there is also a project that United Welsh are running called Wellbeing4U, and that was funded by primary care funding. What is happening is that it's Cardiff and Vale, they have well-being co-ordinators within some of the surgeries in Cardiff and Vale, and they have different types of co-ordinator: one does more intensive work with people, the other one is more of a signposting role. They don't cover all of them; they haven't got the capacity to do that. But they are working with some of the GP surgeries, and they will take referrals.

[339] The interesting thing about that is that was intended partly for social prescribing, but also partly to increase rates of flu vaccination and uptake of screening. But what's actually happened is that they have had numerous referrals—75 per cent of their referrals are people who have a mental health issue and who have attended GP surgeries quite a lot, not necessarily because they need to, but that's their only point of contact, and they don't know where else to go. They worked with one person who had, I think, attended the GP surgery nearly 50 times in six months, but since working with United Welsh has been there about six times in the last six months. What they actually needed—what they find is people actually needing a connection into the community. They need someone either to do the in-depth work with them to build their confidence up so that they can then go and access different community services, or they need signposting.

[340] So, that's actually worked really well, I believe that it's been going for two years. Their findings are really interesting and I believe that there will be further funding. It takes time to set up, but it has worked well, and I think as more GPs come on board, more of them want to have that presence, but there isn't, at the moment, that capacity.

[341] **Jayne Bryant:** That evidence is available then to show how it's helped to reduce the time pressure on GPs, as well, then.

[342] **Ms Pritchard:** We're quite fully costed.

[343] **Ms Connor:** I guess that there's another element to it. It's a signposting service, one element of it, and, of course, if you're signposting to local third sector organisations or services, there's a hidden cost, isn't there? It's not just the cost of employing those connectors within the GP surgery, but it's making sure that you have actually got organisations and services that are properly and effectively resourced that they can signpost people to. So, it's a holistic approach, and I think that's most important.

[344] **Jayne Bryant:** That's what I was going to come on to, about the importance, really, of signposting. Perhaps you could say something particular about people with dementia and their carers. How does that information get out to that group in particular? Is it the same as for everybody else?

[345] **Ms Connor:** On a personal note, having gone through this with a parent, it tends to be through the GP, and then a variety of information is provided. It is then up to the carer to take the step to make those connections, and I know that there are a variety of projects out there that do, actually, come to people who are experiencing Alzheimer's or dementia to support, within their home, individuals and carers directly, so that it's not always about the individual having to go to a centre to access a service, but that there are services that actually come to individuals.

[346] **Jayne Bryant:** I think that's another point, which is about people who are carers, really, and their social isolation and loneliness. It's very difficult for them to get out to access certain services if they're caring for somebody. I don't know if you want to say anything about that, the importance of carers.

[347] **Ms Connor:** Everybody is an individual and everybody will approach the problem in their own way. I guess it's about making sure that there is information in a variety of different formats, and different ways of accessing that information.

13:30

[348] As I say, everybody will access things and take a different approach, and it really is important that we have those more local services that are available to carers to interact with and to access. A lot of services can be set up on a regional basis, but there's nothing that works more effectively than a local service for local people.

[349] **Dai Lloyd**: Caroline sydd nesaf. Rwy'n credu bod rhai o'r cwestiynau rwyt ti'n mynd i'w gofyn wedi'u hateb yn rhannol eisoes.

Dai Lloyd: Caroline is next. I think some of the questions you were going to ask have been partly answered.

[350] **Caroline Jones**: Yes. One has sort of been answered.

[351] **Dai Lloyd**: Ie, dyna ti.

Dai Lloyd: Yes, that's right.

[352] **Caroline Jones**: Okay. There are opportunities to reduce loneliness and isolation in the community—for example, the senior health shop in Barry. How are older people made aware of the existence of the shop? Can we take into account transport and mobility issues? Can you tell me what thoughts you have on that, please?

[353] **Ms Connor**: I would say that that's a fantastic example. It's a brilliant service. It was the first of its kind in the UK, so a great deal of kudos to Age Connects for having the foresight to set that up. It's actually on the main thoroughfare in Barry, so it's in the centre of the town, so it's a highly visible, high-profile site. I guess, within the community of Barry, most people are aware of it, but there are a variety of other mechanisms that Age Connects uses for getting that message out there. It's well used by a variety of other third sector organisations to deliver their services, and I think there are directories that promote the existence of this service, which are available to our colleagues in GP practices and our colleagues in social services and health, as well.

[354] **Ms Pritchard**: And Age Connects has a Good Neighbour scheme in the Vale, so, of course, they'll be able to refer within their own services as well. And it's actually quite a good network of organisations working well together; you know, the British Red Cross has Positive Steps in the Vale and they liaise very closely with Age Connects and Care and Repair. They all work very well together, so they're able to cross-refer, which I think is good.

[355] **Caroline Jones**: Certainly.

[356] **Ms Connor**: There's also an individual worker based within the call centre of the local authority who has the knowledge and the training to be able to signpost people directly if they're phoning up with a query that could be about Alzheimer's or about whether their elderly parent or relative requires a particular service. This individual has got that connection, actually

from within the call centre, and is an Age Connects Cardiff and Vale employee.

[357] **Caroline Jones:** What sort of percentage of people have issues regarding transport and so on?

[358] **Ms Connor:** In the rural Vale, it's high. The transport system is not great. Over the years, we've developed a variety of community transport schemes, but they're not as flourishing, I guess, as we would like them to be. So, there are major transport issues.

[359] **Caroline Jones:** Yes. So, are there any provisions or support in the pipeline that you can envisage to accommodate this?

[360] **Ms Connor:** One of the community transport schemes is called Greenlinks and that will actually pick up individuals from either their homes or near their homes and take them to appointments or activities, and that can be booked in advance. So, that, in the main, is in the western Vale. In the eastern Vale, we've got East Vale Community Transport operating a similar sort of system, but you can see that those are just two elements and the Vale is larger than that and the requirement is larger than that.

