Dogfennau Ategol - Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

Lleoliad:

Ystafell Bwyllgora 3 - y Senedd

Dyddiad: Dydd Iau, 23 Mawrth 2017

Amser: 09.15

I gael rhagor o wybodaeth cysylltwch a:

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Committee Clerk

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Noder bod y dogfennau a ganlyn yn ychwanegol i'r dogfennau a gyhoeddwyd yn y prif becyn Agenda ac Adroddiadau ar gyfer y cyfarfod hwn

- Ymgynghoriad unigrwydd ac unigedd - ymatebion

Ymchwiliad i unigrwydd ac unigedd - Ymatebion i'r Ymgynghoriad

(Tudalennau 1 - 184)

Dogfennau atodol:

Ymchwiliad i unigrwydd ac unigedd - Ymatebion i'r Ymgynghoriad

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LI 02 Gofal mewn Galar Cruse (Saesneg yn unig)

LI 03 Local Area Coordination Network (Saesneg yn unig)

LI 04 Y Groes Goch Brydeinig (Saesneg yn unig)

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Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

Ymchwiliad i unigrwydd ac unigedd
Ymatebion i'r Ymgynghoriad

Mawrth 2017

Cynulliad Cenedlaethol Cymru
Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

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Ymchwiliad i unigrwydd ac unigedd
Ymatebion i'r Ymgynghoriad

Mawrth 2017

Cynulliad Cenedlaethol Cymru
Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

Sefydlwyd y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon ar 28 Mehefin i archwilio deddfwriaeth a dwyn Llywodraeth Cymru i archwilio deddfwriaeth a dwyn Llywodraeth Cymru i gyfrif drwy graffu ar ei gwariant, ei gweinyddiaeth a'i pholisïau, yn cynnwys y meysydd a ganlyn (ond heb fod yn gyfyngedig iddynt): iechyd corfforol, iechyd meddwl, iechyd y cyhoedd a llesiant pobl Cymru, gan gynnwys y system gofal cymdeithasol.

Aelodau cyfredol y Pwyllgor:

Dai Lloyd AC (Cadeirydd)
Plaid Cymru
Gorllewin De Cymru

Dawn Bowden AC
Llafur Cymru
Merthyr Tudful a Rhymni

Jayne Bryant AC
Llafur Cymru
Gorllewin Casnewydd

Angela Burns AC
Ceidwadwyr Cymreig
Gorllewin Caerfyrddin a De Sir Benfro

Rhun ap Iorwerth AC
Plaid Cymru
Ynys Môn

Caroline Jones AC
UKIP Cymru
Gorllewin De Cymru

Julie Morgan AC
Llafur Cymru
Gogledd Caerdydd

Lynne Neagle AC
Llafur Cymru
Torfaen

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06		Penny Gripper	Penny Gripper
07		Cymdeithas Tai Cadwyn	Cadwyn Housing Association
08		MHA	MHA
09		Gwasanaethau Gwirfoddol Morgannwg	Glamorgan Voluntary Services
10		Mantell Gwynedd	Mantell Gwynedd
11		Canolfan i Ymchwil Heneiddio a Dementia a Chanolfan i Heneiddio Arloesol, Prifysgol Abertawe	Centre for Ageing and Dementia Research and The Centre for Innovative Ageing, Swansea University
12		Coleg Brenhinol yr Ymarferwyr Cyffredinol	Royal College of General Practitioners
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16		Gofalwyr Cymru	Carers Wales
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20	Cyngor Gofal Cymru	Care Council for Wales
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26	Cymdeithas Cwnsela a Seicotherapi Prydain	British Association for Counselling and Psychotherapy
27	Cymdeithas Ponthafren	Ponthafren Association
28	Macmillan Cymorth Canser	Macmillan Cancer Support
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Campaign for Better Transport

National Assembly for Wales Inquiry into loneliness and isolation ~ Response from Campaign for Better Transport

15 February 2017

1. Campaign for Better Transport welcomes the opportunity to respond to the Assembly's inquiry. Established for over 40 years, we are a national charity working in England and Wales to promote more sustainable transport. Through research and campaigning, we advocate policy and public investment decisions that support better bus and rail services and alternatives to major road building. Our comments, below, are organised around the main points from the inquiry announcement.

Evidence of the scale of loneliness including factors such as housing, transport, community facilities, health and wellbeing services

2. There have been significant cuts to buses in the last ten years in Wales. The total Welsh spend on supported buses declined by £4.2million from £20.7 in 2010-11 to £16.4 in 2015-16. Overall, this is a reduction of more than 20 percent. See our report: http://www.bettertransport.org.uk/sites/default/files/pdfs/Buses_In_Crisis_Report_2015.pdf

3. In 2015-16, all but five of the 22 Welsh local authorities made cuts to bus funding. 32 bus services have been reduced or altered and 21 were withdrawn altogether. In addition, some private bus companies have collapsed, leaving people without a bus service – e.g. http://www.dailypost.co.uk/news/north-wales-news/gha-coaches-two-hundred-buses-11766724

4. When a bus service is withdrawn, or even when it reduces in frequency (e.g. no longer running on Sundays, or no longer running in the evenings), it prevents people travelling not only to social and health services but to see friends and family and remain independently mobile. This is particularly true in rural areas of Wales.

5. Many older people rely completely on the bus for their daily lives, and are less likely to have a car than other age groups. Buses are especially important to older women and older people on low incomes (see http://wales.gov.uk/docs/statistics/2012/121023sb982012en.pdf)

6. The link between cuts to buses and loneliness is well documented – e.g. https://www.bevanfoundation.org/wp-content/uploads/2013/12/Buses-a-lifeline-for-older-people.pdf

Ways of addressing problems of loneliness and isolation in older people, including interventions to specifically address the problems and other projects with wider aims.

7. We believe that the solution to loneliness lies in enabling people to remain active and independent for as long as possible, continuing to make their own trips to see family and friends and to participate in community life. This necessitates provision of reliable public transport.

8. We are sceptical that demand responsive transport can fully replace timetabled public transport, as the hurdle of booking trips deters users and makes spontaneous travel impossible (see https://www.transportfocus.org.uk/research-publications/publications/demand-responsive-transport-users-views-pre-booked-community-buses-shared-taxis-2/)

9. The Wales Bill will give local authorities new powers to plan their local bus networks, including through franchising and new forms of partnership schemes. This provides new opportunities to increase passenger numbers, and the viability of bus services, through measures including linking bus and rail; through multi operator and multi modal ticketing; through better use of data to improve bus information; and more ambitiously through franchise or concession models which could cross-subsidise rural services from the operation of profitable urban routes. In Jersey, bus franchising made savings of £800k / year while improving frequency on some routes and introducing five new routes (see http://hctgroup.org/uploaded/Practical%20bus%20franchising%20-%20the%20Jersey%20model.pdf)

10. We urge the Welsh Government, and local authorities, to protect funding for buses; to recognise their social value in reducing isolation, loneliness and their health impacts; and to ensure that the social and health impacts of buses are taken into account in transport valuation methodologies.

11. In addition, the Welsh Government should consider the potential of commission mainstream public transport together with services such as patient transport; social service transport; and school and college transport, in order to make better use of public money and make more services viable. This approach (known as Total Transport in England and Fully Integrated Transport in Scotland) is in early stages but looks a promising way to allocate and coordinate resources more efficiently leading to better outcomes for passengers, especially in rural areas.

February 2017

Lianna Etkind
Campaign for Better Transport

Campaign for Better Transport's vision is a country where communities have affordable transport that improves quality of life and protects the environment. Achieving our vision requires substantial changes to UK transport policy which we aim to achieve by providing well-researched, practical solutions that gain support from both decision-makers and the public.

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LI 02

Ymchwiliad i unigrwydd ac unigedd

Inquiry into loneliness and isolation

Ymateb gan: Gofal mewn Galar Cruse

Response from: Cruse Bereavement Care

I would just like to take this opportunity of drawing your attention to the above in bereaved people. Losing a loved one, often late in life, can be one of the most isolating experiences especially if you have been a carer. If I may just give one case study. Gentleman came to us six months ago. Aged in his 50s. He has been looking after his mother for several years but lost his temper the Christmas before last because he was so tired. He is feeling so guilty about this. He was receiving help from the mental health team but they are now reducing their imput which is making him anxious. This man wanders around town, would like to volunteer but feel unable to do so at this time as he keeps bursting into tears. He visits two of our friendship groups and goes from town to town to do so. He is totally 100 per cent 'lost'. We do our best with the resources that we have. We signpost and support the best way we can.

I have recently attended a meeting where the 'Population Needs Assessment' was shown to us. Bereavement was in two sections. However, surely, as this is the one thing we will all experience as a community this should be at the forefront of needs. Bereavement is now gaining a stronger voice but we still need to make it louder.

I would be grateful if bereavement could be taken into your account in the assessment.

LI 03

Ymchwiliad i unigrwydd ac unigedd

Inquiry into loneliness and isolation

Ymateb gan: Local Area Coordination Network

Response from: Local Area Coordination Network

Submission to the Inquiry into loneliness and isolation by the Health, Social Care Committee of the Welsh Assembly by the Local Area Coordination Network CIC

This submission is being made to offer Local Area Coordination as an example of a way of working that is nationally and internationally contributing to the reduction in isolation, loneliness and increase in individuals and communities' connectedness and capacity.

1. Introduction to Local Area Coordination

1.1 Local Area Coordination is an evidence-based approach to supporting people as valued citizens in their communities. Through a focus on building natural, supportive relationships, and helping people understand their own gifts & contribution, it enables people to pursue their vision for a good life and to stay safe, strong, connected, healthy, and in control.

1.2 Building on long term international evidence, there is a growing body of evidence from England and Wales of how Local Area Coordination supports people to build natural relationships, connect (or reconnect) to social networks and become active contributing members of their community.

1.3 As well as building the skills, knowledge and confidence of people and the community, Local Area Coordination is an integral part of system transformation. It simplifies the system and provides a single, accessible, local point of contact for people in their local community.

1.4 Currently Local Area Coordinators are working in 6 areas of Swansea and 3 areas of Neath Port Talbot with expansion to a further 3 areas planned for Spring 2017.

2. Who Local Area Coordinators work with

2.1 Local Area Coordinators support people and families in their local community:

- Who may be unknown to/ineligible for services to build their own, their family's and community's resilience and/or reduce the need for services whenever possible (capacity building)
- At risk of crisis or dependency of services to build resilience in their local communities through the development of networks and local solutions, therefore eliminating or reducing the need for formal services (prevention and demand reduction/avoidance)
- Already dependent on services to build personal connections, community contribution, reducing reliance on formal services, wherever possible (service reduction/efficiencies)

2.2 From local reporting & public evaluations we understand that older people (60+) form a significant percentage of the people Local Area Coordinator's work with. Locally we understand older people form approximately 40% of the cohort

Coordinators worked with in the 1st 18 months. Loneliness and isolation is a significant reason people contact the Local Area Coordinator. In 1 Welsh area it is the primary issue people identify for contacting Local Area Coordination for level 2 support (51%). An evaluation by Swansea University of Local Area Coordination in Swansea and Neath Port Talbot is expected to be published by April 2017 and will give detailed information on the impact and outcomes.

3. How does Local Area Coordination work?

3.1 The Local Area Coordinator role combines a range of traditionally separate roles and delivers in the community alongside local people. The role includes elements of functions often called information provision, signposting, planning, advocacy/self advocacy, peer support, relationship networks/circles of support, community building, community connecting, care and support planning or service navigation.

3.2 Local Area Coordinators work in a defined geographical area. There is no formal assessment or eligibility to be introduced to a Local Area Coordinator. Local Area Coordinators are introduced to people through their network of relationships in the community, membership of associations or groups or via formal services.

3.3 Local Area Coordination then starts with a positive conversation with a person and a focus on strengths, natural supports and finding non service solutions to make their vision of a good life happen.

3.4 The table below outlines the core elements of the approach from 2 different perspectives

How it works from a person or community's point of view	**How it works from a system's point of view**
The work with each person is different but will include supporting someone (or, when appropriate, them and their family) to: • Develop their vision for a good life • Recognise their own strengths and real wealth • Get information on what is available • Make use of and build their own networks • Strengthen their voice • Take practical action for change • Create new opportunities within the community • Use local services or personal funding where relevant but as the last consideration, not the first	LAC provides an integrated approach bringing together: • Health • Adult social care • Children and family services • Housing • Public health • Emergency services • Voluntary and Community organisations of all sizes • Local communities members, groups and leaders Collective action and shared responsibility is integral to the design and ongoing management of Local Area Coordination. This is especially demonstrated through the recruitment of Local Area Coordinators that is jointly led by people, communities and system leaders.

3.5 Central to Local Area Coordinators' practice is to be alongside the person (or family) whilst they lead and direct the design and implementation of their vision. There is no time limit to their support, and the aim is always to be supporting people build their capacity (doing "with" and not "for") and not to create dependency. The relationship between the person and Local Area Coordinator and how they interact therefore changes over time.

3.6 Local Area Coordination becomes a natural contact point for people in their community – intentionally pushing the service system back to create space for natural personal, family, and community solutions. As well as building strong partnerships with services to support a personalised (or whole-family) approach for the person, Local Area Coordinators also invests in supporting people to build capacity and strength in their local community.

4. Evidence

4.1 Evidence from a variety of sources shows that where Local Area Coordination is effectively designed and implemented with and by local people, there are highly consistent positive outcomes for people, families, and communities and for systems change.

4.2 The table below summarises the recent studies in England and Wales

System impacts	Impacts for people
Reductions in: • Isolation • Visits to GP surgery and A&E • Dependence on formal health and social services • Referrals to Mental Health Team and Adult Social Care • Safeguarding concerns, people leaving safeguarding sooner • Evictions and costs to housing • Smoking and alcohol consumption • Dependence on day services Social Return on Investment: £4 return for every £1 invested in 2 separate SROI	When asked about the impact of support from Local Area Coordination, people have reflected significant and consistent improvements in quality of life: • Increased valued, informal, support relationships – reducing isolation, • Increasing capacity of families to continue in caring role, • Improved access to information, • Better resourced communities, • Improved access to specialist services, • Support into volunteering, training and employment, • Preventing crises through early intervention, • Changing the balance of care to the use of more informal supports and diverting people from more expensive services.

4.3 Further information is available here: http://lacnetwork.org/local-area-coordination/evidence-base/

5. Examples of Local Area Coordination in practice in Wales

5.1 Example one

5.2 The local social work team introduces a young man with learning disabilities, who lives at home with his Mum and sister, who has 'special needs', & with their close extended family. There were issues of coping with recent bereavement, isolation & anxiety. The young man would also like to meet people of his own age. His mother is also a full time carer who supports his sister & both grandparents.

5.3 The Local Area Coordinator supported both the young man & the whole family (separately and together) to think about what was important to and for them – practical things they could do to address some of their challenges & build a good life.

5.4 Supported the young man to

- Access activities at the local library
- Coffee mornings/attending local groups
- Volunteering opportunities

5.5 Supported mum to

- Connect with and be part of a group of people with a shared experience of caring for someone with Alzheimer's. They meet regularly.
- Connect with the local Carers Centre for free support sessions and to a local organization for counseling support

5.6 Outcomes

- Reduced isolation
- Increasing natural and peer relationships
- Increased knowledge of and connecting with community resources and local community services
- Family more confident and able to continue in caring role
- Reduced service contact

5.7 Example 2

5.8 Andrea is in her 80's & lives alone, she has family who live far away. Andrea has had two strokes & lives with osteoporosis. These illnesses have led to Andrea being fearful of leaving her house in case she falls & the potential consequences. She previously experienced a very long recovery period in hospital after her 2nd stroke, when she was unable to leave her bed & suffered further illnesses, bed sores, depression & the anxiety of being alone on discharged. For 12 years Andrea has lived with this fear & has stayed in her home & relied on a neighbour to do her shopping.

5.9 The LAC took time to get to know Andrea & to find out what was important to her, exploring what a good life would look like for her. Andrea's key priority was to leave her home & start gardening again. She also expressed her desire to learn how to use her laptop, so she could Skype her family & to be able to shop online.

5.10 The LAC supported Andrea to become familiar with the internet, & she was able her to see her family for the 1st time in years via Skype. Andrea was so overwhelmed by this experience that she was motivated to leave her house in order to visit them. Andrea to set small but realistic goals to work towards leaving the house. Initially into her garden, then out for a short drive supported by the LAC & finally on her own, she walked to the coffee shop. The sense of accomplishment was huge for Andrea, &

she has gone on longer bus journeys and no longer feels isolated or anxious & has visited her family in London.

6. Contact details for submission: Samantha Clark, Chief Executive

E: [redacted] M: [redacted] w: http://lacnetwork.org/

LI 04
Ymchwiliad i unigrwydd ac unigedd
Inquiry into loneliness and isolation
Ymateb gan: Y Groes Goch Brydeinig
Response from: British Red Cross

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

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

About us:

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

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

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

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

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

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

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

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

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

3. Our recent report *'Trapped in a Bubble'* (2016)[2], commissioned by the British Red Cross in partnership with Co-op, highlighted that 88% of respondents to a nationally representative public survey – and 90% of respondents from Wales – consider loneliness a very serious issue in the UK. Findings from the survey also indicate that loneliness is something that most people have experienced to some degree, and many are dealing with levels of loneliness that may have a negative impact on their quality of life. Half of those surveyed feel lonely at least sometimes and only one in five said they have never felt alone. 18% feel lonely 'always' or 'often' – the equivalent of almost 458,000 people in Wales.

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

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

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

6. The WHISC evaluation (2016) of the Red Cross *Gofal* project in Wales, which provided outcome focused befriending support to people over the age of 50, identified that many of the individuals accessing the service lived alone, had lost family and friends through bereavement and their social contact was limited. Many were physically impaired through age or ill-health, suffering from depression and anxiety, or had lost their independence and confidence following

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

a stay in hospital. Service users reported being isolated due to no access to transport and/or living in a rural area or having lost their social connections due to health issues or as a consequence of moving home.

The impact of loneliness and isolation on older people

7. On the surface, it can be hard to tell who is feeling lonely or isolated. This hidden issue is problematic because it affects people's health and wellbeing and impacts on public services. Our literature review bringing together findings from more than 100 published studies from over 40 years[3] set out many of the impacts. A lack of social connections can be linked to cardiovascular health risks and increased death rates, blood pressure, signs of ageing, symptoms of depression and risk of dementia. It could be as damaging to health as smoking and as strong a risk as obesity. Lack of social networks can be linked to poor diet, heavy drinking and increased risk of re-hospitalisation after an illness. Increased service usage by older people experiencing loneliness could cost up to £12,000 per older person over the next 15 years.

The *Trapped in a Bubble* report identifies the negative impacts of loneliness across a range of biological, psychological and social domains. The physical implications of loneliness often make it harder for people to undertake everyday tasks and routines and make it more difficult to engage with others. Respondents reported feeling tired, in poor health, anxious and existing symptoms being exaggerated. Loneliness was also recognised as leading to a lack of confidence, feeling alone, depression, and negative thoughts which at worst triggered thoughts of self-harm and suicide.

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

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

Ways to address loneliness and isolation in older people

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

11. There is a strong case for intervening to prevent chronic loneliness, given its devastating wider effects on health and wellbeing – and resultant pressure on NHS and care services. Preventing minor situations escalating into crises is more cost-effective than picking up the

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

pieces – and better for the individual. Our long-established record of service provision shows that providing low level support – such as assisting somebody to return home from hospital, making sure they have enough to eat or take their medication, rebuilding their confidence and independence – can generate real impacts in individual's lives, as well as generating savings to the public purse. An independent economic analysis of such services identified cost savings related to a reduced need for care and support equivalent to £880 per person.[4]

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

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

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

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

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

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

18. According to the WHISC *Gofal* evaluation, service users' emotional health, social networks and feelings of loneliness were improved as a consequence of the service. All beneficiaries of the service reported that having someone to talk to did reduce their feelings of loneliness and isolation and expressed a preference for face-to-face interaction. Beneficiaries also reported

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

that their confidence had grown which enabled them to leave the house and socialise and they had built long-term opportunities to maintain social contact within their communities.

Examples of services which address issues of isolation and loneliness:

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

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

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

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

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

Current policy

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

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

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

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Alzheimer's Society Cymru
Unedig Yn Erbyn Dementia
United Against Dementia

Dr. Dai Lloyd AM,
Health, Social Care & Sport Committee,
National Assembly for Wales,
Cardiff, CF99 1NA
seneddhealth@assembly.wales

4th March 2017

Dear Dr. Lloyd,

Re: Inquiry into loneliness and isolation

On behalf of Alzheimer's Society Cymru, please find below a response to the Health, Social Care & Sport Committee's inquiry into loneliness and isolation.

Alzheimer's Society is the UK's leading support and research charity for people with dementia, their families and carers. We provide information and support to people with any form of dementia and their carers through our publications, National Dementia Helpline, website, and more than 2,000 local services. We campaign for better quality of life for people with dementia and greater understanding of dementia. We also fund an innovative programme of medical and social research into the cause, cure and prevention of dementia and the care people receive.

Overview

Alzheimer's Society Cymru welcome the Committee's focus on loneliness and isolation. As we noted in our letter to the Committee in August 2016, loneliness and isolation are a growing concern in Wales, with clear links to dementia.

From a definitional standpoint, Alzheimer's Society has made clear[1] that we regard loneliness and isolation as two separate states. In general terms, we support the differentiation made by the LGiU[2]:

- **Social isolation**: an objective state determined by the quantity of social relationships and contacts between individuals, across groups and communities.
- **Loneliness**: a subjective state based on a person's emotional perception of the quality of social connection they need compared to what is currently being experienced.

We also note academic work[3] which has identified the differences between emotional and social loneliness – with the former being an absence of a significant other with whom a close

[1] Alzheimer's Society (2013) *Dementia 2013: the hidden voice of loneliness*, London: Alzheimer's Society.
[2] LGiU (2016) *Loneliness and social isolation in older people*, London: LGiU.
[3] Weiss, S (1973). *Loneliness: the experience of emotional and social isolation*, Massachusetts: MIT Press.

emotional attachment is formed[4] and the latter relating[5] more to a lack of a social network or group of friends, neighbours or colleagues.

Within a Welsh context, our increasingly older population means that Wales is likely to have an increasingly large population of lonely older people, and we are concerned that data suggests[6] older men in Wales are the loneliest cohort of people in the UK. The Older People's Commissioner for Wales has said that loneliness and isolation is a "*modern day epidemic*"[7] in Wales, whilst at a UK level nearly 10% of over-65s see friends or relatives less than once a month.[8]

Transport and rurality

Alzheimer's Society Cymru also want to stress the important role played by transport in people's social connections. We strongly believe that local authorities have a responsibility to make sure people with dementia can access appropriate activities. Among the people with dementia who participated in our *Dementia 2013: the hidden voice of loneliness* report[9], there was an overwhelming feeling among people with dementia who lived alone that a lack of transport prevents them from getting out and taking part in activities. 88% of people with dementia who responded to the survey said they rely on family and friends for transport.

We have found that many of the concerns around isolation and loneliness for people living with dementia and their carers and families are often more pronounced in rural areas. Our *Dementia in Rural Wales* report[10] showed that the isolation felt by people with dementia and their carers was intensified by rurality. In particular, unpaid carers often face social isolation and a lack of support networks – this is exacerbated in rural areas by distance, lack of public transport and other factors. We also know that if people with dementia are not signposted to appropriate services at the time of their diagnosis, there is an increased risk that they will become isolated and at risk of reaching crisis point before they access services.[11] Even when services and support are available, distances and travel times often mean that their usefulness was limited.

The impact on physical and mental health and wellbeing

We welcome that the Committee's terms of reference for this inquiry asks whether loneliness and isolation "*disproportionately affect certain groups such as those with dementia*". There are clear links between loneliness and dementia.

From our *Dementia 2013: the hidden voice of loneliness*[12] report, we know that 39% of people with dementia said they felt lonely, rising to 62% of people with dementia who live on

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[4] Burholt, V (2011). "Loneliness of older men and women in rural areas of the UK" in *Safeguarding the Convoy: a call to action*, Abingdon: Campaign to End Loneliness / Age UK.
[5] Alzheimer's Society (2013) *Dementia 2013: the hidden voice of loneliness*, London: Alzheimer's Society.
[6] WRVS (2012) *Loneliness rife amongst older men*, Cardiff: WRVS.
[7] Care & Repair Cymru (2013) Older People's Commissioner sings Care & Repair praises, Cardiff: Care & Repair Cymru.
[8] Rodrigues, R., Huber, M. & Lamura, G. (eds.) (2012) "Facts and Figures on Healthy Ageing and Long-term Care: Europe and North America", Vienna: *European Centre for Social Welfare Policy and Research*: p35/6.
[9] Alzheimer's Society (2013) *Dementia 2013: the hidden voice of loneliness*, London: Alzheimer's Society.
[10] Alzheimer's Society (2016) *Dementia in Rural Wales: the three challenges*, Cardiff: Alzheimer's Society.
[11] Alzheimer's Society (2015) *Diagnose or disempower? Receiving a diagnosis of dementia in Wales*, Cardiff: Alzheimer's Society.
[12] Alzheimer's Society (2013) *Dementia 2013: the hidden voice of loneliness*, London: Alzheimer's Society.

their own. Difficulties in maintaining social relationships and other features of dementia contributed to this, with 35% of people with dementia saying they'd lost friends after a diagnosis. Nearly two-thirds (63%) of people with dementia surveyed said that they felt anxious or depressed. We also know that 70% of respondents had stopped doing things they used to because of a lack of confidence. Diminished confidence can lead to a loss of independence, as people with dementia may feel concerned about what could happen if they leave their home, or reactions from other people.

We are aware of research[13] suggesting that feelings of loneliness (but not social isolation) can predict the onset of dementia, with feelings of loneliness being associated with the development of dementia, even when objective indicators of social isolation and other covariates were controlled for. However, conflicting research[14] has argued that whilst there is some evidence to support the proposition that loneliness is a consequence of dementia there is little evidence to support the notion that loneliness 'causes' dementia.

Addressing the problem and policy solutions

Whilst the following is not an exhaustive list, we believe the following suggestions could all form part of any action plan to help reduce isolation and loneliness in Wales:

- Alzheimer's Society Cymru note that Welsh Labour committed[15] ahead of the 2016 Assembly election to "*develop a national strategy and take action to tackle loneliness and isolation*". We welcome this, and strongly recommend that any strategy should include a discrete section on dementia, given the particular effects on this community.
- Alzheimer's Society has recently launched our innovative Side By Side[16] befriending service, in a bid to reconnect people with dementia with their communities and favourite pastimes. Launched in response to the loneliness and isolation so many people with dementia report experiencing, the service has been piloted since 2014, and now has a waiting list of almost two thousand people with dementia across England, Wales and Northern Ireland.
- Work being done to create Dementia Friendly Communities across Wales have made important steps in reducing loneliness and isolation. We now have over 30 Dementia Friendly Communities, and these are an important vehicle for reducing social isolation and loneliness. Work undertaken has already begun to identify what it means to be dementia friendly; more now needs to be done to raise awareness of what it means and encourage businesses, organisations and communities to commit to becoming dementia friendly.
- There is also evidence[17] to suggest that intergenerational contact is more effective in combating loneliness than contact with one's own age group although both are important). Intergenerational practice and change negative perceptions, increase participation of older people in lifelong learning, enhance civic participation and active

[13] Holwerda, T., Deeg, D., Beekman, A., van Tilburg, T., Stek, M., Jonker, C. & Schoevers, R. (2012) "Feelings of loneliness, but not social isolation, predict dementia onset: results from the Amsterdam Study of the Elderly (AMSTEL)", *Journal of Neurology Neurosurgery & Psychiatry*, BMJ Journals.

[14] Victor C., Pikhartova, J., Woodrbidge, R. (2015) "Is loneliness a cause or consequence of dementia?", *Gerontologist*, vol.55, p.593.

[15] Welsh Labour (2016) Tackling loneliness and isolation in our Welsh communities, Welsh Labour website.

[16] Alzheimer's Society (2017) Side By Side, Alzheimer's Society website.

[17] Age UK (2010) *Loneliness and Isolation Evidence Review*, London: Age UK.

citizen, reduce fear of crime, improve community cohesion and more.[18] There should be more support to help spread best practice for intergenerational projects.

- We note the comments[19] of the Campaign to End Loneliness and Age UK that action to reduce loneliness should primarily be driven by local authorities. We would encourage local authorities in Wales to use resources such as those produced by the LGA and Age UK[20], the LGiU,[21] and the JRF[22] to combat loneliness. We would also recommend that mapping and addressing loneliness and isolation should form an outcome measure for local authorities' strategies and part of Public Service Boards' Local Wellbeing Plans. Those experiencing or at risk of loneliness should be involved in mapping local assets, determining responses, and co-producing solutions.[23]
- Finally, we would propose that the Welsh Government's draft Dementia Strategic Action Plan should include an awareness of the impact of loneliness and isolation on people affected by dementia.

We trust this information is of assistance. Alzheimer's Society Cymru would be only too happy to give oral evidence as part of the inquiry; please contact me if you would like to arrange this or if you have any queries in relation to our submission.

Yours sincerely,

Dr. Ed Bridges
External Affairs Manager (Wales)
[redacted]

[18] Beth Johnson Foundation (2011) *A Guide to Intergenerational Practice*, BJF: Stoke-on-Trent.
[19] Campaign to End Loneliness and Age UK (2015) *Promising approaches to reducing loneliness and isolation in later life*, Age UK: London.
[20] LGA, Campaign to End Loneliness, and Age UK (2016) *Combating loneliness – A guide for local authorities*, LGA: London.
[21] LGiU (2016) *Loneliness and social isolation in older people*, LGiU: London.
[22] Joseph Rowntree Foundation (2013) *Loneliness resource pack*, Joseph Rowntree Foundation: York.
[23] LGA, Campaign to End Loneliness and Age UK (2016) *Combatting loneliness: A guide for local authorities*, London: LGA.

LI 06
Ymchwiliad i unigrwydd ac unigedd
Inquiry into loneliness and isolation
Ymateb gan: Penny Gripper
Response from: Penny Gripper

Inquiry into loneliness and isolation

The Committee will aim to assess the extent and impact of loneliness and isolation experienced by people in Wales, particularly older people, and how it can be addressed, by considering:

Why particularly older people???? This is a serious issue across the whole age range, particularly for vulnerable groups such as those with disabilities, especially those which affect social function such as Autism Spectrum, Mental health, and some neurological conditions. It affects people who are unemployed and living in poverty in rural areas, or areas which are otherwise wealthy, including commuter belts. It is a serious problem for new mothers, again particularly if they have moved into an area and have no social networks. In mental health we have managed to get this recognised in the Together for Mental health delivery plan as a whole age range issue. This can also be a real problem in inner city areas and where communities are not stable with houses being bought and sold, or tenants moving in and out frequently. It can particularly affect transient communities such as students, and may be a part of the reason for the onset of psychosis often first presenting in students living away from home. It can be a problem for self-employed people in jobs that don't involve a lot of contact with people, and also for carers of any age. As an intelligent person with Aspergers I have experienced loneliness and isolation – not always from not being in the same place as others, but from not being accepted and included in those settings, from an early age. I was particularly isolated (not in contact with others for about 22 hours a day) from the end of my pregnancy and when my son was little, which contributed to peri-natal mental health problems and since I developed mental health problems again at the age of 38 following unemployment due to work-place bullying.

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

In my work with people with mental health problems I have not heard any stories of people's experience that has not included loneliness and isolation, as a factor in the development of their mental health issues. I believe there is an evidence base for the destructive influence of loneliness and isolation on mental health for people of any age, although I cannot give you the references I'm sure a lit search would furnish them.

The level of stigma and discrimination at all levels of Welsh society amplifies this once mental health problems set in. The Time to Change Wales project has created even more felt stigma and discrimination for those with mental health problems expected to work for nothing to give presentations, act as champions or lead projects. It feels demeaning, exploitative and deeply unjust that the people who suffer as a result of stigma and discrimination are expected to sacrifice themselves by working for nothing to right a wrong that they did not cause. Those involved also get totally inadequate and insufficient support, creating a real risk to them in this work. The project has put many mental health service users out of work who were delivering training on mental health awareness for a fair income. The emphasis on negative experiences, rather than on showing what we can achieve, and what we have in common with those who do not have mental health problems just exacerbates the 'poor thing' mentality that we are trying to escape. It is deeply humiliating to be treated in this way, and leads many to shy away from social contact to avoid it. The attitude that people with mental health problems should not be paid for essential work is deeply entrenched in all levels of Welsh public life, with service user and carer representatives usually being the only people

round the table in high level committees who are not being paid. The use of time banking to avoid paying a minimum wage is unacceptable, and should not be tolerated. This attitude is particularly entrenched in our biggest mental health charities, who continue to get Welsh government funding and seats on government committees despite this engrained blindness to the consequences of keeping people with mental health problems in poverty, and re-enforcing their feelings that they are not valued by society. The poverty this condemns service users to, is an added factor in isolation.

The difficulty accessing appropriate treatment, such as emotional coping skills courses and interventions for people with mild to moderate problems exacerbates the problem, and increases the number of people who go on to develop more severe problems. Stress management courses which are poorly delivered or over-crowded are putting people off seeking help. The evidence base for skills learning is that didactic courses make very little impact. Rooms full of people are not accessible to people who suffer high anxiety in large groups. If we are looking for evidence base and environments which support building relationships and friendships then the stress management model should be one with an interactive style and small group work as well as refreshment breaks where people can get to know each other.

It stuns me how new developments for leisure and health facilities are increasingly being built out of town away from public transport hubs. Many hospital facilities cannot be accessed by visitors using public transport as it is impossible to get there and back in a day. This means that people on wards cannot have visitors. In Carmarthenshire there is a persistent tendency to place mental health, and now a new health development in Llanelli, which is in the furthest South Eastern corner of the region. Hywel Dda is an area with very poor public transport links, especially between counties. The new psychotherapy service has been placed a good 20 minutes walk from the nearest bus stop, on a route that has only 5 buses a day. Great if you have money enough to have a car, but excluding anyone who doesn't, who cannot walk an hour each way from the local station/bus station.

Local Authority Gym facilities are a really important way to improve life for people with mental health problems, but the prescription scheme in Carmarthenshire limits the hours of access to the gym, so that I cannot get there by public transport in the hours available. Difficulty getting benefits when you have a mental health problem – much exacerbated by PIP introduction, means even the £2 per session Gym fee for on prescription exercise is excluding.

Local education courses are also excluding people now by reducing the number of courses and only giving courses that lead to some kind of qualification – something that not all are able to achieve. They also tend to exclude people who have qualifications already, which means that these people, if they have other disadvantages can become isolated. One local lady with a mental health problem was accessing a pottery class for several years, which kept her stable. After the council introduced a rule that you could not do the course for more than two years, she was soon on an in patient psychiatric ward for several months. This was a false economy. Local education courses need to be recognised as an extremely important venue for vulnerable people of all ages to make friends and meaningful relationships.

- the i**mpact** of loneliness and isolation on older people in terms of physical and mental health and wellbeing, including whether they disproportionately affect certain groups such as those with dementia;

It is critically important that isolation and loneliness are not seen as a problem just of older people, and not even a more of a problem for older people than others. It is far harder to be isolated and alone all your life, or at a young age when you see no prospect of this improving. It has physical and mental health effects for people of all ages, with unhealthy life-styles, often addiction to digital media, other addictions, comfort eating, lack of physical exercise and all the physical consequences of that. For people of all ages the consequences have a huge cost on the health and social services, and impact not only on the individuals but on others in their sphere of influence, such as carers, relatives, neighbours. At present there are far more facilities and community projects for older people and people with learning disabilities to have social contact and quality of life, than for disabled adults who are not in education, training or employment.