[361] **Ms Pritchard:** It's quite patchy, isn't it? Dinas Powys Voluntary Concern are very good with transport. They take people to hospital appointments as well and do the bus service to the local GPs. Age Connects, with Good Neighbour, have volunteer drivers, but transport is something that comes up all the time, as a real gap.

[362] **Caroline Jones:** Okay, thank you.

[363] **Dai Lloyd:** Symudwn ymlaen. Rhun, efallai bod yna rai cwestiynau, eto, sydd wedi'n rhannol cael eu hateb, ond mae'r llawr i ti.

Dai Lloyd: Moving on. Rhun, maybe some of the questions, again, have been partly answered, but you have the floor.

[364] **Rhun ap Iorwerth:** Os cawn ni edrych ar natur wirfoddol y grwpiau rydych chi'n ymwneud â nhw, mae yna heriau penodol yn codi o'r ffaith mai gwirfoddol ydyn nhw. A allech chi ddweud wrthym beth ydy'r prif

Rhun ap Iorwerth: If we could look at the voluntary nature of the groups that you're involved with, there are specific challenges arising from the fact that they are voluntary. Could you tell us what the main challenges

heriau rydych chi'n eu hadnabod? Mae cyllid, rydw i'n dyfalu, yn un eithaf amlwg, a recriwtio gwirfoddolwyr, hyfforddi gwirfoddolwyr hefyd. Beth ydy eich barn chi?

are that you can identify? Funding, I can imagine, is quite an obvious one, and the recruitment of volunteers, the training of volunteers as well. What's your opinion?

[365] **Ms Connor**: Probably the second-most concerning issue for small, third sector organisations—and medium-sized and possibly larger organisations—in the Vale, and the Cardiff and Vale region is the short-term element of funding, and the difficulty, then, for an area like the Vale to be able to retract funding from major funding bodies. The Vale is viewed as the 'leafy vale' and so if we're not actually in receipt of resources directly from local authority or health board, it can be a massive challenge to access resource. It's also an element, I guess, of ICF—that there's been a short-term approach to some of that funding and the issue around lack of notice, or very short notice, that resources are coming to an end, or that uncertainty between a one-year contract and possibly extending it into a second year, so that those organisations haemorrhage staff with the skills, the knowledge and the experience. And then you can have a gap in the service provision where they're trying to recruit people back into something that was working perfectly well, but the apple cart has been upset by that lack of continuity in access to resource.

[366] **Rhun ap Iorwerth**: And all of us in our constituencies, I'm sure, will have come across plenty of voluntary organisations who say the same thing. There has been a recognition that short-term financial commitments by Welsh Government or local authorities is a problem and, therefore, three-year funding plans are supposedly becoming the norm. Are you seeing signs that there have been changes that give slightly more long-term security than, say, a few years ago, or not?

[367] **Ms Connor**: No. I would suggest it's the opposite. It's becoming more and more uncertain.

[368] **Rhun ap Iorwerth**: Is the rhetoric that you're hearing confirming what I'm saying, that there's meant to be this shift towards more long-term funding? Are you hearing some of the right things, which then doesn't get matched by actions?

[369] **Ms Connor**: I think the focus on procurement as the mechanism for

engaging with third sector, particularly small third sector organisation, is flawed. It's an extraordinarily onerous mechanism for accessing, perhaps, £15,000, which will make a massive difference. It probably works for £150,000, but, for small amounts to small local organisations, we are putting up barriers and preventing them from accessing funding. I think it's been quite interesting that, over the years, there have been some developments towards working as consortia, so larger organisations working together with small local organisations and helping them through some of those difficulties and barriers. And we certainly have been involved with delivering a consortium project that was lottery funded, entitled Friendly AdvantAGE, and that included some of the larger organisations that were providing befriending services to older people, but it also included some very small, local projects. And it was a great learning experience for those small local projects and organisations being able to work alongside the larger organisations. But there's a cost to that, in supporting and managing consortia working, and so if you're adding that into the formula for bidding for a contract, then you could actually be reducing your chances if the agency that's looking for the service is looking for a reduction in cost.

[370] **Rhun ap Iorwerth:** One separate issue, if I could, as well—. Most of your written submission—and thank you for it—refers to loneliness and isolation issues with older people, but you do reference the fact that younger people in their 30s and 40s with long-term conditions specifically may well be isolated and lonely. Do we have to think of tackling isolation and loneliness in very, very different ways for those different age groups, or are the same models relevant to whichever groups we're talking about?

[371] **Ms Pritchard:** I think what was coming out with that finding—. It was through the Age Connects third sector broker, who is based in the contact centre in the Vale, and that has been going for about two or two and a half years. And that was happening initially when the broker came into place, and the referrals were meant to be frail older people, but they were actually getting a lot of referrals for younger people with long-term conditions, which they weren't necessarily expecting. What people were asking for—people with multiple sclerosis, epilepsy, motor neuron disease and so on—was somebody to help them go to social activities. So, they were probably looking for something slightly different, but they sometimes either didn't have the confidence or they had mobility issues, but they were quite isolated and quite lonely and needed help to go out to do some of the things that they'd done before.

[372] So, I think some of the solutions may be quite different ones; they may not want—. We know that some older people like to have a phone call every week, but people who are a bit younger actually wanted to go out and join in in the communities. So, that came out as a result of the broker role. Like I say, the broker role continues, but the referral process was changed slightly so that it was more the frail elderly. But I still think there's a huge gap. I think there's a huge gap for people with long-term conditions in their 30s and 40s.

[373] **Rhun ap Iorwerth**: What about younger people who face loneliness not through health reasons but perhaps social reasons, because transitions in life, separations and job loss, or whatever it might be, can lead to isolation and loneliness? Has that been something that you've looked at, or mechanisms for dealing with it?