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

  In the first instance isolated and lonely people may be much less likely to engage with services, because it is too difficult to get there, because their social skills are so poor that they cannot engage or their behaviour is seen as unacceptable, or because they do not value themselves enough, or are too anxious. However, as a result of not getting the services they need at a time when serious problems could be prevented, they are likely to become heavy users of services. Often the services they use are the most expensive, such as mental health services. There is a perception that lonely people over use services in order to get contact, but I would be sceptical without good research. In my experience, the people I know who are isolated avoid services.

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

  We need to first address problems of isolation and loneliness for those in our society who are socially excluded, for all kinds of reasons. Services need to be better linked to public transport. Local education needs to be expanded, made available to whoever wants it as long as they want it, with discounts for people on any kind of disability benefit, or income related benefits.

  It is inequitable that discounts for services are only given to students and the retired, when they are often better off than people with disabilities who are unemployed as a result.

  Discounts for people with disabilities needs to be extended to all community facilities such as leisure centres, and planning rules need to be introduced to put these facilities close to transport hubs, or to locate transport hubs next to the facilities. Hospital parking needs to be expanded as services and patient numbers expand, and free bus services provided to all health facilities, from main transport hubs. We need better more long term secure funding for third sector services which provide activities, and support groups for vulnerable groups, and a culture of paying fair wages to people providing public services or contributing to their governance, design and development. We need to do more to create employment for isolated and lonely groups of working age, so that they have established social networks if they survive into retirement. Funding for disability charities from government should be dependent upon them having a default of paying service users for any essential work they do in the funded project, unless and only when the person wants to do the work voluntarily would this not happen. Facilities for social meetings, such as village halls, and funding for social groups should also be better funded to encourage people getting together to share interests and common goals.

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

  You need to look at this the other way around. There are many initiatives for older people and people with learning disabilities, but virtually nothing for other less visible/working age groups. If you deal with loneliness and isolation of people up to the age of retirement, you will set them up with long-lasting social support networks and social skills which they can continue to use when they are old. You need to create and support local community development which is inclusive of all, which celebrates diversity and values everyone.

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

  As far as I can see the situation is worse than it was. When I was in my 40s there was free access to swimming for over 50's. Now I'm over 50 there is discounted access for over 60s.

  We have yet to see what the delivery plan action on loneliness for all ages in mental health will deliver.

  At least older people's loneliness is on the agenda. This means they have far more hope of a solution. The policy agenda for loneliness and isolation has to become age inclusive, starting with young children with language or social skill disadvantages, and including people of working age who are suffering from any kind of social exclusion. Not addressing these problems will lead to more mental health and substance misuse costs, more homelessness, more unhealthy lifestyle caused physical health costs, more pressure on A&E, more demand on social care and more anti-social behaviour and cyber crime.

LI 07

Ymchwiliad i unigrwydd ac unigedd

Inquiry into loneliness and isolation

Ymateb gan: Cymdeithas Tai Cadwyn

Response from: Cadwyn Housing Association

Cadwyn Housing Association's view's on The Health, Social Care and Sport Committee's Consultation: Inquiry into loneliness and Isolation.

1. Loneliness and social isolation are widely recognised as amongst the most significant and entrenched issues facing our ageing society. Wales has a higher proportion of people of state pensionable age than other nations in the UK and the UK as a whole. The proportion of people over the age of 80 is also higher and within rural areas the ratio is generally higher and will increase significantly. Around 80,000 pensioners in Wales rely entirely on the state pension and other benefits as their only source of income. With Wales already having an older population than any other part of the UK (a trend that is set to intensify), the Older People's Commissioner for Wales has said that 'loneliness amongst older people is reaching epidemic proportions'.

2. Main causes of loneliness:

- Retirement: people might miss day-to-day contact with work colleagues, plus the routine of getting ready and going out to work
- Bereavement: chronic loneliness can unfortunately set in after the loss of a partner. Similar feelings of loneliness can arise if one relative moves to a care home and the other is left alone at home
- Lack of friends and companions: friends may have passed away, no longer live in the same area or have restricted mobility that stops them from getting out and about
- Poor physical health: ill health or loss of mobility can make it more difficult to socialise
- Location: your relative may not live near family and friends, particularly if they are living in a residential care home where choices of location might be limited. Modern life means that families are often more 'geographically scattered' – living further apart due to jobs or family break ups.
- Lack of transport: your relative may no longer be able to drive for health reasons, or no longer own a car. If they live in a rural area public transport might be limited.
- Financial problems can also limit travel. Not being able to leave the house as often as they'd like reduces opportunities for social contact and can lead to feelings of social isolation.
- Financial difficulties: in addition to causing stress, financial problems can also limit travel. Not being able to leave the house as often as they'd like reduces opportunities for social contact and can lead to feelings of social

isolation. Depression can also be both a cause and a consequence of loneliness.

3. For many years, housing associations have quietly played a role in building homes designed to tackle loneliness, encourage social interaction and boost wellbeing. From sheltered housing and extra care schemes to whole retirement villages, these homes may have different names but the overarching aim of them is the same: to help older people remain independent and socially engaged. We know older people want to stay active and engaged in their own homes and within their local communities for as long as possible. We welcome the Government's commitment to working with communities to protect local facilities that bring people together, including libraries, leisure centres and museums.

   We would ask that The Government recognises the critical role housing associations' play in improving the health and wellbeing of their tenants. In the last government you brought forward legislation that places the well-being of all people, including older people, at the heart of everything you do. May we please suggest in going forward that the Minister for Social Services and Public Health ensures that housing associations' are recognised as having a pivotal and equal role with health, social care and third sector colleagues as a major contributor on this key priority area.

4. It is clear that transport is vital in keeping older people connected. Lack of appropriate transport can be a major barrier not just to the maintenance of existing social connections, but can also impact on primary care and hospital appointments resulting in far-reaching implications of this gap in provision in terms of older people's health and wellbeing.

5. Loneliness is a bigger problem than simply an emotional experience. Research shows that loneliness and social isolation are harmful to our health: lacking social connections is a comparable risk factor for early death, as smoking 15 cigarettes a day, and is worse for us than well-known risk factors such as obesity and physical inactivity. Loneliness has been linked to a 30% rise in the risk of stroke or coronary artery disease already among the biggest killers in the UK.

Loneliness puts individuals at greater risk of cognitive decline, and one study concluded that lonely people have a 64 per cent increased chance of developing clinical dementia.

6. Older people are high consumers of health and social care. The pattern of demand on primary care services has intensified: the number of times an older person visits a GP practice has increased from seven to thirteen on average in just 13 years. (Age UK November 2015).

7. Research evidence for what works and the outcomes for older people in terms of health and wellbeing: Social Care Institute for Excellence Research briefing 39: Preventing loneliness and social isolation: interventions and outcomes. For this research briefing, the focus had been narrowed to the effectiveness and cost-effectiveness of services aimed at preventing social isolation and loneliness. The review question was 'To what extent does investment in services that prevent social isolation improve people's wellbeing and reduce the need for ongoing care and support?'

   Key Messages 'Social isolation and loneliness impact upon individuals' quality of life and wellbeing, adversely affecting health and increasing their use of health and social care services. People who use Community Navigator services reported that they were less lonely and socially isolated following the intervention'.

   Users (in the research) argued for flexibility and adaptation of services. One-to-one services could be more flexible. 'We need to invest in proven projects. Community Navigator interventions have been shown to be effective in identifying those individuals who are socially isolated'.

8. Kings Fund June 2016: Supporting integration through new roles and working across boundaries**:** **'**The health and social care system has recognised a need to change considerably to respond to changing needs and demands. National policy has highlighted three necessary changes: a shift in care from hospitals to the community; new care models that support the integration of health and social care; and a focus on preventing illness and promoting health and wellbeing. These changes aim to put the individual at the heart of health and social care – to create an integrated system able to deliver holistic and person-centred care to meet people's changing needs, while empowering individuals to actively

maintain their health and wellbeing within the community. It is hoped these changes will support greater efficiency and effectiveness, improve the outcomes of people accessing those services, and deliver cost savings'.

Key Message: 'Our review of the evidence found few examples of truly innovative roles. The most notable examples are care navigators and community facilitators, enablers or link workers. These roles seek to enable individuals and, in some cases, professionals to access and navigate the range of support available from health, social care and the wider community'.

9. Friends of the Elderly: The future of loneliness 2013

'The use of technology for social contact: The past half-century has seen successive waves of communications technologies steadily adding to total volumes of contact; face-to-face contact and call minutes continue to grow, while text messaging, email, instant messaging and social networking all just add more communication to the mix. The proportion of 65+ who use the internet at home is set to rise to 71% in 2020 and 85-90 % by 2030 as costs fall and increasingly user friendly devices and software developed. Many older users already enjoy online social networking and participation will continue to grow rapidly'.

10. Cadwyn Housing Association has developed a unique programme to help address this growing ageing population problem facing society: Citizen Driven Health. It is about putting older people in the centre, and works to prevent loneliness and isolation.

This innovative project is delivered by trained community navigators who provide regular visits to the older person in their own homes; with a holistic and preventative approach, the navigators build up a trusted relationship and are able to identify any early signs of deterioration. By spotting risks early and notifying the most appropriate person to take action, improving safety, enabling early intervention will help avoid unnecessary hospital admissions or inappropriate admission to residential care: improving citizens' outcomes. Through the 'guided conversation' principle it helps the older person make best use of all that is available from all sources within their community to meet their personal health, wellness and life goals, supporting improved socialisation and independent living in their own home.

The navigator helps the older person develop their own personal support network and the aim is to eventually combine this network in the delivery of a technological support system. The technology platform called Shared Well was conceived and designed specifically to support citizen-driven initiatives, where the citizen is the hub of their own support network.

A recent external evaluation of Citizen Driven Health (CDH) reported:
'Many respondents highlighted strong value in the CDH ways of working, with a list of components perceived as being very beneficial to working with frail older people. These included the holistic approach, building on motivations rather than a transactional approach; use of an informal yet semi-structured 'guided conversation' around what matters, building a relationship over time, especially with a named worker; case identification with primary care – reaching older people who formal preventative services might not necessarily have access to; the flexibility of access without eligibility criteria; and the brokering of a range of services and community support that might not always traditionally be seen as helping older people stay independent at home. The evaluation also concluded that CDH has clear and proven benefits, not only to the older person but has resulted in a reduction of health and social care costs'.

The programme meets the key objectives set out in Ageing Well in Wales: Overarching aim: to reduce levels of loneliness and isolation and their negative impact on health and wellbeing as experienced by older people in Wales. It also provides the key elements set out in the Social Services and Wellbeing (Wales) Act and the Wellbeing of Future Generations (Wales) Act 2015: Citizen Driven Health is patient centric, it focuses on person activation and self-management the impact for the older person is greater health and wellness, confidence from being better informed being more in control of their lives and what is important to them to maintain their independence and remain within their own homes and communities for longer.

For further information please contact: Philip Richardson, Head of Supported Housing, Cadwyn Housing Association. [redacted]
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7th March 2017

LI 08

Ymchwiliad i unigrwydd ac unigedd

Inquiry into loneliness and isolation

Ymateb gan: MHA

Response from: MHA

Health, Social Care and Sport Committee
Inquiry into loneliness and isolation

Submitted by MHA
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1 Who is MHA?

1.1 MHA is an award-winning charity providing care, accommodation and support services for older people throughout Britain. We are one of the most well-respected care providers in the sector and amongst the largest charities in Britain, providing services to older people for more than 70 years. We want to tackle isolation and loneliness among older people by connecting older people in communities that care.

1.2 MHA delivers a range of high quality services to 17,000 individuals:

- 4,350 older people living in 84 care homes - residential, nursing and specialist dementia care
- 2,500 older people living independently in 72 retirement living communities with flexible support and personalised care, with a further ten sites in development
- 10,000 older people supported through 66 Live at Home services in the community.

Our services are delivered by 7,000 dedicated staff and enhanced by the commitment of 5,500 volunteers.

1.3 In Wales, MHA provides the following services:

- Four care homes: Coed Craig in Colwyn Bay, Hafan y Waun in Aberystwyth, Morel Court and Ty Gwyn, both in Penarth.
- Two retirement living schemes: Adlington House in Rhos on Sea, Penrth House in Penarth
- Penarth Live at Home scheme

1.4 MHA recognises that loneliness is an increasing challenge that affects many of us as we age and it is manifested physically, emotionally and spiritually. Our ambition is to ensure that every older person can be connected within a community of their choice so they can live an independent and fulfilled later life as they age. As such MHA is pleased to respond to this inquiry where we can, detailing some of the work we have taking place in Wales.

2 Ways of addressing problems of loneliness and isolation in older people, including interventions to specifically address the problems and other projects with wider aims.

2.1 MHA Live at Home schemes

MHA Live at Home (LAH) Schemes aim to support and enable older people to remain in their own homes and to retain their independence for as long as they wish and are able to do so. The Schemes achieve this by providing a range of preventative services that are aimed at reducing social isolation and loneliness, ultimately aiming to delay the need for more intensive services.

2.2 We have ben running LAH Schemes for 25 years. In Wales, we currently run one LAH scheme in Penarth. It opened in 1992 as a befriending scheme and in 1994 it amalgamated with Trinity Church, which provided a lunch club and day centre service. Since then the Penarth scheme has developed to provide a variety of services to older people in the Penarth and surrounding areas.

2.3 The Penarth LAH scheme is run by five part-time staff and approximately 40 volunteers. The services are also highly dependent on volunteers, with recruitment of drivers to assist members attending events, a particular challenge to this scheme.

2.4 Currently the Penarth scheme has 108 members, ranging from 76 years of age to 98. These members mostly live in the Penarth area but also from Cardiff, Sully and Dinas Powys. 87% of members are female. Several members have been referred to the Penarth LAH scheme from local adult social services and health services. The scheme also has close links with Crossroads Dementia Care.

2.5 Services are designed with input from members. However all services are dependent on charitable fundraised income by MHA nationally and locally and commissioned services from the Local Authority.

2.6 Current services provided include:

- Befriending
- Daily lunch clubs Monday to Friday
- Friday Friendship Group
- Weekly LIFT (Low Impact Falls and Trips) exercise group
- Weekly Art Therapy Class
- Monthly Memory Café
- Quarterly Newsletter
- Transport to activities
- Day Trips (on average 5 per year)
- Signposting and information – on issues ranging from health to welfare
- Spiritual support thought a dedicated chaplain and local minister, as needed, weekly varied times.

2.7 The Penarth scheme is aiming to increase its membership by 10% over 2017/18. The scheme has identified that the Barry area in particular would benefit from a new LAH scheme and the staff have been looking for suitable venues, as well as looking at other opportunities with other providers. For example, the Scheme has been building

a relationship with HAFOD Housing Association at Golau Caredig in Barry, with the view to start with a weekly event for residents of this sheltered housing accommodation. The residents are currently being surveyed to establish their interest. There are also plans to link up with other voluntary and community sector organisations and other care providers, such as Home Instead to explore future developments. However this is all very dependent on establishing funding streams to support the development of additional LAH schemes.

2.8 MHA's 10 year strategy aims to expand LAH schemes nationally to reach 36,000 people. We are looking how best we can do this including building on MHA's existing presence in local areas and establishing local demand.

2.9 Loneliness in care homes

We are aware that moving into a care home often comes at a time of crisis for an older person and requires significant adjustment in people's lives, which can mean some people feel lonely within a care home setting. We have been piloting a new way of offering group and individual activities and meaningful activities for residents in some of our care homes, including our two homes in Penarth. This has involved our care home staff and volunteers taking more time to support residents to take part in personalised activities and increasing opportunities for residents in the evenings and at weekends. The project's key aims include reducing boredom and loneliness among residents; unfortunately it is too soon to be able to provide clear evidence of success.

3 Evidence for what works and the outcomes for older people in terms of health and wellbeing

3.1 Live at Home schemes

In 2015, MHA undertook a research project involving over 5,700 people in quantitative research and over 140 participants in qualitative research, which amongst other things aimed to understand the main issues people highlighted as important when facing their own ageing process or that of their loved ones, and issues facing older people as a group.

3.2 Our research involved talking to members of our LAH schemes. They highlighted the combination of friendship and interesting activities as key to their experiences of LAH.

3.3 Several Live at Home Members described the improvements that being part of their scheme had resulted in, particularly in helping reduce feelings of loneliness and boredom:

"I think it's nice that you can get up in the morning and think 'Oh good, I've got somewhere to go', because when you've got nowhere to go it's boring, the day's long…whereas here you've got your Monday lunch club you can come to, you've got your Thursday club, you've got your fish and chips on a Friday…there's always something going on, and then if they've got some trips organised you've got that going on your calendar to look forward to."

Many members stated that on the days when they went to the LAH scheme, they got up in the morning with a sense of purpose and, as one member described it, *"a reason to get up and get dressed"*.

3.4 The volunteers and staff were clearly key to the success of the schemes, with many members describing the care and support they received, and the way they were valued and treated as individuals.

"They just really care…if you're a little bit upset or just need someone to talk to, they've got time for you. Last year I lost my dad and they sent me a card and I thought that was really nice."

"And they remember your birthday, you get a birthday card and they sing to us, because there might be some people that come here that perhaps might only get two or three birthday cards".

3.5 Taking part in Live at Home schemes also had additional benefits for people, with members growing to trust the staff and volunteers and to know they could ask for help with areas of concern. For example, one Manager described being asked for help by a couple struggling to deal with their post, which resulted in her discovering they had considerable financial problems which were, in part, the result of them not claiming their pensions. With her help, they were able to claim the money they were owed, and hence to completely clear their debts.

3.6 We are convinced that our LAH schemes provide an invaluable service, however we are currently developing impact measures for all our LAH schemes to better demonstrate the outcomes our schemes achieve for older people, to support our ambition to reach out to more people.

3.7 Loneliness and dementia

As a provider of dementia care, we are very aware of how isolating people with dementia can feel. One way we aim to address this is through the provision of Music Therapy to people with dementia in our care homes, including Coed Craig in Colwyn Bay and Hafan y Waun in Aberystwyth.

3.8 We know that music therapy improves the quality of life for our residents with dementia. Our therapists encourage our residents to be interactive with the music, by singing, playing simple percussion instruments or responding to musical cues. Sessions are guided by the residents enabling them to use the music to express how they feel.

3.9 MHA's Chief Music Therapist Ming Hung Hsu recently completed a feasibility study[1] to prove the benefits of music therapy as part of his doctorate and showed that music therapy demonstrably improved wellbeing for a sustained period beyond the therapy, and eased negative symptoms of dementia such as anxiety. We know that music therapy improves wellbeing and quality of life, especially for those at the later stage of dementia, where very little else works to address agitation and anxiety. Our

[1] Authors: Hsu, M.H., Flowerdew, R., Parker, M., Fachner, J., and Odell-Miller, H.
Published: July 2015 (BMC Geriatrics, http://www.biomedcentral.com/1471-2318/15/84)

vision is that music therapy should be available to all those with moderate to severe dementia, offered on prescription and referral, in the same way as other better known therapies. At present, we fundraise to provide music therapy for free to our residents with dementia.

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

4.1 We are supportive of any policy solutions that look to develop and support community infrastructure, particularly if loneliness is one of the issues being addressed. We are unable to comment on the cost effectiveness of the Ageing Well in Wales programme, however we are pleased that there is a specific focus on issues affecting older people, particularly in respect of an ageing population and we would like to see the other devolved nations following suit. It would be helpful if such programmes could help bring small locally based voluntary sector schemes together, support them in the development of services and support them to be sustainable in terms of access to resources including funding and volunteers.

4.2 We would like to see social prescribing models adopted more widely. Social prescribing enables GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services. It recognises that people's health is determined primarily by a range of social, economic and environmental factors and seeks to address people's needs in a holistic way and support individuals to take greater control of their own health. In some areas of England, e.g. Rotherham, there is a very effective social prescribing partnership between the local Clinical Commissioning Group and voluntary sector, which is adequately resourced and well run. We know that our Live at Home schemes fit well with this model, having both mental and physical health benefits.

Glamorgan Voluntary Services

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

Introduction to GVS

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

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

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

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

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

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

Answers to Inquiry questions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Ways of addressing problems of loneliness and isolation.

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

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

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

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

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

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

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

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

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

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

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

4. Current policy solutions in Wales.

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

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

If you would like further information, please contact:

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http://www.gvs.wales/

8th March 2017

LI 10

Ymchwiliad i unigrwydd ac unigedd

Inquiry into loneliness and isolation

Ymateb gan: Mantell Gwynedd

Response from: Mantell Gwynedd

Ymchwiliad i Unigrwydd ac Unigedd

Cefndir Ffrindia'

Yn 2011 derbyniodd Mantell gwynedd bron i filiwn o bunnoedd drwy gronfa Llawn Bywyd, Y Gronfa Loteri Fawr i sefydlu cynllun cyfeillio i unigolion dros 50oed yng Ngwynedd oedd yn unig neu ynysig. Nod y cynllun oedd recriwtio gwirfoddolwyr dros 18oed i gyfeillio am ddim mwy na thair awr yr wythnos. Cychwynnodd Cynllun Ffrindia' yn Ionawr 2012 ac yn ystod y pum mlynedd fe recriwtiwyd dros 200 o wirfoddolwyr, ac fe gyfeiriwyd tua 540 o unigolion i'r cynllun. Yn ystod 2015 - 2016 gwnaethpwyd gwerthusiad ar y cynllun drwy ddefnyddio 'Canfod Gwerth Buddiant Cymdeithasol (SROI) ble ddangoswyd fod y cynllun wedi uchafu gwerth o £2.81 am bob punt a fuddsoddwyd. Mae gweddill y dystiolaeth a gyflwynir yn yr adroddiad yma i'w gael yn yr adroddiad, neu o'r adborth uniongyrchol a dderbyniwyd oddi wrth y gwirfoddolwyr ac unigolion y cynllun.

1. Rhesymau

1.1 Iechyd a Lles

Nod Cynllun Ffrindia' oedd i'r unigolion drwy gefnogaeth eu gwirfoddolwr ail greu cysylltiadau cymunedol. Ond, gwelwyd yn nifer o'r cyfeiriadau nad oedd hyn yn bosib am sawl rheswm h.y. symudedd, oedran, cyflyrau. Daeth yn amlwg fod canran uchel o rai dros 80 oed angen cwmni, ond ddim i 'fynd allan' ond i sgwrsio a chymdeithasu yn eu cartrefi. Yn falch o gael cwmni am ychydig oriau, fel yng ngeiriau un unigolyn ' rhywun yn dod trwy'r drws, tynnu eu côt, eistedd i lawr i gadw cwmni gyda mi'.

Gyda'r unigolion dderbyniodd cyfaill gwirfoddol ac eisiau mynd allan o'u cartrefi gwelwyd yn fuan fod hyn o fudd iddynt yn gorfforol a meddyliol. Roedd y gwirfoddolwyr yn 'chwilio' am leoliad i ymweld ag ef. Yn Ne Gwynedd byddai ymweliad a Chanolfan Bywyd Gwyllt Y Dyfi i weld y Gweilch yn lleoliad oedd yn uchel ar eu rhestr. Gyda mynediad 'hawdd' i bobl hŷn ac anabl roedd modd cael budd uchel iawn o'r ymweliad. Lleoliadau poblogaidd arall fyddai Canolfannau Garddio - cyfle i gael ychydig o siopa a chyfarfod pobl eraill. Yn ystod y gwerthusiad un cwestiwn a ofynnwyd i bob unigolyn oedd: Beth oedd Ffrindia' wedi gwneud iddynt hwy? Cafwyd atebion positif bob tro gydag un unigolyn yn datgan 'mae wedi newid fy mywyd', Roedd y cynllun cyfeillio hefyd yn rhoi cyfle i ofalwyr gael 'seibiant', cyfle iddynt hwythau ymgymryd â diddordebau eu hunain.

Afwyd tystiolaeth gan Ffeddygon lleol yn datgan eu bod yn gweld newid yn yr unigolion oedd wedi derbyn cyfaill gwirfoddol h.y. gwell cyfathrebu, uchafu hyder.

1.2 Colli Cymar

Cyplau hŷn wedi arfer gwneud popeth a'u gilydd, wrth golli cymar mae'r unigolyn sydd ar 'ôl' yn colli hyder i fynychu digwyddiadau. Dim hyder i gerdded drwy ddrysau i fynychu digwyddiadau ar ben eu hunain. Esiampl o hyn yw cinio henoed - cyplau wedi arfer mynychu gyda'i gilydd, ac wedi colli cymar ddim yr 'awydd' i fynd eu hunain. Cnlyniad hyn oed colli cysylltiad gyda'r gymuned.

1.3 Lleoliad Cartref

Gall lleoliad eu cartref greu unigrwydd mewn pobl hŷn. Pobl yn ymddeol i fannau anghysbell/pentrefi glan môr/cefn gwlad sydd ddim yn broblem tra mae iechyd/cludiant./symudedd yn bodoli. Tra mae'r gallu ganddynt i fynd allan o'r cartref i fynychu digwyddiadau/siopa dim problem. Cludiant o'r cartref yn creu problemau – angen trefniadau os nad oes gyrrwr ar gael – problemau i fynychu apwyntiadau meddygol yn rheolaidd yn gwneud cyflwr yn waeth.

1.4 Colli Cysylltiad Cymunedol

1.4.1 Ymddeoliad

Mae ymddeol i nifer iawn o unigolion wedi creu unigrwydd. Gweithio yn weithgaredd cymdeithasol ynghyd ac economeg. Cysylltiadau cymunedol ddim mor gryf â rhai'r gwaith ac weithiau'r unig gyswllt tu hwnt i'w teuluoedd agos sydd ganddynt. Bywyd y gweithle yn parhau wedi'r ymddeoliad - gallu cael effaith negyddol. Gall y lleoliad gwaith fod wedi bod cryn bellter o'r cartref, ac felly yn anodd cadw'r cyswllt hynny.

1.4.2 Symud Cartref

Hyn wedi amlygu ei hun yn gryf iawn yn y cynllun, y nifer o unigolion sydd yn byw ar ben eu hunain mewn mannau anghysbell neu wedi ail gartrefu yng nghefn gwlad. Gwelwyd wrth dderbyn cyfeiriadau fod y mwyafrif o rain yn byw ar ben eu hunain, nifer yn weddw. Canran uchel wedi ail gartrefu yng Nghymru yn dilyn ymddeoliad, gwerthu tŷ yn Lloegr a symud i fyw. Bywyd yn dda yn y blynyddoedd cynnar, ond iechyd yn torri lawr, colli cymar yn achosi fod yr unigolyn ar ôl yn cael ei gadael heb gefnogaeth agos. Plant' os oes rhai yn byw a gweithio i ffwrdd a ddim ar gael i gynnig cefnogaeth. Mae bwlch mewn cludiant cyhoeddus weithiau ac felly heb ffordd i fynychu digwyddiadau cymunedol ac felly unigrwydd ac unigedd yn bodoli a dwysau. Dylid amlygu'r problemau yma cyn iddynt ail leoli eu bywydau gan amlygu beth sydd ddim ar gael yn hawdd yng nghefn gwlad Cymru - h.y. cludiant, mynediad i wasanaethau cyhoeddus, gwasanaeth iechyd

2. Tystiolaeth o Raddfa

2.1 Mae llawer o astudiaethau wedi ceisio mesur maint unigrwydd. Yn ôl y Befriending Network (2014), yn 2012 daeth Victor a Yang i'r casgliad bod 6% o oedolion y DU yn unig "bob amser neu'r rhan fwyaf o'r amser", a bod 21% yn teimlo'n unig "weithiau" (gan ddefnyddio data o'r Arolwg Cymdeithasol Ewropeaidd ar gyfer 2006).

2.2 Yn 2010 nododd y Sefydliad Iechyd Meddwl fod 24% o oedolion "yn poeni am deimlo'n unig" a bod gan 37% o'r rhai fu'n cymryd rhan yn yr arolwg ffrind agos neu aelod o'r teulu y credent ei fod yn "unig iawn" (Griffin, 2010).

2.3 Er bod yr astudiaeth hon yn cefnogi'r syniad nad yw unigrwydd yn elfen annatod o heneiddio, a bod gan bobl hŷn botensial o hyd i wneud cyfraniad gwerthfawr i gymdeithas, mae Age UK (2014) hefyd yn dweud bod 40% o'r holl bobl hŷn (tua 3.9 miliwn) yn dweud mai'r teledu yw eu ffrind gorau.

2.4 Mae poblogaeth Prydain, fel llawer o wledydd eraill, yn mynd yn hŷn, a rhagwelir y bydd nifer y bobl sydd dros 65 oed yn cynyddu o 10.84m yn 2012 i 17.79m yn 2037 (Cydffederasiwn y GIG, 2016).

3. Effaith (Unigrwydd/Unigedd)

3.1 Iechyd

Unigrwydd yn effeithio ar iechyd a lles. Y meddwl a'r corff yn 'cau' i lawr – dim ymgysylltiad a'r gymuned yn creu unigedd. Gwelwyd fod cael cyfaill gwirfoddol i unigolion oedd wedi dioddef o isalder yn gwella eu hagwedd ac yn arwain at wellhad tymor hir. Dyma ble roedd cael y person cywir i gyfeillio yn tu hwnt o bwysig – rhaid oedd cael dau o'r un diddordeb i hyn weithio. Cafwyd rhai gwirfoddolwyr ar y cynllun wedi dioddef o unigrwydd eu hunain a fod y cyfeillio a creuwyd drwy gynllun Ffrindia' wedi bod yn ddull iddynt hwythau hefyd wella eu hiechyd.

3.2 Diet

Diet yn newid pam yn byw ar ben eich hun. Ddim eisiau mynd i'r drafferth o wneud bwyd/blas am fwyd ddim yr un fath. Cyd fwyta yn weithgaredd 'cymunedol' ble mae modd cael sgwrs a rhoi y byd yn ei le. Gwelwyd pan oedd yr unigolyn a'r cyfaill gwirfoddol yn mynd 'allan' roedd y baned mewn lleoliad megis tŷ bwyta/canolfan arddio yn bwysig. Nodwyd gan rai pan roeddynt yn cael 'pryd ar olwynion (meals on wheels), roedd 'person' yn ei gludo' a sgwrs i'w gael wrth weini'r pryd – bwydydd wedi ei rhewi ddim yn cael yr un derbyniad.

3.3 Cyfathrebu

Os ar ben eich hun – dim sgwrs na cyfnewid syniadau, colli y ddawn i sgwrsio, dim diddordeb yn y gymuned o gwmpas. Pan roed cyfaill gwirfoddol yn dechrau cyfeillio roedd newid yn ymddygiad a sgwrs yr unigolyn. Roedd cael cyfle i drafod neu ymweld a lleoliad (megis Canolfan Garddio/Lleoliad

Hanesyddol) yn hwb i'r sgwrs hynny. Wrth werthuso'r cynllun gwelwyd fod budd y cyfeillio yn bodoli am ddyddiau h.y. y diwrnod cyn yr ymweliad, yr ymweliad ei hun ac yn aml byddai cofio'r pleser yn parhau am ddiwrnod wedyn

3.4 Symudedd

Gall bod yn unig leihau symudedd oherwydd:

- Gaeth i'r cartref
- Ddim yn symud o gwmpas y cartref
- Cyflwr iechyd
- Oed
- Effaith wedyn ar iechyd corfforol

4. Defnydd o Wasanaethau Cyhoeddus

4.1 Torriadau

Gwasanaethau Cymdeithasol yn gwynebu torriadau yn eu cyllideb – ddim yn gallu cynnig yr un math o gefnogaeth ac yr oeddynt neu fod y gefnogaeth maent yn gallu gynnig gyda cost uchel iddo e.e. traed/ymolchi/gofal cartref. Gwelwyd fod gwasanaeth bwyd i'r cartref wedi dod i ben gyda modd prynu i mewn prydau wedi ei rhewi. Roedd y gwasanaeth bwyd yn rhoi cyfle i gael cyswllt hwyrach ddwy i dair gwaith yr wythnos – dim fan yn danfon bwyd wedi ei rewi unwaith y mis. Mae Age Cymru yn darparu cinio henoed mewn llawer o leoliadau – eto gyda problem o gludiant. OND mae'r gwasanaeth yma yn amrhisiadwy gyda cysylltiadau a chyfeillgarwch yn gallu cael eu creu – cyswllt rheolaidd.

4.2 Prinder

Ychydig o wasanaethau yn lleol – gorfod teithio gan ddefnyddio cludiant preifat i apwyntiadau mewn ysbyty. Cafwyd tystiolaeth yn ystod y cynllun fod unigolyn wedi talu bron i £100 i gael tacsi preifat fynd a hi i ymweld a'i gwr yn yr ysbyty – taith o tua 30 milltir un ffordd + y tacsi yn gorfod aros. Dim cludiant gymunedol na chyhoeddus.

4.3 Cost

Wrth werthuso Ffrindia' ychwanegodd y cynllun werth o £2.81 ar gyfer bob £1.00 a fuddsoddwyd. Gan fod Ffrindia' wedi ei gyllido drwy'r Gronfa Loteri Fawr nid oedd cost i'r unigolion. Gwelwyd yn ystod Cynllun Ffrindia' ein bod yn cyflwyno gwybodaeth am wasanaethau oedd ar gael i gefnogi pobl hyn, megis gwasanaeth siopa. Problem: nifer ohonynt ddim am dalu am y gwasanaeth. Roedd yn well ganddynt archebu o'r siop leol am nwyddau 'drytach' na talu am wasanaeth fyddai yn cynnig mwy o amrywiaeth iddynt am lai o gostau.

5. Ffyrdd i Fynd i'r Afael a Phroblemau Unigrwydd ac Unigedd

5.1 Cefnogaeth

- Cadw'r gefnogaeth yn ymarferol, hyblyg
- Mudiadau Cenedlaethol ddim bob tro a'r ateb

- Gweld beth sydd yn bodoli yn lleol – weithioau mudiadau bychain yn gallu cynnig gwasanaeth fwy ‘besposke’
- Gweithgareddau lefel isel yn gallu bod yn fwy effeithiol
- Canlyniadau gorau pryd mae’r ateb wedi ei deilwrio i’r unigolyn
- Cludiant
- Cyfarfod mewn grwpiau ddim bob amser beth sydd yr angen
- Parchu barn yr unigolyn

LI 11
Ymchwiliad i unigrwydd ac unigedd
Inquiry into loneliness and isolation
Ymateb gan: Canolfan i Ymchwil Heneiddio a Dementia a Chanolfan i Heneiddio Arloesol, Prifysgol Abertawe
Response from: Centre for Ageing and Dementia Research and Centre for Innovative Ageing, Swansea University

Health, Social Care and Sport Committee
Inquiry into loneliness and isolation

Swansea University
Prifysgol Abertawe

Response from the **Centre for Ageing and Dementia Research** and the **Centre for Innovative Ageing, Swansea University**

The Centre for Ageing and Dementia Research (CADR) and Centre for Innovative Ageing (CIA) is pleased to feed into the committee's inquiry into loneliness and social isolation in later life. The comments below will focus on prevalence, and risk factors associated with loneliness and social isolation in later life, reflecting the expertise and strengths within the Centres.