[374] **Ms Connor**: We have a project that's been running for the last six months called Pave the Way, which is working, in the main, with people of all ages with mental ill health. And what we're finding is that to enable that development of confidence, we need to look at a foundation stage for people getting out and about. They need to have that buddy—they need to have a volunteer buddy, as it happens in the case of this particular project—to provide them just with that general confidence building to take them and support them to go to activities that they want to go to, that they, perhaps, used to go to, but through a life event, have lost that confidence. And what we're finding is that, actually, some of those individuals who required the buddy in the first place go on to become buddies themselves.

[375] I think this is probably an approach that we need to be looking at for more and more of our lonely and isolated members of the community. It's about recognising that they have assets as well; they're not just requiring a service—they can give back. And once they've got that confidence—

[376] **Rhun ap Iorwerth**: That could be relevant to people of any age.

[377] **Ms Connor**: Yes, absolutely.

[378] **Dai Lloyd**: Ocê. Y cwestiwn olaf gan Angela.

Dai Lloyd: Okay. The final question from Angela.

[379] **Angela Burns**: I just want to pick up on some of the stuff that you said to Rhun and to Jayne about the GP surgeries and also Positive Steps—both

are fantastic projects. People go to them or are picked up because they're going to the GP for the twentieth time in one minute and are taken forward. Do, for example, the Barry third sector champions actually go back into the health boards as well? Because I think Rhun mentioned transitions, and one thing we've really learned is that transitions is a key area for people who experience loneliness. So, the GP might know when someone's going to come out of hospital and the hospital, because they're supposed to do their due diligence about whether they can go back safely, should know whether there's someone at home and should have a pretty good feeling for whether they've got friends and neighbours around them or not. Is there a way of being able to link that kind of thing up to the champions who can then, perhaps, say to the third sector organisation, 'Beryl Jones is going to come out. She's all on her own, she's 92 and she's just recovered from a broken femur. Can we get around to her, because she's probably going to be quite isolated and probably lonely in her home?' I just wondered if it was—. I'm not sure how good the health boards are at engaging with all this process.

13:45

[380] **Ms Pritchard:** I'm not convinced that that necessarily happens, but what will happen is that the Age Connects hospital discharge service will pick up some of the people, depending on how good the referral process is within the health board and with, say, the social workers who are on the wards. So, I would say that within Cardiff and Vale health board there's a fairly good knowledge about Age Connects hospital discharge, because the hospital discharge will kick in as soon as someone comes out and provide six week or four weeks of quite practical support. But the fact that they've been picked up by that service will mean that Age Connects will refer to other services, either their own or they'll refer to, say, the Red Cross or Contact the Elderly or whoever. But I don't think that the knowledge of the hospital discharge service is across everywhere in the health board, I would say, because I go to some of the clinical board meetings, and sometimes with Age Connects—we talk about that service, and there are still people who don't know about it.

[381] So, there is a sort of onward—. It can be, I have to say, quite difficult getting into some of those meetings in the health board, even though we have pretty good contacts, so we make the most of them when we get there. But it is interesting sometimes when you see people and maybe the clinicians, perhaps, who don't always know that there is this service, which is health board funded, anyway. So, we do an ongoing—. That's part of the role that we do—to support organisations to promote what they're doing—but I

think we've still got a bit of a way to go before it is fully joined up.

[382] **Angela Burns:** I think the champions in the GP surgeries are a great idea, but if we can make them look at that kind of system, but be a bit more proactive, because, again, a GP will know if somebody's died, so they're going to have access to knowledge that perhaps would take a long time to filter out in other areas. I also just wanted to quickly ask you if you'd seen much evidence that recent legislation in terms of the Social Services and Well-being (Wales) Act 2014 or indeed the Well-being of Future Generations (Wales) Act 2015 has actually started to impact on the way organisations are working and looking towards the well-being aspect of people's health.

[383] **Ms Connor:** I guess the involvement of third sector in the development of the population needs assessments and the well-being assessments has provided a new line of connection to ensure that we are getting that knowledge and information in and out of statutory services in particular. For the third sector, I guess a lot of what is included in those particular documents, many were already ahead of the game and already delivering on those lines, so it is perhaps more about our statutory partners and the way that they look to deliver. I think it's quite interesting that there's a stated commitment, I think, coming from lots of regional partnership boards, having seen the evidence of the needs assessments, that social isolation and loneliness is an absolute priority that's come out very high in all of those assessments, but that there's this commitment to moving some resource towards prevention, and I guess we're not seeing that happening yet. I'm ever hopeful, but I guess there's also a little caveat about whether they're viewing it as a movement of resource to their own preventative services, whereas what we're talking about, particularly against loneliness and isolation, are those community-delivered local services that are the ones that are of most support to people who are suffering from loneliness.

[384] **Angela Burns:** Reading your paper, for which I thank you, my final question would be: what would you like to see on your wish list of the isolation and loneliness strategy being produced by the Government? You do end up in your conclusion saying that a national indicator and the fact that loneliness and isolation are getting this kind of airtime are two big wins. Would you like to add a third win to that?

[385] **Ms Pritchard:** What we do is we promote the third sector. We know of all the different services that are out there, and there are absolutely brilliant third sector services, but sometimes we still have to persuade our partners of

the efficiency and the effectiveness of services when we know some of them have been running for ages. And it would be nice to be able to get past that point really where—. Everyone has to evidence what they're doing and that's absolutely fine, and I think the third sector's very good at doing that, but sometimes we are explaining again how brilliant the hospital discharge service is, or how excellent a befriending service, or how brilliant Dinas Powys Voluntary Concern are, and we feel like, sometimes, we are going over old ground and that there should be that sort of acknowledgement really, rather than us constantly having to encourage partners to understand.

[386] And the governance of the third sector: we've had some interesting conversations with some partners who have expressed concerns about the governance, and we've explained how organisations have a board of trustees, how they recruit staff, how they recruit volunteers, what checks they do, because it's actually quite a well-governed sector. So, I suppose it's that really; it's kind of moving on a little bit from that persuading that we do to that joint acknowledgment by all partners. And then I think we'll move forward a little bit more to having some of those more important talks about how we further develop services in the future.

[387] **Angela Burns**: I'm so glad you've brought up that point, because I know that people have come to see me and they've been frustrated because they've had a project that's run well, is doing well, and is delivering results, but they can't get the funding because actually what people want to see is a new project. And you think, 'Well, why not just carry on with the one that's working? Do we have to keep reinventing the wheel?'

[388] **Ms Connor**: It's one of the greatest frustrations, and we've certainly had that example with the lottery-funded Friendly AdvantAGE befriending scheme that I talked about earlier. And, from that, we did, after a great deal of lobbying and hard work, and with the support, actually, of the local authority in the Vale, manage to get some elements of the befriending schemes funded through the ICF. But you would have thought that was a given, really, that that particular strand would have been there to pick up on some of those issues, and could then have addressed a lot more on the preventative side.

[389] **Angela Burns**: Okay. Thank you.

[390] **Dai Lloyd**: Ocê. Mae ein hamser ni ar ben. Diolch yn fawr iawn **Dai Lloyd**: Okay. Our time is up now. But thank you very much to the both

i'r ddwy ohonoch chi—sesiwn arbennig yn fanna. Diolch hefyd, fel mae pawb wedi'i ddweud, am eich tystiolaeth ysgrifenedig ymlaen llaw. Mi fyddwch chi hefyd yn derbyn trawsgrifiad o'r cyfarfod yma i gadarnhau bod pethau yn ffeithiol gywir. A chyda cymaint a hynny o eiriau a allaf i ddiolch i chi unwaith eto a chyhoeddi i fy nghyd-Aelodau gwnawn ni dorri am egwyl fach o bum munud rŵan cyn y sesiwn nesaf? Diolch yn fawr.

of you. It was an excellent session. Thank you also, as everyone has said, for your written evidence beforehand. You will also receive a transcript of the meeting to confirm that everything is factually accurate. And with those words could I thank you again, and announce to my fellow Members that we'll have a five-minute break before the next session? Thank you.

Gohiriwyd y cyfarfod rhwng 13:52 a 13:57.
The meeting adjourned between 13:52 and 13:57.

Ymchwiliad i Unigrwydd ac Unigedd: Sesiwn Dystiolaeth 10—Men's Sheds Cymru
Inquiry into Loneliness and Isolation: Evidence Session 10—Men's Sheds Cymru

[391] **Dai Lloyd**: Croeso yn ôl, felly, i'r adran olaf o'r Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon am heddiw. Rydym ni yn symud ymlaen i eitem 7, parhad o'r ymchwiliad i unigrwydd ac unigedd, sesiwn dystiolaeth rhif 10. Mae'r sesiwn dystiolaeth yma yn dod oddi wrth Men's Sheds—cabanau dynion, efallai, cabanau dynion Cymru, Men's Sheds. Croeso i Rhodri Walters, uwch-reolwr prosiect a datblygu Men's Sheds Cymru. Rydym ni wedi clywed toreth o dystiolaeth, felly, yn yr amser, rydym ni'n mynd yn syth i mewn i gwestiynau, ocê, Rhodri, ac wedyn mae'r cwestiwn cyntaf o dan ofal Jayne Bryant.

Dai Lloyd: So, welcome back to the last part of the meeting of the Health, Social Care and Sport Committee for today. We move on to evidence session 10 on the inquiry into loneliness and isolation. This evidence session is from Men's Sheds—*cabanau dynion,* maybe, in Welsh. I welcome Rhodri Walters, senior project and development manager with Men's Sheds Cymru. We have heard quite a bit of evidence, so, in the time we have, we'll go straight into questions, if that's okay, Rhodri, and the first question is from Jayne Bryant.

[392] **Jayne Bryant:** Diolch, Chair. Good afternoon. Perhaps you could just outline a little bit more about Men's Sheds, why you started, and how you're tackling social isolation and loneliness through your project.

[393] **Mr Walters:** Yes, absolutely. My involvement with Men's Sheds started probably about five years ago. I was working in the university sector at the time, working on the Wales-Ireland INTERREG programme, and whenever I was on the ferry kept reading these stories in the Irish papers about Men's Sheds and how all these communities were really pulling together. As someone who's always worked in social-type projects, something really struck me about the beautiful simplicity of it all, really. They were small, genuinely community-led groups and they were springing up all over the place. At that time there were about 130, I think, in Ireland, and these days there are about 300 in Ireland. I looked into it a bit more and saw that it started off in Australia. There are over 2,000 sheds in Australia. Obviously, that's pretty much linked to the increased population there. But they were really part of the national culture there. Every major town or large village seemed to have a shed there and they were generally seen as the place to go to. In some ways, I guess, they're replacing the old role of the church or the pub or the old community centre there.

14:00

[394] But they were somewhere not just for the shed members themselves but for other community members. People were very aware that they could pop down there and perhaps the shed could help them out or, most importantly, if they had men in their lives who had time on their hands for whichever reason—and that's what we keep on coming back to, Men's Sheds are for any men, any age, any background. They haven't got to have an issue as such, it's just, if they've got time on their hands and they would benefit from the company of others, the sheds are for them.

[395] So, I just looked into it further and tried to get a couple of things going in Wales, and then managed to get lottery funding, which is how we're currently funded, for a three-year programme, to fund a very small, part-time team. But we've now managed to get up to about 35 sheds across Wales. Going on those Irish and Australian stats, the saturation point or the point we're aiming for in Wales would be about 110 sheds. That's the stage we're at at the moment: we're trying to seek further funding to see if we can get up to that higher level of sheds, which would mean men across Wales

would have a shed within easy-ish distance to get to—

[396] **Jayne Bryant:** So, what sort of thing happens when you go to a shed, then? Perhaps you could explain a bit more. Are they are all different, or—?