Introduction

1. Loneliness and Social isolation are distinct but related concepts. Loneliness can be defined as "the unpleasant experience that occurs when a person's network of social relations is deficient in some important way, either quantitatively or qualitatively"[1] In contrast, social isolation is an objective measurement, based on the absence of contact with other people, which can be quantified, and integration with other members of society. It is the opposite of good social support.[2] Individuals with a small number of meaningful ties or who have no social network are, by definition, socially isolated. People who have a small number of social ties are at greater risk of becoming lonely. However, older people can be lonely but not isolated, or isolated and not lonely, or both isolated and lonely or neither.[2]

Evidence for the scale and causes

2. Data from the Cognitive Function and Ageing study -Wales (CFAS-Wales) found that 25.3% of older adults in Wales reported being lonely and 26.9% socially isolated.[1]
3. The causes of loneliness and social isolation are multifactorial and complex. Pathways into loneliness and social isolation may be the result of single life event i.e. bereavement or may result from cumulative events or losses over time.[1,3]
4. Our research has identified a range of factors which increase vulnerability to loneliness and social isolation. These include; living in a rural area, bereavement, marital status (being single, divorced or widowed), advanced age, living alone, retirement, financial resources, admission to a care home, disability, sensory impairments, being a carer or giving up caring,

being in poor health, functional impairments, cognitive impairment, living more than 50 miles from family and having low levels of participation in religious or community groups.[1,3-5]

5. Although there are similarities in the risk factors associated with loneliness and social isolation later life, interim results from CFAS Wales identified key differences in the risk factors associated with the four categories of loneliness and social isolation. Risk factors predicting being lonely but not isolated included depression, poor health, and low self-esteem. Predictors of being isolated but not lonely included having a low level of education, advanced age (85years and over) being male, childless, depression, poor health, and low levels of interpersonal control (the individual's ability to interact with others). The predicators of being both lonely and isolated included advanced age (85years and over) being male, divorced or separated, childless, depression, poor health low self-esteem and low levels of interpersonal control.[3]
6. For older people receiving formal care services in Wales: our research found that extracare environments provided the conditions for increased social interaction and this was particularly effective for older widows. However, there was no difference in the levels of loneliness between three living environments (community, residential care and extracare sheltered housing). Analysis of qualitative data illustrated the point that although social interactions were increased in extracare environments the exchanges did not necessarily lead to high quality and emotionally satisfying social relationships. Social interactions appeared to be fairly superficial in nature, and consisted of encounters in the communal living areas in the facilities rather than in the private confines of the residents' flats.[6]
7. Qualitative research we have conducted with older lonely adults in Wales, as part of the CFAS-Wales study has identified precursors which increase vulnerability to loneliness and social isolation with age. These include personality traits such as shyness, or introversion which may inhibit the development of social networks across the individual life course.[5] Our research indicates that these personality traits may also act as a barrier, preventing older people engaging in group activities aimed at alleviating loneliness and social isolation.
8. Financial constraints in later life have been found to increase vulnerability to loneliness and social isolation in later life. Research undertaken in Canada found loneliness was higher among long term residents in newly affluent rural communities. Financial constraints prevent older adults participating in activities and organizations, which result in reduced social connections, increasing vulnerability to loneliness.[7] This finding is supported by our qualitative research conducted as part of CFAS Wales, which found that limited financial means constrained some older adults from accessing support services which would help alleviate their loneliness.[3]
9. Our research indicates that driving cessation can also be a casual factor in some people becoming lonely and or isolated in later life.[3]

Impact of loneliness and isolation on older people

10. Our research demonstrates the impact of loneliness and social isolation on the physical and mental wellbeing of older adults in Wales. Preliminary analysis using interim data from the CFAS Wales study, found a statistically significant association between loneliness and depression, with 59.1 % older participants who reported being sad or depressed all or most of the time were also lonely[3]. The research evidence shows that depressive symptoms have a

significant impact on loneliness, whereby greater levels of depressive symptoms increase levels of loneliness.[7] Depression was also found to be predictive of being 'lonely not isolated' and 'lonely and isolated'. These findings were supported in the qualitative study with some lonely and isolated older adults referring to it as being in a 'very dark place.' [7]

11. Our research in Ireland suggests that depression is a 'cognitive process' that moderates how intensely people react to their personal levels of social contact and support, and their functional ability to participate fully in society. Adjusting one's expectations regarding quantity and quality of social contact - *desired* social relations - in light of one's physical ability to maintain social ties is more difficult to achieve for those with depression.[4]
12. There is evidence to suggest that some older adults use alcohol as a mechanism to cope with loneliness. Findings from our qualitative study show that some older adults use alcohol as a way of alleviating the negative emotions associated with being lonely and /or isolated. While others spoke about their fear of turning to alcohol in order to cope with loneliness.[3]
13. Regardless of the pathway into loneliness and social isolation, we found that the onset of loneliness and social isolation represented a significant threat to the individual's identity. The evidence shows that loneliness and social isolation disrupt an older person's sense of self, challenging notions of who they are, their social roles, personality and interests, as well as challenging the assumptions they hold about their relationships with others. This can have implications for their loneliness trajectory. [3]
14. Disabled older adults are disproportionately affected by loneliness and social isolation in later life. We found that greater disability is associated with greater levels of loneliness.[1,4] This is supported in the qualitative work undertaken as part of CFAS Wales which found that older participants with physical or sensory impairments were chronically lonely.[3]
15. Older adults with cognitive impairments are disproportionately affected by loneliness and social isolation. The research evidence shows that people with severe cognitive impairment have fewer social contacts than those with moderate or no cognitive impairment. The greater the severity of cognitive impairment the greater the loneliness. We argue that the ways in which society interacts and treats older people can shape their social relationships, which can result in them being excluded from contact with family, friends and neighbours. Ageing stereotypes and society's expectations regarding older people can also influence and shape how an older person with cognitive impairment perceives themselves.[1]
16. Interim data from CFAS Wales identified a socio economic gradient in loneliness. Older adults living in local authority housing and those with lower educational attainment were found to be at greater risk of loneliness as they aged.[3.]
17. Research undertaken in Birmingham with minority elders aged 65+ found very high prevalence of loneliness (between 24 and 50%) among older adults from China, Africa, Pakistan, Bangladesh and the Caribbean. Prevalence of loneliness among older adults from India was similar to that found in older adults across the UK.[8]
18. Research in South Asia, and in England and Wales with migrants from collectivist cultures found that all of the groups studied hold certain expectations concerning the role of the family. On the whole, the *Multigenerational: Younger Family* networks appear to be the desired network type in collectivist cultures. These networks are family focused networks and demonstrate normative differences in networks between collectivist and individualistic cultures. Locally integrated or diverse networks that have a high salience of contact with

friends, family and involvement in community (and bear some similarities to the Multigenerational: Older Integrated or Middle Aged Friends networks) are more robust in individualistic cultures and less prone to loneliness and other negative wellbeing outcomes. This, however, is not the case in collectivist cultures. Contrary to individualistic cultures we found that the most robust networks are privatized family focused networks that include few non-kin members, that is those that we called *Multigenerational: Younger Family* networks. Deviation in network configuration resulted in worse well-being outcomes for older migrants, in terms of worse quality of life (with the exception of Middle Aged Friends) and greater loneliness. Thus, the cultural normative expectations about sources of support and family forms have a bearing on the extent to which networks can protect or buffer an older person from adverse outcomes.[9,10]

The impact of loneliness and isolation on the use of public services in Wales.

19. There is a significant gap in the research evidence in Wales on the impact of loneliness and social isolation on the use of public services. Research evidence is needed to ascertain the extent of healthcare utilisation and service usage among lonely and/or isolated older adults in Wales.

Ways of addressing problems of loneliness and isolation in older people,

20. Interventions that focus on increasing social contact may be valuable for people with few family or friends or those who have experienced a reduction in their social network. However, our research demonstrates the complex interplay of factors which contribute to loneliness and social isolation in later life. The effectiveness of interventions is therefore dependent on our understanding and addressing the complexity of loneliness and social isolation, the needs of different groups of older people and the barriers which prevent people overcoming loneliness and social isolation. Our research indicates that individualised responses to loneliness and social isolation interventions may be required.

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LI 12
Ymchwiliad i unigrwydd ac unigedd
Inquiry into loneliness and isolation
Ymateb gan: Coleg Brenhinol yr Ymarferwyr Cyffredinol
Response from: Royal College of General Practitioners

Loneliness and Isolation in Wales

RCGP Wales repsonse to Consultation by Welsh Government Health, Social Care and Sports Committee

1. RCGP Wales represents GPs and doctors in training as GPs in Wales. We welcome this consultation as we are aware that large numbers of patients across Wales are troubled by loneliness and this was reflected in the recent report by Age Cymru. This is compounded by the increasing age of the population and the gradual urban drift plus changing family dynamics with increasing single householders and single parents. Isolation and loneliness is not simply a rural problem but is commonly seen in the high-rises of our cities and amongst the busy estates and terraces. It can affect the employed and the unemployed and all ages.

2. GPs may see some patients who complain of depression, when the person may have low mood and sadness is miss-attributed to clinical depression, but it can result in true clinical depression. Other forms of mental health problems can often result in loneliness and isolation due to the problems arising from difficulties for those affected to go out and socialise e.g. agoraphobia, severe anxiety disorders, minor learning disability or being ostracised. For some of these people the mental health measure and the primary care mental health support services could be helpful but the services are often over stretched and can be difficult for some to access. Improvements in some of these services could potentially reduce some of the problems.

3. Physical disability may limit some people’s ability to socialise due to lack of suitable transport support. Disability both physical and mental plus unemployment can mean that there is limited funding to help support transport to social groups resulting in isolation. Some GPs and clusters are linking with local groups to sign post patients for localised support.

4. Bereavement is often a real trigger. A caring relative may have stopped work or lost contact with friends and social networks due to the deterioration in the health of a cared for relative. GPs potentially can help identify these people as carers. Carers may not have the same GP as the cared for person or make it clear to the doctor that they are carers. There needs to be an increase in public awareness of the definition of carers and the fact that social services have a duty to assess them in relation to their own needs. Sadly, this does not happen quickly enough and support from social services is limited. Once the carer becomes bereaved then if there has been support this ceases as the carer ceases to be a carer. There may be additional problems due to changed income, loss of confidence in rebuilding social networks or entering the workforce. Social services need to be able to continue to support this group following bereavement. In some areas, this occurs. For a few living in council supported disabled properties, they are asked to move out into alternative accommodation very quickly occasionally away from what support networks they still have and Social Services need to handle these situations more

sensitively.

5. Mechanisms need to be developed to enhance local community cohesion. These can potentially be triggered by groups who have similar needs e.g. midwives, or antenatal classes encouraging young mothers to meet after they have their babies. Local venues can be encouraged to help by enabling them to meet easily, say in community centres, libraries, local pubs or coffee shops. These can be drop in rather than membership groups. GP surgeries could advertise the meetings as could local shops and community groups. Local authorities may be able to help support some of these events.

6. Socialising and exercising is good for mental wellbeing so “walks/runs in the park” or Saturday runs are needed. Valeways is a charity in the Vale of Glamorgan supported by the local authority which promotes walking for easy to more difficult routes. Services such as ‘Mind’ have walking groups which are not for “serious” walking, but more of a chat and getting some physical exercise. Churches may have initiatives such as “Messy Church” which get together generations to do crafting activities. The University of the Third Age has a broad range of activities available to the older age group. Local Authority’s run evening classes that can lead to social integration. For some of those who are isolated it may be difficult to access these services either due to poor transport, fear or other commitments e.g. caring.

7. Some communities have a lot of activities available for all ages and these are advertised locally or via the internet e.g. Wenvoe Village between Barry and Cardiff have several village groups and a monthly community magazine advertises these in ‘Wenvoe What’s On’. In the small market town of Llanfyllin, Powys there is a ‘Good Companions Club’, which meets weekly from March to December. They go on short trips have people in to talk to them on various topics and have parties at Christmas. This is popular with the elderly. In addition, they run a monthly Lunch Club at the local hotel. This involves a hot meal then cake and cup of tea or coffee for £6. Transport is provided for both by volunteers.

8. GPs are in some cases able to identify loneliness and isolation if it is reported or searched for in their patients. There are organisations and groups, who are already providing some of the solutions but GPs are not always aware of these nor are the public. Some way of improving awareness is required and also helping and supporting those who are reluctant to participate to try.

Health, Social Care and Sport Committee Inquiry into loneliness and isolation

Care & Repair Cymru (C&RC) "Improving Homes, Changing Lives".

We are a national charitable body and actively work to ensure that all older people have homes that are safe, secure and appropriate to their needs.

Care & Repair Cymru is committed to improving the health and well-being of older people in Wales by providing advice and assistance with home improvements, adaptations and general repairs. We work in partnership with a number of organisations including the Welsh Government, Local Government Housing and Social Care Teams, NHS, Occupational Therapists, third sector organisations such as Age Alliance Wales, the Older People Commissioner, and housing associations to ensure that older people have access to a range of housing and social solutions that enable them to live in housing that meets their individual needs.

There are 13 Care & Repair Agencies covering the whole of Wales. Each agency provides a wide range of services and support for older and vulnerable people, helping them to remain living independently in their own homes and communities.

Care & Repair Agencies

The 13 Care & Repair Agencies in Wales operate to the same boundaries as local government, and provide housing services to some 47,000 older people every year. The type and scale of services we provided in 2014/15 was:

Core Care & Repair Service

- 30,176 older people helped
- 60% of people helped were over 75 years old
- 11,332 (38%) of people helped received the intensive Casework service
- 898 people received help to apply for additional welfare benefits which increase household income by £4.1m
- £508,541 raised on behalf of 850 clients from charitable funds to pay for repairs or adaptations
- £12m repairs and adaptations facilitated
- 1937 older people helped to make their home more affordable to heat

Rapid Response Adaptations

- 17,739 older people helped
- 4467 of whom helped to return home from hospital
- 15,454 of whom had works that helped prevent hospital admission
- Average time enquiry to completion was 9 days

Managing Better

Following a three year investment from Welsh Government of £1.25m under the Sustainable Social Services Third Sector Grant, Managing Better has been developed through an innovative collaboration between Care & Repair Cymru, RNIB Cymru and Action on Hearing Loss Cymru.

The new service features Managing Better Caseworkers in every part of Wales, helping older people (50+) who live in poor housing, have a sensory impairment and are frail, have dementia, or are vulnerable in other ways. The service will work with primary healthcare practitioners, GPs, hospitals, social care, and third sector organisations to reach older people most in need of help, to keep them safe, warm and independent at home.

The Managing Better Caseworkers, working out of local Care & Repair Agencies, will visit older people in their own homes, assess their needs and identify bespoke solutions to the housing problems they face

This response was composed by Care & Repair Cymru and reflects the views of the Care & Repair movement across Wales.

1. Scale and Causes of the problems of isolation and loneliness

Our Caseworkers deliver a home visiting service to owner occupiers, vulnerable families, disabled and older people, and those suffering from cold related health conditions. Loneliness is commonly seen in older people, especially those who have no family living close by, those with poor health and those living in poor housing , unsafe and damp homes. Some don't see anyone for weeks on end, and find it difficult to attend local groups due to being unable to drive and/or finding it difficult to access public transport. This may be due to a number of factors not limited to mobility issues, lack of confidence and/or sensory loss e.g. eyesight problems. A visit by a Caseworker means that not only support to access a wide range of services including help with home adaptations etc. but also an opportunity to actually see someone and talk to someone.

A common feature of our home-visiting services is that we are able to pick up emotional instability first hand from face-to-face assessment and thus see many people that feel profoundly lonely and are excluded from conventional social networks. It often takes sensitive discussion to highlight these issues and whereas rurality, geography, remoteness provide a natural profile, even in urban, close-knit communities the impact of bereavement, trauma, dementia and mental health can lead to loneliness and a feeling of helpless isolation. As up to 40% of our referrals can be self-referrals, we often reach people at risk during the early preventable stages of loneliness as well as the more entrenched 'cries for help".

Our Agency in Pembrokeshire commented that the area is popular with retirees who often end up isolated from family living in different parts of the country. There are a lot of people who are isolated because of the geography and this is exacerbated by the way communities are changing. There are few regular buses in rural areas and neighbours can feel remote, especially when they are comprised of younger and increasingly busy or mobile families. However loneliness is as much a feature in towns and built up areas, as many older people live on estates where they see no one regularly even though they are surrounded by people. A telling case in point is the amount of people in Pembrokeshire that cannot have a lifeline emergency alarm installed because they do not have at least two people they could name as local responders.

Demographic changes have led to deep-seated social changes, whereby attractive 'retirement communities' like Ceredigion, Conwy, Pembrokeshire and Powys have accommodated thousands from inward migration without the natural local support networks to support their independence. Services are often sparse and remote and this increases vulnerability and makes many 'hard to reach'. In many of these scattered communities, there are examples of economic depletion where younger family members have been forced to move to urban areas. In addition, and so adding Gwynedd, Anglesey and Carmarthenshire as examples, are those that prospered through farming, forestry and the national trust economy, or on small holdings, who might now be isolated and left behind as erstwhile viable ways of life have now

become unviable. This might be exacerbated by the impact of Brexit on rural Wales. Powys has the highest trend of ageing in Wales, highlighted in the last census, and our under-resourced frontline services are challenged to address significant housing challenges as well as the scars of loneliness in homes literally 'up a mountain' or 'at the end of a dirt track'. We have anecdotal evidence of visits being undertaken in areas where caseworkers felt driving conditions were probably unsafe.

Another issue we commonly come across is those individuals who are living in cold and damp homes and those living in homes in a poor state of repair. These clients will avoid social interaction due to the embarrassment factor. They are afraid of people seeing how they live and are reluctant to invite people into their homes thus becoming further isolated and having fewer opportunities for social interaction.