[397] **Mr Walters:** I think the key thing about Men's Sheds is it's an approachable brand, which people can really relate with. The 'sheds' bit is perhaps a bit misleading, because they haven't got to be a shed, they can be a disused shop unit or the back room of the community hall—anything, really. It's just a place where men can get together. They haven't got to be doing traditionally manly things like woodwork and metalwork and stuff. Equally, they could be doing creative writing, art, computers—the ones in Pembroke Dock listen in to ferries as they come in and things. I don't know if that's legal, but I'm sure it's okay. [*Laughter.*] It's basically whatever it takes to get a common interest. But the most important thing, really, is that kettle in the corner of the room. When they get together, they have a cup of tea. The entire notion of the shed is that men are very bad are talking face to face, but they're quite good at talking shoulder to shoulder. So, when they're doing some sort of activity together, that's when they'll share concerns about health or, obviously, in the context of today, isolation and loneliness.

[398] **Jayne Bryant:** So, as you've just outlined, that's the specific need that men have—they find it much harder to generally communicate.

[399] **Mr Walters:** Yes. Yes, it's definitely recognition and acknowledgement of isolation and loneliness as a key thing for men, particularly, I think, as they get older as well. If you call something an 'isolation and loneliness prevention group', you're not going to get many people to come along—[*Laughter.*]—but people are very happy to go to the sheds. Some people are very quick to recognise, 'Yes, I'd benefit from that'. You see in other cases that men come along to 'help out' for a few weeks. Perhaps they help out with this and that and then they slowly stay a bit longer and would eventually admit, almost, that they're shed members.

[400] **Jayne Bryant:** I think, as you say, the language that we use is really, really important to try to get to people. What about different ages? Are they generally older people who are going to these or—?

[401] **Mr Walters:** They are at the moment. In those more mature shed markets of Ireland and Australia, there's a better cross-section of age groups. In Wales, it does tend to be white men, 60 plus, perhaps due to

retirement or bereavement having more time on their hands. We'd love it to be a better cross-section, but I suspect that's something that can come with time. It's certainly something we're looking to attract younger people to.

[402] **Jayne Bryant**: Okay, thanks, Chair.

[403] **Dai Lloyd**: Caroline nesaf. **Dai Lloyd**: Caroline next.

[404] **Caroline Jones**: Diolch, Chair. Good afternoon, Rhodri, lovely to meet you. Could you please tell me to what extent Men's Sheds is able to meet the needs of men at high risk of loneliness and isolation, and particularly carers and those from BME communities or those who are LGBT or have mental health issues or other illnesses or impairments?

[405] **Mr Walters**: I think, for me, one of the things that attracted me to it and the reason it's been able to go up to 35 sheds so quickly is, to some degree, it's quite disorganised, it's quite informal—and I mean that in a very positive way.

[406] **Caroline Jones**: It's spontaneous, yes.

[407] **Mr Walters**: Yes. Hopefully, that means that the sheds generally do reflect their communities, and, because there's no shed co-ordinator there, because you haven't got to go in and register and fill in lots of ESF forms and things straight away—people can literally just pop in for a cup of tea or something to start off with. We would like to think that that's a key part of its attractiveness to people, that they don't feel that they're joining a sort of project or a scheme or a service. I suppose that's where it does draw comparisons then to those things that used to be in communities, such as the pub, for example. I think, particularly for some people, perhaps the rugby club or something would be the place they'd go to socialise. For some people, that doesn't suit them. If there are alcohol issues, for example, or something like that, meeting people in a pub is not going to be the best option. I think that's the accessibility bit of it; that it's actually run by community members. Sometimes there's a very random group of people there, but once they start to pull together, it's nice to see that brotherhood between them, then.

[408] **Caroline Jones**: And how accessible is it for men with limited mobility?

[409] **Mr Walters**: Obviously, each shed is different. When we are assisting

people to set them up, we always try to make sure that they are in the most accessible places possible. Obviously, they're not highly funded, highly organised projects, so sometimes it's not perfect to start off with, but that informality can mean that people really do pull together to make sure that it is properly accessible for everyone.

[410] **Caroline Jones**: Yes, the community spirit.

[411] **Mr Walters**: Because sometimes, you could build a very accessible building, but it's not very accessible for people, whereas a less perfect building is actually a far more accessible place to access, then, if that makes sense.

[412] **Caroline Jones**: Thank you. And how are people referred to, or made aware of, the scheme? And its links with statutory and non-statutory bodies.

[413] **Mr Walters**: I think one of the biggest challenges we've had to start off with is to explain that there are no referrals there. In my experience, if you refer somebody into something, they could sit there with their arms crossed for half an hour and can't wait to leave. So, any shed member has to want to be a member and want to be there. It's an unusual relationship with the statutory sector. Obviously, we welcome any interest and attention we get from there, and passing information on and telling people about the sheds and what we can do for them is really useful, but it's tricky, then, if it's seen as a free service where people can be pushed on to, really. Unfortunately, that's our experience of referrals, often; people aren't quite sure where to send someone, so they just jump from one service to the next.

[414] **Caroline Jones**: Thank you. It sounds very exciting.

[415] **Dai Lloyd**: Rhun.

[416] **Rhun ap Iorwerth**: Diolch. Rydych chi wedi egluro yn barod mai cyllid loteri sy'n talu amdanoch chi. Mae'r math yna o gyllid yn mynd ac yn dod, felly rwy'n cymryd eich bod chi'n cynllunio am ddyddiau ar ôl y cyllid loteri. Beth ydy'r her i chi o ran gwneud i'r cynllun yma fod yn gynaliadwy yn yr hirdymor? A pha

Rhun ap Iorwerth: Thank you. You've already explained that lottery funding pays for you. That kind of funding comes and goes, so I take it you're planning for days after the lottery funding. What is the challenge for you in terms of making this scheme sustainable in the long term? And how similar is that challenge to that

mor debyg ydy'r her yna i chi i bob mathau o grwpiau gwirfoddol tebyg eraill?

faced by other, similar voluntary groups?

[417] **Mr Walters:** Byddaf i'n ateb yn Saesneg, os caf i.

Mr Walters: I'll answer in English, if that's okay.

[418] **Mr Walters:** At the moment, we're going for a new batch of lottery funding. As for any third sector group, there's always that nervous period between being close enough to the end of the project to be able to apply for something, but then that nerve-wracking period of will we or won't we get it. It's tricky to know which fund to go for, because if we go for more mental health-based funding, for example, there's the danger then that it's seen as a mental health project, and so on, and so on.

[419] In trying to plan for the long-term sustainability, we're actually setting up a co-op now, as an association of Welsh Men's Sheds. So, I've got three or four shed leaders, if you like, those who've been running sheds for a longer period of time, to work with the Wales Co-operative Centre to set up a co-operative. My belief is that once there are enough sheds in Wales, hopefully, there is no need for people like me anymore and there is no need for funding, because it will just have a life of its own there. Obviously, that's a bit of a utopian view in the meantime. You know, it will take a long time. And with a small amount of membership fees and so on from each shed, it's unlikely that we'd ever get to a number where that co-operative could employ a number of people, and so on.

[420] The strong thing for us, though—. It's a challenge when we go into new groups, for example. I don't know if we suffer from project fatigue in Wales, sometimes. You know, people are so used to 'them' coming in and sorting things out, and often the first thing that people talk about is, 'Oh, they should do something about it'. And the challenge I come back with is: who are 'they'? We are 'they', now, and it's the difference—but I'd like to think with this project that it's all about communities actually taking responsibility for things themselves.

[421] Of course, we're there to help with some of the boring things—you know, help them with the constitution or advise them perhaps what insurance is needed, and so on. But we do always try to put the responsibility back on the communities there. Often, within any group of people who are interested, there are two or three people there who can really take it to the

starting point, and that's often not the men; it's often the women who will come along to start with. Over 50 per cent of the sheds have actually been started by women. I don't know, perhaps the women have got more get-up-and-go to get these things going in the first place. But the key thing for us is that it doesn't start to look like an overly funded project, if you like.

[422] I heard you ask the group before about their wish list. My wish list wouldn't be for lots and lots of money. I think that too much money would probably change and distort the Men's Sheds concept too much. I don't know if I'm going to get the wish list question as well, but—

[423] **Angela Burns**: I'll ask you now: what's the wish list? [*Laughter*.]

[424] **Mr Walters**: There we go. I think the wish list for us is an awareness from town and county councils and other public bodies, in essence, that if they have land or resources there, then it is actually okay to give them to the community now and again. It's a struggle we find—often we can identify publicly owned buildings there that are going to waste that would be absolutely perfect for something like this, but often there is a culture of resistance there. They're not being used for anything else and, as far as I can see, this is a great use of public resource. I've got some stats for you to see the difference it makes to people's lives there. Some sort of guidance or—[*Inaudible*.]—from the Assembly could be very useful in saying that it is a good use of public money for these resources to actually be—not given away, but handed across on very low-cost leases and so on.

[425] **Rhun ap Iorwerth**: Rydych chi wedi sôn am y *stats*. Rwy'n cymryd, wrth ichi wneud cais am arian i bwy bynnag, eich bod chi angen gallu profi eich bod chi wedi gwneud hyn ac wedi gwneud y llall—a diolch yn fawr iawn i chi am ddod â hwn efo chi. A allwch chi grynhoi'r math o dystiolaeth sydd gennych chi eich bod chi yn gwneud gwahaniaeth i bobl o ran iechyd a llesiant, ac unigrwydd, o bosib, yn yr achos yma?

Rhun ap Iorwerth: You've mentioned the stats. I take it that, as you make applications for money, you are able to prove that you've done this and done that and so forth—thank you very much for bringing that with you. Could you summarise the kind of evidence that you have that you are making a difference to people in terms of their health and well-being, and loneliness in this case?

[426] **Mr Walters**: You'll see some stats being passed around there. As you can imagine, we've conducted numerous surveys and scoping exercises and

so on to try and get the next batch of funding. The numbers from my perspective are very, very high—it's usually in the eighties or nineties there about people recommending the sheds to others and recognising that they have a place to go in the community now. An interesting stat is that 37 per cent of Men's Sheds members have never joined a group before, so this is the first time they've really tried something like this, which is pretty unusual for social projects.

[427] Working with other social projects, you do tend to see the same people and the same type of support groups sometimes, so this does attract a different type of person. I think the key thing is that they're people who would have never acknowledged, perhaps, beforehand that they have a loneliness issue really; they just know that they have got time on their hands and they would like to know more people in the community and so on. Perhaps that's reflected in the geographical spread of sheds in Wales as well—there tend to be clusters around coastal places in particular: on the north Wales coast, for example, those places like Colwyn Bay, Rhyl and Prestatyn and so on. There are real clusters there. Does that reflect people who have recently moved to the area? There's a lot of social research there. I also know where the gaps are: there are too many gaps in the Welsh Valleys, for example. Perhaps that goes back to the project fatigue side of things and perhaps there are more things to be doing there.