Clearly programmes like Telecare, digital inclusion, social media and Skype can be of great value, but the significant challenges of responder services, poor transport and broadband coverage are all too common. A strategic focus on technological assistance is vital in these areas. Care & Repair services have a strong track record of supporting technology introduction in a sensitive, user-friendly way and making good demonstration of the benefits of keeping in contact.

2. The impact of loneliness and isolation on older people

From a physical perspective, loneliness means that as people grow older they are more prone to falls, and because they are lonely / isolated, there are instances when these falls go undetected and unreported the risks to the individual are increased. From a mental health perspective stimulation via human interaction means a loss of confidence and response. The impact of isolation and loneliness has an effect on health and well-being in older people generally. In terms of general well-being, in many cases this seems to have an impact on peoples' motivation to begin with – they look after themselves with less care, become cut-off and eventually lack the confidence or means to access the support or help they may need to live independently to a good standard. As a result their isolation causes potential deterioration in health.

Someone who is concerned or wary of falling but has a lack of responders for a lifeline may become less mobile as they begin to limit the amount they move around in the home. The profound impact on personal resilience and undermined confidence from a fall is highlighted by the statistic that first time fallers are 50% more likely to fall a second time. It has been found that between 40% and 50% of older people with sight loss fear falling to the extent that they reduce their levels of activity (Royal College of Optometrists, 2014). Yet, evidence from RNIB indicates that early cataract removal reduces falls by 34%. Over 500 people fall in the home every day across the UK, and housing hazards are a major contributory factor. Structured exercise programmes can reduce falls by up to 37% and offer a great model for confidence-building and social interaction, but their resource is narrow and transport is a barrier in rural Wales. The burden of falls on the NHS and on the individual is more usually measured by interventions that merely address physical trauma; however the Royal College of Physiotherapy have assessed the cost in terms of quality of life is 6.4 times this burden: isolation and loneliness are part of this calculation.

A Caseworker in Pembrokeshire visited a client recently who has to stand at the door and flag passers-by down if she wants to open a jar of food – such people are inevitably going to look for convenient, but not necessarily sufficient means of nutrition. As a similar case in point, a 97 year old client living in the middle of Pembroke Dock has to try walking to the local supermarket to get her food – but explained that if she is tired she just come back without the shopping she set out for.

In terms of those with dementia related illnesses, the isolation can be hazardous at worst and at the least, create an environment where there is no daily stimulation for the person whatsoever. This is particularly difficult as the average neighbour or person who could potentially help may not fully understand that the person has a cognitive impairment at all – or not know how to best interact with them.

Care & Repair Cymru

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

This is an added problem for public services, as the knock on effect of the issues in Questions 1 and 2 above means that more are admitted to hospitals and rely more on help from public services. Many of the factors causing expense in health and social care (trips and falls etc) have a link in part to isolation and loneliness, although this can be difficult to quantify. The most unnecessary expenses in health and social care costs are those that could have been prevented – and loneliness is a key contributor in the mix of deteriorating standards and safety at home.

Care & Repair services operate a safe-discharge housing intervention with all primary acute hospitals, utilising our RRAP service to address home safety. There are so many cases of older people that have been de-skilled following a trauma and are far less able to manage in their home as they did prior to hospitalisation, and this has a knock on effect for accessing the wider community. A slide into dependency on more formal care can lead to rapid loneliness, depression and even mental health issues. Keeping people active, independent and healthy is key to addressing loneliness and isolation. This in turn might well reduce the costs to the state.

4 Ways of addressing problems of loneliness and isolation in older people

Care & Repair's face-to-face contact with older people, many of which are 'repeat clients' or 'clients for life' have a significant but unquantifiable impact on loneliness and maintaining contact. Equally, as we deliver wellbeing and prudent health messages on a Making Every Contact Count basis, we can encourage older people to seek redress for some of their problems and refer-on or signpost to other community services. The strength of 'being known' and 'being at the heart' of local communities is that many of these community links are informal and so local pensioner groups, sporting, dance, choral, artistic, lifelong learning, gardening, reminiscence gatherings or linking to memory clinics, leisure and exercise, utilising community transport will be known first hand. There are many examples of a real 'lifeline' being given to seriously depressed and lonely clients through this type of needs matching.

Befriending groups are one solution, but the barriers are transport (costs and availability, especially in rural areas). 1 2 1 befriending is a better solution, but the barriers include demand and ability to attract suitable volunteers to support and the costs of providing this service. Structured 1 to 1 befriending delivered by the third sector is usually a **free to access** service but it is not a **free to run** service. All volunteer befrienders have to be properly trained, supervised and DBS checked which all needs to be properly resourced. The nature of volunteering means volunteers will come and go on a regular basis so a lot of time, effort and expense goes into the recruitment, training and matching of suitable volunteers to people who need a befriender. There is also a cost implication associated with a volunteer befriender getting to and from a visit or training. A balance needs to be found between the costs of a volunteer befriender visiting someone and trying to match people more locally to save costs. The priority should always be on the quality of the befriending match of volunteer to client, ensuring the best outcome for the individual who is isolated.

You also need motivated, well trained and well supported staff to recruit, train and support befrienders which has cost implications. The nature of volunteering means a high turnover of volunteer befrienders. Any effective befriending service needs a well-structured and properly resourced recruitment, training and support framework, ideally one that is quality assured (e.g. Investors in Volunteers or the Approved Provider Standard APS through the Mentoring and Befriending foundation).

The nature of current befriending funding (small scale funding and short termism) can have an impact on the motivation of staff to deliver effective befriending solutions.

Clients accessing Care & Repair agencies services definitely benefit from the home visiting aspect of our work but client demand and staff workload means there is huge pressure to provide a service and not the funding to match to support it. Visiting clients who are lonely or isolated by dedicated caseworkers across Wales would have huge health and cost benefits.

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

The way in which many services are delivered does little to combat loneliness and isolation. So much is carried out over the phone now rather than face to face that this does little to reinforce the individual's sense of being an important member in society when dealing with many organisations. Care & Repair Agencies see the majority of clients at home in a face to face situation and take a holistic interest in their whole situation.

Agencies work closely in partnership with Health, Mental Health, Social Services, Occupational Therapy, social workers, etc. who are used to referring into us for their service users who are vulnerable and need us to support them to access help.

We are working across all the community networks in Wales on a day to day basis, including working with people in the most rural areas, and collaborate across county boundaries. Making communities aware of what we offer, what help is available – speaking to clients, their families and making them aware of the referral process is crucial and Caseworkers are visiting clients on a daily basis and identifying at first point of contact those who need help / those eligible for help.

Our services have a proven track record of collaborative partnership working and there are many latent community resources that might 'volunteer' a resource to address loneliness. Police-Fire & Rescue-Ambulance, Telecare response, housing floating support, Scouts & Guides, College volunteer groups, OAP groups, WI, tenant groups, as well as more established befriending, national exercise & leisure, etc. could link as a community hub in a more joined up way to look at community wellbeing and enable key parts of Wales' innovative policy ambitions.

Clair Houston

Policy & Research Officer

LI 14

Ymchwiliad i unigrwydd ac unigedd

Inquiry into loneliness and isolation

Ymateb gan: Samaritans

Response from: Samaritans

Ymateb Samaritans Cymru i ymgynghoriad

Ynghylch Samaritans Cymru:	Mae Samaritans yn elusen gofrestredig â'r nod o ddarparu cymorth emosiynol i unrhyw un sydd mewn trallod emosiynol. Yng Nghymru, mae Samaritans yn gweithio'n lleol ac yn genedlaethol i godi ymwybyddiaeth o'u gwasanaeth ac estyn allan i gymunedau lleol i gynorthwyo pobl sy'n cael trafferth i ymdopi. Maent yn ceisio defnyddio eu harbenigedd a'u profiad i wella polisïau ac arferion ac yn gyfranwyr gweithgar i'r gwaith o ddatblygu a rhoi ar waith Gynllun Gweithredu Atal Hunanladdiad a Hunan-niwed Cymru 'Siarad â Fi 2'.
Cysylltwch â:	Emma Harris (Swyddog Polisi a Chyfathrebu)
E-bost:	[redacted]
Ffôn:	[redacted]
Gwefan:	www.samaritans.org/wales
Cyfeiriad:	Samaritans, Yr Ail Lawr, 33-35 Heol yr Eglwys Gadeiriol, Caerdydd, CF11 9HB

Ymchwiliad i unigrwydd ac unigedd

Mae Samaritans Cymru'n croesawu'r cyfle i ymateb i'r ymchwiliad hwn i unigrwydd ac unigedd. Mae Samaritans yn bodoli i leihau nifer y bobl sy'n marw trwy hunanladdiad. Er bod hunanladdiad yn aml yn cael ei weld ar ei ben ei hun, mae'n bwysig adnabod ehangder a chymhlethdod y ffactorau risg sy'n dod cyn hunanladdiad ac ymgeisiau at hunanladdiad.

Gall unigrwydd ac unigedd gael effaith ddifrifol ar iechyd corfforol a meddyliol ac mae'n un o'r ffactorau risg ar gyfer ymddygiad hunanladdol a

hunanladdiad. Mae'n un o'r rhesymau mwyaf cyffredin pam mae pobl yn ffonio ein llinell gymorth yn y Deyrnas Unedig. Gall bod yn unig yn gymdeithasol wneud unigolyn yn fwy agored i feddyliau ac ymddygiad hunanladdol.

Canfod grwpiau risg uchel

Mae'n bwysig cofio bod unigrwydd ac unigedd yn broblem iechyd cyhoeddus a all effeithio ar bobl o bob oed, gan ganolbwyntio ar grwpiau risg uchel.

- **Pobl Ifanc**

Yn 2010, comisiynodd y Sefydliad Iechyd Meddwl arolwg ar unigrwydd ymysg oedolion ledled y Deyrnas Unedig a chanfu fod y bobl ifanc rhwng 18 a 34 oed a holwyd yn fwy tebygol o deimlo'n unig yn aml, o boeni am deimlo ar eu pen eu hunain ac o deimlo'n isel oherwydd unigrwydd na phobl hŷn na 55 oed.[1]

Un o'r rhesymau posibl y priodolir y ffigurau hyn iddo yw'r defnydd cynyddol o'r rhyngrwyd a chymdeithasu ar lein. Mae plant heddiw'n cael eu geni i fyd cymhleth y gallwn gael trafferth i'w ddeall, un lle mae'r cyfryngau cymdeithasol, defnydd o'r rhyngrwyd a thechnoleg gwybodaeth a chyfathrebu wedi'u gwreiddio yn eu datblygiad cynnar, eu plentyndod a'r cyfnod pan fônt yn aeddfedu. Yn baradocsaidd, mae mwyfwy o dystiolaeth y gall cyfryngau *cymdeithasol* fod yn achosi unigrwydd ac iselder ymysg y glasoed. Mewn astudiaeth ddiweddar yn yr Unol Daleithiau ar effaith defnyddio'r cyfryngau cymdeithasol ar deimladau o unigedd cymdeithasol, canfu Prifysgol Pittsburgh fod defnyddio'r cyfryngau cymdeithasol am fwy na dwy awr y dydd yn dyblu'r tebygrwydd y byddai unigolyn yn teimlo'n unig yn gymdeithasol.[2]

- **Dynion**

Mae dynion yn grŵp â risg uchel o unigrwydd ac unigedd yng Nghymru, a gall hyn gael canlyniadau hynod ddifrifol oherwydd paradocs rhywedd ymddygiad hunanladdol. Yn ffigurau diweddaraf y Swyddfa Ystadegau Gwladol ar hunanladdiad yng Nghymru, dynion oedd 81% a menywod oedd 19%.[3]

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[1] Jo Griffin, *The Lonely Society*, Sefydliad Iechyd Meddwl 2010
[2] *Social Media users more likely to feel isolated* http://www.medicalnewstoday.com/articles/316206.php
[3] *Suicides in the United Kingdom: 2014 registrations* https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2014registrations

Yn ein hadroddiad yn 2010, 'Men and Suicide', lle edrychodd pum gwyddonydd cymdeithasol blaenllaw ar y problemau mae'r grŵp risg uchel hwn yn eu hwynebu, un o'r prif bethau oedd yn effeithio ar ddynion oedd anllythrennedd emosiynol. Mae dynion yn tueddu i fod â llai o ymwybyddiaeth a gallu i ymdopi â'u hemosiynau trallodus eu hunain a rhai pobl eraill. Mae hyn oherwydd y ffordd mae dynion yn cael eu dysgu, drwy gydol eu plentyndod, i fod yn 'wrol'. Nid yw hyn yn pwysleisio sgiliau cymdeithasol ac emosiynol – maent yn dysgu credu bod cael trafferth i ymdopi'n gyfystyr â gwendid. Cyfyngedig yw'r cyfleoedd i ddatblygu sgiliau emosiynol yn ddiweddarach mewn bywyd. Mae hyn yn creu 'croniad' mewn dynion – croniad o drallod, ynghyd ag anawsterau wrth gyfaddef bod ganddynt broblem neu wrth geisio cymorth, a all arwain at argyfwng, chwalfa a theimladau ac ymddygiad hunanladdol. Golyga hyn bod dynion, wrth wynebu unigrwydd ac unigedd, yn llai tebygol o estyn allan am gymorth fel mae menywod yn ei wneud. Mae hyn yn gwneud ymddygiad hunanladdol yn fwy tebygol.[4]

- **Pobl hŷn**

Mae pobl hŷn yn arbennig o agored i unigrwydd ac unigedd a gall hyn gael effaith ddifrifol ar iechyd meddyliol a chorfforol. Mae hanner y bobl hŷn na 75 oed yn y Deyrnas Unedig yn byw ar eu pen eu hunain ac mae 1 o bob 10 yn profi unigrwydd dwys.[5]

Gall pobl hŷn fod yn unig yn gymdeithasol am amryw o resymau megis iechyd gwael, peidio â bod yn ganolbwynt i'w teulu mwyach, ymddeoliad, incwm is, gofalu am rywun arall, a marwolaethau gŵr neu wraig a ffrindiau.

Un o'r rhwystrau i fynd i'r afael ag unigrwydd ac unigedd ymysg pobl hŷn yw anhawster wrth adnabod y rheiny sy'n wynebu'r risg mwyaf.

Mae astudiaethau wedi dangos bod pobl sy'n unig yn gymdeithasol yn teimlo mwy o straen, fod ganddynt hunan-dyb is, a'u bod yn fwy tebygol o fod â phroblemau gyda chysgu na phobl sydd â chymorth cymdeithasol cadarn. Mae unigrwydd ac unigedd yn creu mwy o risg dirywiad gwybyddol, ac mae'n un o'r ffactorau risg ar gyfer hunanladdiad ymysg pobl hŷn.

Ffyrdd o fynd i'r afael ag unigrwydd ac unigedd

- **Rhoi Siarad â Fi 2 ar waith**

[4] 'Men, Suicide & Society' Samaritans. Mae crynodeb a'r adroddiad llawn ar gael http://www.samaritans.org/about-us/our-research/research-report-men-suicide-and-society

[5] *'About Loneliness'* http://www.campaigntoendloneliness.org/about-loneliness/

Fel cyfranwyr a chefnogwyr i Siarad â Fi 2, rydym yn croesawu'r ffaith ei fod yn canolbwyntio ar arwahanrwydd fel un o ffactorau risg hunanladdiad a chysylltiedigrwydd cymdeithasol fel un o'r ffactorau gwarchodol. Er mwyn gwreiddio'r ffactor gwarchodol hwn mewn cymunedau yng Nghymru, mae'n hanfodol i ymyriadau cyffredinol, dethol a dynodedig i gyd gael eu defnyddio.

Er mwyn cyflawni hyn, mae angen fframwaith clir i roi Siarad â Fi 2 ar waith. Dylai fod gan bob awdurdod lleol gynllun atal hunanladdiad sy'n cymryd ffactorau risg a gwarchodol i ystyriaeth; mae angen inni weithredu'n lleol er mwyn atal hunanladdiad yn effeithiol yng Nghymru.

- **Mapio Unigrwydd**

Mae mapio unigrwydd yn caniatáu i wasanaethau lleol ac awdurdodau lleol gydweithio i ddefnyddio data sy'n bodoli eisoes i ragweld lle mae'r preswylwyr mwyaf unig yn byw, gan ganiatáu i adnoddau cyfyngedig gael eu targedu at y bobl a'r lleoedd sydd eu hangen fwyaf. Mae cartrefi â dim ond un meddiannydd, deiliad cartref 65 oed neu hŷn, bod mewn ardal incwm isel a pheidio â pherchen ar gar ymysg y dangosyddion.

Dylid ystyried mapio unigrwydd yn gam ataliol a all helpu i liniaru'r risg hon ymysg yr unigolion sy'n fwyaf bregus.

- **Grwpiau Cymunedol ac Allestyn**

Mae cysylltiad cymdeithasol yn un o'r ffactorau gwarchodol rhag risg hunanladdiad ac ymddygiad hunanladdol. Un ymyriad sy'n mynd i'r afael ag unigrwydd ac unigedd yw cymryd rhan mewn grwpiau cymunedol ac allestyn.

Yn nhermau sicrhau ffactor gwarchodol cysylltiad cymdeithasol, gall thema neu natur grwpiau cymunedol ac allestyn fod yn eang ac yn amrywiol. Mae llythrennedd digidol, chwaraeon, rhifedd sylfaenol, celf a chrefft, cerddoriaeth a boreau coffi i gyd yn enghreifftiau o grwpiau sy'n cyflawni canlyniad cysylltiad cymdeithasol.