[428] Mid Wales has big gaps and I think, in Welsh rural communities, no matter how many older Welsh farmers who I speak to in events and things, it's very hard to get them to come along. There are very low levels of being able to admit that there's perhaps a loneliness problem there. Perhaps people have led quite solitary lives as farmers in the first place. But Welsh language and Welsh agricultural communities—we are finding hard to get to them at the moment. The design of our next project reflects that a bit. For a start, we've got more staff resource. At the moment, we've realised that for a small country, it takes a very long time to drive around Wales and that's a very difficult challenge for us. But definitely, the next thing is to try and get to those communities without a voice, be they in the Welsh hillsides or be they actually in Newport or the centre of Cardiff in BME communities, as you mentioned earlier. Our next challenge is to get this message to the communities that haven't engaged with us so far, basically.

[429] **Rhun ap Iorwerth**: Roedd yn ddiddorol nawr eich bod yn sôn am gymunedau iaith Gymraeg. A oes

Rhun ap Iorwerth: It was interesting there that you mentioned Welsh-speaking communities. Is there an

bwriad i gael rhai sy'n cyfarfod yn y Gymraeg? Ac i agor y peth yn ehangach, pa mor bwysig yw hi bod y math yma o grwpiau, beth bynnag ydyn nhw, yn *bespoke* ar gyfer y gymuned y maen nhw wedi'u targedu atyn nhw?

intention to have those who meet in Welsh to open up more broadly, and how important is it that this kind of group, whatever these groups are, are bespoke for the communities that they're targeting?

[430] **Mr Walters:** That's absolutely right. The tailoring of the group to the interest and the area is key. In the coastal areas, perhaps it's more to do with renovating an old boat, for example, or in an agricultural community, perhaps there's an old tractor to restore or something like that. The truth is that we don't know why there is less of an intake amongst those Welsh-speaking communities. It could be that there are alternatives out there, other things: perhaps just going down to the mart every week. That's the biggest shed out there, almost, if you like. You know, it's the same type of setup: just bump into people, have a chat and so on. Are there better community groups in those areas? Does the local pub or the church, for example, still serve that purpose and there's less need for it? We don't know, really. It's still quite a young movement in that sense.

14:15

[431] **Rhun ap Iorwerth:** Ydy rhai ohonyn nhw yn cyfarfod yn Gymraeg?

Rhun ap Iorwerth: Do some of them meet in Welsh?

[432] **Mr Walters:** We haven't got an exclusively Welsh-speaking shed yet, but probably reflective of Wales, within the shed, there are some people who speak Welsh to each other, and they flip to English.

[433] **Rhun ap Iorwerth:** Cwestiwn arall: ar wahân i'r *obvious,* beth fyddech chi'n dweud yw'r gwahaniaeth rhyngoch chi a Merched y Wawr neu'r WI?

Rhun ap Iorwerth: Another question. Apart from the obvious, what would you say is the difference between you and Merched y Wawr or the WI?

[434] **Mr Walters:** Very little difference, and that's the best comparison we've got, really, in trying to explain it. Men's Sheds are basically the Women's Institute or Merched y Wawr, for men, basically. There's nothing sexist or anti-women about Men's Sheds in any way. It acknowledges the fact that men behave differently when they're in a single gender space. It's amazing

how men do change once there are women in the room and so on. Some of the conversations that men have with each other are quite different, and perhaps that's where the real sort of health benefits comes out of it, certainly, when they're able to have those chats one on one, with somebody they've built trust with.

[435] **Rhun ap Iorwerth**: Diolch yn fawr.

[436] **Dai Lloyd**: Angela.

[437] **Angela Burns**: I was just interested to ask you about the demographics. I would assume, probably wrongly, that your Men's Sheds men are probably in their sixties in the main, or is it quite broad?

[438] **Mr Walters**: Generally, it's the older groups, yes. There's fantastic potential for inter-generational work there, in both directions—the older men perhaps learning IT skills from the younger ones, and obviously passing on your skills and so on to the young unemployed people, for example. There's not enough of it at the moment. We'd love to see more of it. It does tend to attract older men at the moment—55 plus, say. And it's hopefully something, as the movement matures, more and more people will—. The sheds will grow themselves and we'll have a more interesting mix of people.

[439] **Angela Burns**: So, how do you find a Men's Sheds leader? How do you start one up?

[440] **Mr Walters**: The start-up process is interesting sometimes. The way we tend to do it is that we spend a lot of time just trying to raise awareness of it, and hopefully, lots of people across Wales have heard of Men's Sheds now in the first place. We do that through social media, for example, and lots of traditional meetings in a town hall type of setup. The way it starts is usually if you get two or three people in an area who are interested, we try and form them into a small little action group, and the key thing is that they haven't got to be shed members, they're just people who'd like to see a shed in the area. And it usually sort of grows from there. Sometimes, the shed leaders are those people. It's fair to say it's not a perfect world. Sometimes, you attract people who are not particularly helpful, or destructive to the cause. You get lots of wannabe property developers who want to take over the local castle or the county hall and turn it into a massive shed. They're usually quite well known in the community, if I can say that. They're usually always associated with this type of thing, and sometimes, they fizzle out

quite quickly. But you usually see a couple of people there, perhaps a treasurer, for example, somebody who's worked in accounts before, who's happy just to take a small part. And, usually, somebody who's quite organised and likes to take it on. But it's a happy balancing act then between not getting somebody who's too domineering, so it turns into their shed.

[441] The important thing is that the shed is owned by all the men there, and that they all feel that they're part of running it, really. There's nothing to say 'On Tuesday morning, you have to be building bird boxes' for example. They entirely decide when they meet, for how long they meet, what they're going to do and so on, and I think that's probably the biggest challenge for us, to know when to stay out of things, really. Because ultimately, it's their shed, and they can do what they want with it.

[442] **Angela Burns:** I think this is such an interesting concept, because unlike pretty much everything else we've heard about, which is funded, referred, organised, known by the powers that be—whether that's local authority or a health board driving it, or underpinning it or whatever—this is almost a bit like a renegade organisation and actually you need that freedom to allow people to contact it and drive it in the direction that they want. And I guess you've probably answered this question already by your reference to the WI, but I'm just wondering if we can—. Do you think this is really easy to transport to other groups of people?

[443] **Mr Walters:** I think, possibly, the message I guess we're advocating in a bizarre way is organised chaos, really—that we haven't got to all rely on very strict funding pots and very strict schemes of works, and so on, to get real social results there. I'm a strong believer that if you get communities to generally feel that it's their project, they don't become reliant on outside project workers, because the danger there, we all know, is that people move on to other jobs or funding runs out, and the entire thing collapses then. If we're too reliant on too much funds as well, obviously each fund has its own life cycle and money runs out. So many very good projects have finished in the past just because there's a gap of a few months funding perhaps, and people naturally leave to other jobs, and so on. So, I guess we're advocating a hands-off approach—that, as long as we can get people up and running and support them from a distance, which is where the Co-op will come in as well, and where a lot of our work lies at the moment, the communities can actually help themselves, really.

[444] **Angela Burns:** Are there any examples of Men's Sheds doing outreach?

You know, the guys have all got together and said, 'Look, we know about Fred who is stuck in this house down the road and can't come out. Let's go down and visit.'

[445] **Mr Walters:** Absolutely. They're involved in community regeneration work, whether that's just replanting the pots in the local train station, or something like that, down to fixing things in the local park. I suppose that's where the disorganised bit comes in very useful, because they don't have to go through a tender process. As long as there's permission to do what they're supposed to be doing, it's sort of okay, and it's to get that sort of message out there. But certainly, yes, community members in distress, and so on, is certainly—. Even if the gate has fallen off on No. 10 Downing Street, it's still something that the shed can help out with, because, you know, I think there's a real gap there. There's nothing equivalent, really, out there at the moment.

[446] **Angela Burns:** Well, honestly, all power to your elbow. We've heard very clearly what you would like to see on the wish list. Earlier on, we had the WLGA in, and it is something that I know the smaller organisations fight with—this ability to have a bit of wriggle room in a very process-driven bureaucracy, which is what underpins most of Wales. So, we'll definitely take that kind of idea forward, but it's really great. Now I know about the listening to the ferries in Pembroke Dock, I shall be phoning up my local men's shed and asking if I can come along for a visit. Are non-men allowed?

[447] **Dai Lloyd:** Non-men have set up most of them. [*Laughter.*]

[448] **Mr Walters:** That's the biggest dilemma sometimes. There are some women's sheds starting up as well, and you get all of these rhetorical questions coming in, and the answer is, 'We don't know—it's down to the shed members and the movement.' There's nothing wrong with any of these things, and what are the rules? The important thing is that they can set the rules themselves.

[449] **Angela Burns:** But it's about having that space, isn't it? And I think particularly, actually, for men, it's very difficult to find a space where they feel able to talk about stuff without really talking about stuff. So, yes, truly, great idea and I hope it prospers well in Wales.

[450] **Mr Walters:** So, I'll tell Pembroke Dock to expect a visit. [*Laughter.*]

[451] **Dai Lloyd:** Grêt, diolch yn fawr iawn. Mae'r amser ar ben am y cwestiynau. Diwedd y sesiwn. Diolch yn fawr, Rhodri, am dy bresenoldeb a hefyd am ateb y cwestiynau mewn modd mor raenus. Byddi di'n derbyn trawsgrifiad o'r cyfarfod yma ddim ond i gadarnhau ei fod o'n ffeithiol gywir a dy fod ti'n hapus efo fe. Gyda hynny, a allaf i ddiolch yn fawr iawn i ti am dy bresenoldeb?

Dai Lloyd: Thank you very much. Our time is at an end. We have reached the end of the session. Thank you, Rhodri, for your attendance and for answering the questions in such a polished way. You will receive a transcript of this meeting to check for factual accuracy and that you're happy with it. I'd like to thank you for your attendance again.

14:24

Papurau i'w Nodi
Papers to Note

[452] **Dai Lloyd:** Fe symudwn ni ymlaen i eitem 8, i'm cyd-Aelodau, a phapurau i'w nodi. Bydd Aelodau wedi gweld y llythyrau canlynol: gohebiaeth gan y Coleg Brenhinol Meddygaeth Brys; gohebiaeth gan Goleg Brenhinol y Meddygon; y llythyr y gwnes i ddanfon at Ysgrifennydd y Cabinet; a hefyd, yn dilyn ymchwiliad i ofal sylfaenol, rydym ni wedi cael gwybodaeth ychwanegol gan Fwrdd Iechyd Lleol Aneurin Bevan ynghylch arian datblygu clystyrau, a gwybodaeth yr un peth oddi wrth fwrdd iechyd prifysgol Abertawe Bro Morgannwg hefyd ynglŷn â datblygu clystyrau. Unrhyw beth i'w nodi gennych yn fanna? Na. Hapus?

Dai Lloyd: We'll move on to item 8, for my fellow Members, and papers to note. Members will have seen the following letters: correspondence from the Royal College of Emergency Medicine; correspondence from the Royal College of Physicians; the letter that I sent to the Cabinet Secretary; and following the inquiry into primary care, we've had additional information from Aneurin Bevan Local Health Board regarding cluster development moneys, and some further information from Abertawe Bro Morgannwg university health board regarding cluster development funding. Anything to note there? No. Happy?

14:24

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 17.42(vi).

Motion:

that the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order 17.42(vi).

Cynigiwyd y cynnig.
Motion moved.

[453] **Dai Lloyd**: Eitem 9, cynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o weddill y cyfarfod. Cyn i ni fynd mewn i sesiwn breifat, a yw pawb yn gytûn? Pawb yn gytûn. Diolch yn fawr.

Dai Lloyd: Item 9, a motion under Standing Order 17.42 to resolve to exclude the public from the remainder of the meeting. Before we go into private session, is everyone content? Everyone is content. Thank you.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 14:25.
The public part of the meeting ended at 14:25.