Nod sefydliadau fel Men's Sheds Cymru, sy'n dweud bod allgau cymdeithasol yn broblem gudd ond arhosol mewn llawer o gymunedau, yw mynd i'r afael â'r broblem trwy greu grwpiau cymunedol i ddynion gael dilyn eu diddordebau, datblygu rhai newydd, perthyn i grŵp unigryw, teimlo'n ddefnyddiol ac yn fodlon a chael ymdeimlad o berthyn[6]. Mae mudiad Men's Sheds, a sefydlwyd yn Awstralia yn 2005, erbyn hyn wedi ymsefydlu ac yn tyfu yn y Deyrnas Unedig. Fodd bynnag, mae sefydliadau fel Men's Sheds yn

[6] '*What is a Men's Shed?* http://www.mensshedscymru.co.uk/what-is-a-mens-shed/

cael eu cefnogi a'u hariannu gan y Trydydd Sector ac mae angen diogelu eu cynaliadwyedd er mwyn gwarchod y rheiny sy'n fwyaf bregus –

> *"Mae'n rhoi rheswm imi godi yn y bore ac am ddau ddiwrnod yr wythnos dwi'n teimlo bod gen i waith ystyrlon. Dwi'n teimlo'n dda wrth helpu a gweithio gyda dynion sydd yn aml yn teimlo'n unig yn y gymuned. Byddai angen rheswm da iawn arna i i beidio â dod" Bill, 67*

> *"Mae'r Sied wedi codi fy mywyd. Des i o hyd i'r Sied ar adeg dda, roeddwn i'n teimlo'n isel." Brian*

Mae'n hanfodol bod y mathau hyn o grwpiau cymunedol neu allestyn cymdeithasol yn cael eu cydnabod am eu buddion i iechyd: mae cysylltiedigrwydd cymdeithasol yn mynd i'r afael ag unigrwydd ac unigedd, a gall weithio i gyrraedd y bobl sy'n wynebu'r risg uchaf o gael eu hallgau'n gymdeithasol.

Bygythiadau presennol i grwpiau cymunedol

Wrth i fwyfwy o lyfrgelloedd a chanolfannau cymunedol gau yng Nghymru ac wrth i Gymunedau yn Gyntaf ddod i ben, rydym yn pryderu y bydd y cymunedau hynny sy'n fwyaf bregus yn gweld cynnydd mewn unigrwydd ac unigedd oherwydd diffyg y cysylltiad cymdeithasol mae'r canolfannau a chynlluniau hyn yn ei ddarparu.

Dylid canolbwyntio mwy ar grwpiau cymunedol fel math o ataliaeth ac ymyrraeth gynnar ar gyfer unigrwydd ac unigedd yng Nghymru, a dylid llunio datrysiadau polisi i gynyddu cyfranogiad cymunedol.

Atodiad

I gael mwy o wybodaeth am y cysylltiad rhwng hunanladdiad a'r defnydd o'r rhyngrwyd -

Priorities for suicide prevention: balancing the risks and opportunities of internet use Prifysgol Bryste Dr Lucy Biddle, Dr Jane Derges, Yr Athro David Gunnell (Prifysgol Bryste) /Dr Stephanie Stace, Jacqui Morrissey (Samaritans)

LI 15
Ymchwiliad i unigrwydd ac unigedd
Inquiry into loneliness and isolation
Ymateb gan: With Music in Mind
Response from: With Music in Mind

Health Social Care and Sport Committee Inquiry into Loneliness and Isolation

Public Consultation

Submission from members of With Music In Mind C.I.C. 6th March 2017.

1.Background:

With Music In Mind is a Community Interest Company based in South Wales that was set up in 2015 to run singing and social networking groups for people at risk of loneliness or social isolation, or at risk of worsening physical or mental wellbeing. The organisation currently runs three groups in Cowbridge, Barry and Neath, for anyone aged 50 and over.

Liz Fletcher, a group member, approached Managing Directors Sarah Miles and Kate Whitestone, to ask if With Music In Mind could respond the consultation above. Therefore, Liz designed an anonymous questionnaire for group users to complete and she then analysed the results (attached). Kate Whitestone led all three With Music In Mind groups in brief workshops to find out the members thoughts on the **causes of loneliness and isolation**, the **impact of loneliness and isolation** and **what can be done to tackle the problems of loneliness and isolation**. The workshops were well received by the groups and plenty of discussion ensued. A summary of their response is below:

2.The causes of loneliness and isolation:

By far the most common reason given for loneliness was **bereavement**. **Ill health and disability** was the next most common response. Discussion around this matter revealed the cycle of **ill health → loneliness → ill health**.

'Separation of family', 'moving away', 'being isolated within a city/town' and **'break up of communities'** were all points that brought about discussion of how communities and families are differently organised now, in comparison to 50 years ago, and that this can lead to loneliness and isolation of individuals. Included within this area of discussion were also **'empty nest syndrome'** and **'lack of family support'** and **divorce/separation**.

Other points that were raised were to do with geographical isolation and practical issues, including **rurality**, **lack of or poor transport** and **poor mobility**. Mobility also fed into an area of discussion around **lack of confidence** making it difficult to get out. Confidence issues were also linked to **depression, mental health stigma, shyness and 'inability to develop social skills'**, which the groups felt contributed to loneliness and isolation.

Finally, the groups also felt that **financial difficulties** and **unemployment** were factors in developing loneliness and isolation.

3.Impact of loneliness and isolation:

All three groups felt that the main impact of loneliness and isolation was **depression**. **Suicidal thoughts, low self esteem, anxiety, despair and low confidence** were also mentioned. **General ill health** was also thought to be a consequence of loneliness and this was linked to a tendency to '**not looking after yourself'** as a result of loneliness and isolation.

The groups discussed that other consequences of loneliness were **withdrawal from company or society** and **becoming further isolated**. They also felt that it leads to **a greater reliance on medication and social care or services.**

4.Addressing the problem

The groups' ideas around addressing the problem of loneliness and isolation fell into two broad categories; the first was around self-help and the second was around provision for people who are lonely or isolated.

Self help:

The most common suggestion from the members was that those who are lonely or isolated should **join groups** that interest you. They also suggested that **joining church** could be a good way to tackle loneliness. Another idea was of **volunteering** in a local venture such as a charity shop and it was also discussed that **being a good neighbour, being an active member of the community and being involved with your family** would be a good way of avoiding or reducing loneliness.

When discussing that depression is not only an effect of loneliness but also a cause, it was suggested that **seeking medical advice** early was important.

Provision:

The group members felt that **groups with activities** were an excellent way of tackling loneliness and isolation. However, it was also felt that there were several possible barriers to accessing such groups that also need to be addressed. These include, **reducing costs** or keep costs low to service users, providing or arranging **adequate transport, better publicity** of services available, **more volunteers** to run groups, and **facilitation** for certain people to be able to access groups (e.g. support for those with anxiety or mobility issues). Other activities or services that were suggested were **letter writing** initiatives, a **'telephone tree'** and **cross-generational activities** including 'skill exchanges'.

With regards to the bigger picture of loneliness and isolation the group members felt that there should be **more support from influential people** such as **Assembly Members and Members of Parliament** around tackling the problem. They also discussed that there should be more work done **to increase knowledge and change attitudes** around loneliness and that people should be made aware of the concept of **socialising as a way to maintain or improve mental and general health**. Group members thought that GPs and other health professionals should consider **prescribing social groups** as a treatment.

We hope that you find this submission useful and we look forward to reading the results of the inquiry.

Yours

Kate Whitestone Sarah Miles

Managing Directors
With Music In Mind C.I.C.
www.withmusicinmind.co.uk

5.The Questionnaire

In an effort to obtain 'evidence' for this consultation, I devised an anonymous questionnaire for members of With Music In Mind. We had 25 responses from the Cowbridge group and 6 from Neath, reflecting the membership of both groups. The Neath group is due to close shortly as it is too small to be viable.

These are very small numbers when considering national policy, but there is nothing more powerful than direct information and quotations from the people directly affected by the problem of loneliness and isolation

Overall 64% of respondents live alone, although this was 72% in the Cowbridge group. Over half in the Cowbridge group were widowed, and it was mentioned several times that people's marriage or partner was the thing keeping them from loneliness. The number of years being widowed was spread equally from newly widowed 0-2years, 2-10years, and 10-20years.

When asked if they were lonely (yes/no/sometimes), overall 71% answered yes or sometimes, the Cowbridge group being 86% - a tremendously high figure. When asked if they could become lonely if one thing in their lives changed, the answer came back at 81%.

The questionnaire also asked if there were days when they did not speak to/meet anyone. Nearly half the overall (45%) replied yes.

The questionnaire asked who they felt supported by. The choices given were: NHS, Social Care, Friends, Family, Church, Other. In the Cowbridge group, 68% were supported by Friends, and only 40% by Family. Overall 36% felt they had no family support. About a third felt supported by the Church, and about 20% the NHS. There were 6% overall who made it clear they felt they had no support at all.

The last question on the Questionnaire was: *If WMIM suddenly finished, would you miss it (a lot/a bit/ not much)*, 97% replied 'a lot', a resounding endorsement of the validity of a group of this sort.

6. Summary

The replies from this simple questionnaire seem to indicate that there are indeed a large number of people either lonely or isolated already, or who could easily tip into it with one simple life event.

Lonely and isolated people are often quiet people in the background of society, whom nobody notices until something goes wrong. Then they can become an enormous drain on the finances of social and health care in its widest context. If someone noticed them before this happened, they would have a network of contacts to help them through, or maybe even to have prevented the 'disaster' in the first place.

It seems to me that spreading a little money over a wide area, working with Voluntary and Community Interest Groups, could save enormous sums in the long run. Big prestige, headline

making projects so beloved of politicians cut little ice when all you want is a friendly face and to feel cared for.

Words coming up most frequently in the questionnaire were:
Friends, cheerfulness, fun, company, like singing, enjoyable, lifts your mood, Laughter.

And here are some direct quotations from the questionnaire:

'Feel uplifted'

'Very sad and lonely without husband'

'Singing and laughter help so much'

'Really upset about this' *(closing of Neath group)*

'There would be a huge hole in the week' *(without the group)*

'Such happy friendly people who truly care'

'Because of the friendliness of the group, I feel wanted and I feel looked after'

'It's the only thing that keeps me going'

Liz Fletcher
Member With Music In Mind, Cowbridge

LI 16

Ymchwiliad i unigrwydd ac unigedd

Inquiry into loneliness and isolation

Ymateb gan: Gofalwyr Cymru

Response from: Carers Wales

Health and Social Care Committee - Inquiry into loneliness and isolation

1. Carers Wales is part of carers UK. We welcome the Committee's inquiry into loneliness and isolation. Isolation and loneliness has an impact on caring and relationships and affect carers of all ages.

2. Carers are not a homogenous group and will have different needs depending on their caring situation. Carers Wales is restricting this evidence to how isolation and loneliness affects carers of all ages and their caring relationships and much of the issues raised and the evidence will be equally relevant for older people who are caring as well as younger carers.

3. In Wales according to the last census in 2011 there were 369,186 carers. Of these carers 87,173 were aged 65+ and 131,120 aged between 50-64.

4. More needs to be done for all carers of all ages to improve carers' well-being and alleviate the loneliness and isolation that they encounter. The Welsh Government Well-being statement for people who need care and support and carers who need support contain national well-being outcomes and the personal outcomes that individuals may wish to achieve. These outcomes are not age specific and more could be done to ensure that specific monitoring information is requested about the well-being of older carers through the national outcomes framework. However we would wish to see this evidence gathered for carers of all ages to see what is being done to alleviate loneliness and isolation for all carers.

5. Welsh Government's Declaration of Rights for Older People clearly spells out the rights of older people In Wales that includes rights that may help older people prevent becoming lonely or isolated. The declaration should be taken on board by statutory bodies to ensure that older people have a clear steer about what sorts of services should be provided for older people in their commissioning processes.

6. The Future Generations Act and Social Services and Well-being (Wales) Act should also steer statutory bodies to commission services based on population needs which include older people. The services commissioned should have due regard to include services or initiative that help to prevent/alleviate loneliness and isolation.

7. **Why might carers feel alone? -** Social isolation is about how many social contacts a person has, while loneliness is a feeling of a lack of companionship. Loneliness is a feeling that can come and go, or it can be something a person feels all the time[i]

8. Isolation and loneliness is something that many carers face as a result of their caring responsibilities. Contrary to popular belief loneliness isn't always about being on your own.

9. Carers in general put the person they look after first which no longer leaves them time to meet other family or friends. Compounded by the extra costs of caring this may mean that carers can no longer afford to participate in social activities. It is therefore important that carers are identified early and provided with information about their rights as well as information on possible benefits they may be able to claim.

10. More must be done to improve understanding amongst the public and service providers about the impact of loneliness and isolation, including adverse impacts of health and well-being.

11. It is also important that carers are made aware of their rights and are made aware of any practical local support they may be able to access in order to allow them to spend time with family and friends, access local groups and any leisure activities they may wish to undertake to enable them to have a life outside of their caring role.

12. A carer's needs assessment should be offered as soon as a carer is identified by statutory services.

13. A record must be kept of the number of carers identified and offered an assessment. Given that the for the vast majority of older people their first point of contact and regular contact is likely to be with a community based health service action could be taken by Welsh Government to encourage them to identify carers to ensure they are signposted appropriately to relevant organisations.

14. 8 in 10 (83%) of carers who responded to Carers UK's State of Caring survey 2014 have felt lonely or socially isolated because of their caring role. This is as a result of not being able to get out of the house much (55% rising to 64% for those caring for 50 hours or more a week); not being comfortable talking to friends about caring (36%); not having time to participate in social activities(61%); not being able to afford to participate in social activities (45%)
15. **Finances -** Social isolation can be a particular problem for those who are struggling financially as the costs of socialising are often the first thing that carers cut back on to make ends meet.

16. This has been compounded by a sharp rise in household expenditure and the impact of welfare reform changes which makes it difficult for carers to have any spare money for social activities.

17. The extra costs of caring and disability can also include higher energy bills, specialist food, higher phone bills, higher transport costs, having to buy specialist care products and having to finance aids, equipment and adaptations to the home. This is often

accompanied by a steep drop in income if carers have to cut their hours at work, take on lower paid more flexible work, or take early retirement.

18. With 54% of carers struggling to pay household bills and 35% cutting back on essentials like food and heating to make ends meet [ii], it can be impossible to find the money for things like replacement care or even a coffee with friends.

19. Carers Wales State of Caring Survey 2015 just under half of those in Wales who responded to the survey (47%) who said they were struggling to make ends meet said that they were cutting back on seeing friends and family to save money; (61%) said that they were worried about the impact that their caring role would have on relationships with friends and family.[iii]

20. **Carers Health and Well-being -** Without the right support, at the right time carers often find their own health and well-being suffering as a result of caring. By putting their loved ones first, carers can put their own needs last and struggle to find time for themselves and their social networks. This can increase the feelings of loneliness and isolation which can have a serious impact on carers' physical health, mental health and their relationship with others.

21. 80% of carers who responded in Wales to our State of Caring Survey 2015 reported that caring has had a negative impact on their health. 73% said that they find it difficult to get a good night's sleep while over half (51% said they struggled to maintain a healthy diet. Worryingly this also has a consequence on carers' mental health with 87% reporting that they feel stressed, 79% saying that they felt anxious and 56% reported that they had suffered from depression as a result if their caring role.[iv] - "I have no time for myself at all any day". "I am getting close to depression and all the doctor says is 'go for a walk'. That's OK if you can leave the person you care for!"

22. **Relationships -** Caring can be a fulfilling and positive experience for many people, however many people find that taking on a caring role can have a damaging effect on their relationships and social life which can lead to isolation and loneliness.

23. There are many factors that can affect carers' isolation and feelings of loneliness including how often carers can see friends and family. Financial restrictions which I have mentioned above can impact as well as a lack of available and affordable replacement care or support services can impede carers ability to have a life of their own. Another major factor is also the condition that the disabled person may have that impedes their ability to communicate. An example would be an individual with a neurological condition which could exacerbate the feeling of loneliness even though the person is present.

24. **Practical Support -** Practical support with caring such as help from care workers or replacement care is essential for many carers to have a life outside caring and be able to maintain social relationships. Without this support, carers are often pushed to

breaking point and have to give up work, take early retirement and social contacts and networks may be lost. Some may even find themselves having to give up caring and many end up with their own health problems. All the above can exacerbate the feelings of loneliness and isolation. It is essential that when carers come across any statutory agency be it health or the local authority that they are told of their rights under the Social Services and Well-being (Wales) Act and are offered carers needs assessments. Carers Wales State of Caring Survey 2015 found that: 43% of carers said the amount of care and support that had been arranged by social services had been reduced; 14% said that the care and support service had been closed and that no replacement was offered; 8% said that they had cut down on the amount of care and support they got because costs had increased. "I get three days of day centre but I can only get mam there once a week". "I tried to get help from my local authority and from my GP but was told all they can do is provide a list of care agencies that would require payment". "I was told by social services that no help is available"

25. Recommendations

26. Protect funding for carer support and ensure that there are adequate resources available to implement the Social Services and Well-being (Wales) Act 2014.

27. Ensure that there is robust monitoring of the Social Services and Well-being (Wales) Act 2014 to ensure that carers are being identified and offered advice, assistance or support to meet their well-being and other needs.

28. Increase efforts to identify carers across all statutory services including health and ensure that carers are signposted appropriately to support that will help meet their needs.

29. Ensure that the Declaration of Rights for Older People in Wales is widely distributed amongst statutory services to ensure that statutory bodies and service providers who work for, or on behalf of older people know what is expected of them to ensure the well-being of older people in Wales.

30. Ensure that there is access to regular, flexible breaks for older carers and understand the strain that caring can place on relationships and the ability to undertake social activities that may make carers less isolated and lonely.

31. Ensure that loneliness and isolation are issues that are embedded in all the Welsh Governments work including any strategies that it produces.

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[i] The Campaign to End Loneliness has more information about loneliness and isolation, including different types of loneliness http://www.campaigntoendloneliness.org/

[ii] Carers UK State of Caring Survey 2014

[iii] Carers Wales State of Caring 2015

[iv] Carers Wales State of caring 2015

LI 17
Ymchwiliad i unigrwydd ac unigedd
Inquiry into loneliness and isolation
Ymateb gan: Conffederasiwn GIG Cymru
Response from: Welsh NHS Confederation

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

Introduction

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

Overview

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

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

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

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

Terms of Reference

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

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

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

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

9. Other risk factors that been identified include;
   - Single/Divorced/Widowed;
   - Living in a care home;
   - Bereavement;
   - Carer;
   - Retired;
   - Ethnicity (1st generation);
   - Gay/Lesbian;
   - Dementia;
   - Sensory impairment/s;
   - Living in high crime/high deprivation areas;
   - Veterans; ex-service personal have reported that they have issues integrating back into civilian life;
   - Living in sheltered accommodation; and

- Nursing and residential homes where older people feel they have no sense of purpose.

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

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

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

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

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

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

those who are, or who are at risk, of loneliness and isolation to better understand the impact of loneliness and isolation on public services.

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

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

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

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

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

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

19. Group activities in particular have been seen to be helpful in enabling people out of loneliness and isolation.[xvii] This supports the view that effective interventions are;
    a. Group interventions with an educational themes or specific support functions;

b. Interventions that target specific groups, for example women, carers or people with health needs;
c. Interventions where participants are involved in setting up and running the group (co-production);
d. Interventions developed within or run by an existing service;
e. Interventions with a sound theoretical basis; and
f. Interventions with a technological element, for example using video-conferencing or the internet.[xviii]

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

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

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

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

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

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

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

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

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

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

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

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

and others. As well as improving well-being, this may in turn reduce reliance on public sector services, including the NHS.

Conclusion

30. As highlighted in our response loneliness and isolation are both a social and health issue. Evidence has demonstrated the impact loneliness and isolation has on physical and mental well-being but more needs to be done to identify individuals who are, or may be at risk of, loneliness and isolation. Furthermore a better understanding of the support services available at a local level needs to be developed to ensure this support is tailored to an individual's needs and that people are engaged to enable them to access local opportunities and reconnect with their communities.

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[vi] Ageing Well in Wales, Loneliness & Isolation http://www.ageingwellinwales.com/en/themes/loneliness-and-isolation.
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[viii] Ageing Well in Wales, Loneliness & Isolation http://www.ageingwellinwales.com/en/themes/loneliness-and-isolation.
[ix] Julianne Holt-Lunstad, 2015. Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review.
[x] Age UK, 2015. Loneliness and Isolation Evidence Review.
[xi] Alzheimer's Society, April 2013. Dementia 2013: The hidden voice of loneliness.
[xii] A study in the Journal of the American Medical Association in 2007.
[xiii] Age UK, 2015. Loneliness and Isolation Evidence Review.
[xiv] Older People's Commissioner for Wales, 2013. A Thousand Little Barriers.
[xv] Gardiner C, Geldenhuys G & Gett M. 2016. Interventions to reduce social isolation and loneliness among older people: an integrative review.
[xvi] Local Government Information Unit, 2016. Loneliness and social isolation in older people.
[xvii] Age UK, 2010. Loneliness and Isolation Evidence Review.
[xviii] Centre for Policy on Ageing, 2014). Loneliness - evidence of the effectiveness of interventions.
[xix] Older People's Commissioner for Wales, 2013. A Thousand Little Barriers.

LI 18

Ymchwiliad i unigrwydd ac unigedd

Inquiry into loneliness and isolation

Ymateb gan: Comisiynydd Pobl Hŷn Cymru

Response from: Older People's Commissioner for Wales

Ymateb gan

Gomisiynydd Pobl Hŷn Cymru

i

Ymchwiliad Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon Cynulliad Cenedlaethol Cymru i Unigrwydd ac Unigedd

Mawrth 2017

I gael rhagor o wybodaeth am yr ymateb hwn cysylltwch â:

Comisiynydd Pobl Hŷn Cymru,
Adeiladau Cambrian,
Sgwâr Mount Stuart,
Caerdydd, CF10 5FL
02920 445030

Gair am y Comisiynydd

Mae Comisiynydd Pobl Hŷn Cymru yn llais ac yn eiriolwr annibynnol ar gyfer pobl hŷn ledled Cymru, gan sefyll i fyny a siarad ar eu rhan. Mae'n gweithio i sicrhau bod y rheini sydd yn agored i niwed ac mewn perygl yn cael eu cadw'n ddiogel ac yn sicrhau bod gan bobl hŷn lais sy'n cael ei glywed, eu bod yn cael dewis a bod ganddynt reolaeth, nad ydynt yn teimlo'n unig nac yn dioddef gwahaniaethu a'u bod yn derbyn y cymorth a'r gwasanaethau sydd eu hangen arnynt. Yr hyn mae pobl hŷn yn ei ddweud sydd fwyaf pwysig iddyn nhw sy'n llywio gwaith y Comisiynydd ac mae eu llais wrth galon popeth mae hi'n ei wneud. Mae'r Comisiynydd yn gweithio i sicrhau bod Cymru'n lle da i heneiddio ynddo – nid i rai pobl yn unig ond i bawb.

Mae'r Comisiynydd Pobl Hŷn:

- Yn hyrwyddo ymwybyddiaeth o hawliau a buddiannau pobl hŷn yng Nghymru.
- Yn herio unrhyw beth sy'n gwahaniaethu yn erbyn pobl hŷn yng Nghymru.
- Yn annog yr arferion gorau wrth drin pobl hŷn yng Nghymru.
- Yn adolygu'r gyfraith sy'n effeithio ar fuddiannau pobl hŷn yng Nghymru.

Ymchwiliad Cynulliad Cenedlaethol Cymru i Unigrwydd ac Unigedd

1. Fel Comisiynydd Pobl Hŷn Cymru rwy'n croesawu'r cyfle i ymateb i Ymchwiliad Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon Cynulliad Cenedlaethol Cymru i unigrwydd ac unigedd[1]. Mae hwn yn ymchwiliad y mae gwir ei angen oherwydd, er gwaethaf yr ymwybyddiaeth gynyddol o unigrwydd, mae angen gweithredu ar frys er mwyn deall maint y sefyllfa a'r hyn sydd angen ei wneud i fynd i'r afael â'i effeithiau niweidiol a phellgyrhaeddol.

2. Mae bron i 800,000 o bobl 60 oed a throsodd yng Nghymru, sef dros chwarter y boblogaeth; yn yr ugain mlynedd nesaf, mae disgwyl i'r ffigur hwn gynyddu i dros filiwn. Dylai'r ffaith bod Cymru yn genedl o bobl hŷn gael ei gweld fel rhywbeth cadarnhaol.

Maint ac effaith unigrwydd ac unigedd

3. Mae unigrwydd ac unigedd yn effeithio ar bobl o bob oedran, ond mae'n effeithio'n arbennig ar y bobl hŷn 'hynaf'. Tra bod 17% o bobl 75-79 oed yn dweud eu bod yn teimlo'n unig, mae'r ffigur hwn yn codi i 63% ar gyfer rhai dros oed 80[2]. Mae dros 75% o fenywod a thraean o ddynion dros 65 oed yn byw eu hunain. Amcangyfrifir bod 9,000 o bobl hŷn yng Nghymru yn treulio Dydd Nadolig ar eu pen eu hunain, ac mae unigrwydd ac unigedd yn aml yn gwaethygu dros y Nadolig. Mae'n bwysig cofio, fodd bynnag, fod unigrwydd yn effeithio ar lawer o bobl hŷn bob dydd o'r flwyddyn. Gall rhai pobl hŷn fynd o ddydd i ddydd, wythnos i wythnos, neu, mewn rhai achosion, o fis i fis heb weld neb, a gall teimlo'n unig ac ynysig arwain at nifer o ganlyniadau iechyd negyddol, gan gynnwys marwolaeth, morbidrwydd, iselder a hunanladdiad.

4. Yn y blynyddoedd diwethaf mae toriadau ariannol i wasanaethau cymunedol a oedd yn 'achubiaeth' – gan gynnwys bysiau

[1] http://www.senedd.cynulliad.cymru/mgConsultationDisplay.aspx?id=248&RPID=1508153482&cp=yes
[2] http://www.royalvoluntaryservice.org.uk/Uploads/Documents/How_we_help/loneliness-amongst-older-people-and-the-impact-of-family-connections.pdf

cyhoeddus, toiledau, llyfrgelloedd, canolfannau dydd a dysgu gydol oes – wedi cael effaith aruthrol ar iechyd a lles pobl hŷn, gan eu gwneud yn fwy agored i beryglon unigrwydd ac unigedd. Yn ogystal â'r newidiadau mewn gwasanaethau cymunedol, gall nifer o 'bwyntiau sbarduno' eraill achosi i bobl hŷn fod yn unig ac ynysig, gan gynnwys colli partner, cael diagnosis o salwch difrifol ac anableddau, yn ogystal ag ymddeol neu golli swydd yn annisgwyl[3].

5. Rwyf wedi dweud o'r blaen bod unigrwydd ac unigedd yn datblygu'n epidemig iechyd cyhoeddus[4]. Fel y dywedais cyn y ddadl yn y Cynulliad ar unigrwydd yn Ionawr 2017, mae unigrwydd ac unigedd yn faterion trawsbynciol sy'n cael effaith ddifrifol ar iechyd a lles pobl hŷn. Canfu ymchwil gan y Gwasanaeth Gwirfoddol Brenhinol, er enghraifft, fod 17% o bobl hŷn yng Nghymru yn teimlo'n unig ar brydiau, tra bod hanner yr holl bobl hŷn yn dweud mai'r teledu yw'r prif gwmni iddynt. Gall unigrwydd ac unigedd arwain at ystod o effeithiau ar iechyd corfforol a meddyliol niweidiol, ac mae effaith unigrwydd ar iechyd cynddrwg ag ysmygu 15 sigarét y dydd[5]. At hynny, caiff ei gysylltu â phryderon iechyd meddwl a chyflyrau cardiofasgwlaidd, pwysedd gwaed uchel ac mae'n cynyddu'r risg o ddementia 64%[6].

6. Mae o fudd i bawb sicrhau bod llai o bobl hŷn yn dioddef unigrwydd ac unigedd. Mae dull ataliol a gwneud yn siŵr bod pobl hŷn yn fwy gwydn ac yn llai agored i unigrwydd yn hanfodol. Mae dull o'r fath o fudd i'r unigolyn ac yn lleihau'r angen am wasanaethau iechyd a gofal cymdeithasol costus. Byddai ymyrraeth fel cynllun cyfeillio, er enghraifft, yn costio £80 y pen y flwyddyn a gall arbed tua £300 y pen y flwyddyn mewn costau iechyd a gofal cymdeithasol[7]. Yn syml, ni all y GIG a darparwyr gofal cymdeithasol fforddio delio ag unigrwydd fel y gwnaed yn y gorffennol: atal yw'r ateb.

[3] http://www.coop.co.uk/Corporate/PDFs/Coop_Trapped_in_a_bubble_report.pdf
[4] https://www.homecare.co.uk/news/article.cfm/id/1573649/loneliness-public-health-epidemic-plague
[5] http://www.campaigntoendloneliness.org/threat-to-health/
[6] ibid

[7] http://www.scie.org.uk/publications/briefings/briefing39/

Heneiddio'n Dda yng Nghymru a Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru)

7. Mae'r graddau y mae unigrwydd a'r unigedd yn effeithio ar bobl hŷn yng Nghymru yn peri pryder mawr ac mae angen i hyn gael ei nodi a'i gydnabod fel blaenoriaeth leol a chenedlaethol. Mae'n un o'r themâu blaenoriaethol yn Heneiddio'n Dda yng Nghymru, y rhaglen bartneriaeth genedlaethol i wella iechyd a lles pobl 50+[8]. Mae Heneiddio'n Dda yn fudiad cymdeithasol sy'n canolbwyntio ar ymyriadau isel eu cost, mawr eu heffaith sy'n galluogi ac yn grymuso pobl hŷn i fyw bywydau iach, gweithgar, diogel a hapus yn eu cymunedau. Drwy ddull ataliol a dull seiliedig ar asedau, hy buddsoddi mewn pobl hŷn, gall Heneiddio'n Dda helpu i leihau unigrwydd ac unigedd a datblygu cymunedau sy'n gyfeillgar i bobl hŷn ar draws Cymru. Mae Heneiddio'n Dda yn darparu canolbwynt adnoddau ar-lein i helpu i roi sylw i unigrwydd ac unigedd mewn cymunedau, a bydd canllaw a gyflwynir maes o law yn rhoi i unigolion gyngor a chymorth ar sut i ddelio ag effeithiau unigrwydd[9].

8. Mae datblygiadau eraill sy'n digwydd ar lefel genedlaethol a lleol wedi fy nghalonogi. Mae'r dangosyddion cenedlaethol dan Ddeddf Llesiant Cenedlaethau'r Dyfodol (Cymru) yn cynnwys 'Canran y bobl sy'n unig', a ddylai helpu i ddarparu gwell dealltwriaeth o faint unigrwydd yng Nghymru[10]. Mae fy Nghanllawiau diweddar i Fyrddau Gwasanaethau Cyhoeddus ar baratoi eu Cynlluniau Llesiant Lleol yn cynnwys nod lefel uchel i leihau nifer y bobl oedrannus y mae unigrwydd ac unigedd yn effeithio arnynt yn yr Awdurdod Lleol, ac rwy'n croesawu'r ffaith bod unigrwydd yn cael ei gydnabod fel un o'r blaenoriaethau yn rhaid o'r asesiadau drafft o lesiant lleol[11].

[8] http://www.ageingwellinwales.com/wl/home
[9] http://www.ageingwellinwales.com/wl/resource-hub/li-resources
[10] http://gov.wales/docs/desh/publications/160316-national-indicators-to-be-laid-before-nafw-cy.pdf
[11] http://www.olderpeoplewales.com/Libraries/Uploads/PSB_Guidance_w.sflb.ashx

9. Dywedais yn glir yn fy ymateb i Fil Iechyd Cyhoeddus (Cymru), er fy mod yn croesawu ymrwymiad Llywodraeth Cymru i lunio strategaeth genedlaethol i roi sylw i unigrwydd ac unigedd yn ei Rhaglen Lywodraethu[12], rwy'n credu bod hwn yn fater mor bwysig, sy'n wynebu rhai o'r bobl fwyaf agored i niwed mewn cymdeithas, fel y dylai hefyd gael ei gynnwys yn y Bil[13]. Drwy ei hepgor o'r Bil presennol, rydym yn colli cyfle ac mae angen gweithredu pellach i godi unigrwydd i safle uwch ar yr agenda iechyd cyhoeddus.

Ymchwilio a hyrwyddo arferion da

10. Mae ehangder, dyfnder ac effaith unigrwydd ac unigedd yng Nghymru yn sylweddol. Fodd bynnag, mae angen gwneud mwy o ymchwil i ddeall y sefyllfa'n well. Gall unigrwydd ac unigedd effeithio ar bawb ac mae uwchlaw daearyddiaeth, ethnigrwydd, dosbarth economaidd-gymdeithasol, oedran, cyfeiriadedd rhywiol a nodweddion gwarchodedig eraill. Mae bylchau i'w cael yn y gwaith ymchwil ac mae angen gwneud gwaith pellach i gryfhau'r sylfaen dystiolaeth, gyda mwy o fuddsoddi ac adnoddau i lenwi'r bylchau hyn. Er enghraifft, mae angen gwneud gwaith pellach er mwyn deall sut mae unigrwydd yn effeithio ar bobl sydd â chyflwr cronig gydol oes neu gyflwr cronig sy'n cyfyngu arnynt, pobl sydd wedi cael anabledd, ymfudwyr a chymunedau LGBT.

11. Mae angen gwneud gwaith ymchwil pellach hefyd i ddeall yn well sut mae unigrwydd yn effeithio ar bobl ar draws cwrs eu bywyd, ac a oes rhai ffactorau - fel swildod a mewnblygrwydd, neu berthyn i grŵp economaidd-gymdeithasol penodol - yn cael effaith gronnol ar anallu pobl i gael mynediad i rwydweithiau cymdeithasol. Mae arnom angen dealltwriaeth well o pam bod pobl hŷn yn eu holl amrywiaeth yn wynebu unigrwydd ac unigedd ar draws Cymru, y gwahanol ffactorau a'r effeithiau cronnol sy'n gallu achosi unigrwydd, ynghyd â gwell cydnabyddiaeth o gymhlethdod unigrwydd.

[12] http://gov.wales/docs/strategies/160920-taking-wales-forward-cy.pdf
[13] http://www.olderpeoplewales.com/Libraries/Consultation_Responses_2016/161216_HSC_S_Committee_Inquiry_into_Public_Health_Bill_OPCW_CYM.sflb.ashx

12. Mae Heneiddio'n Dda yng Nghymru yn darparu llwyfan ar gyfer amlygu ymchwil ac arferion da, megis gwaith a wnaed gan y Ganolfan Ymchwil i Heneiddio a Dementia (CADR)[14], i annog partneriaid i weithio gyda'i gilydd a hyrwyddo ymyriadau positif sy'n rhoi sylw i unigrwydd ac unigedd a sicrhau bod pobl hŷn yn parhau i fod yn weithgar yn eu cymunedau. Mae ymyriadau a gweithgareddau fel te-partis *Contact the Elderly*[15] a *Men's Sheds*[16], sy'n galluogi pobl hŷn i adennill eu synnwyr o hunaniaeth ac adennill sgiliau cymdeithasu a chyfle i ail-ymgysylltu â chymunedau ehangach, yn chwarae rhan hollbwysig i fynd i'r afael ag unigrwydd ac unigedd ymysg pobl hŷn.

13. Mae'r prosiect 'Camau Cadarn' yn cael ei gyflwyno gan y Groes Goch Brydeinig a'r Gwasanaeth Gwirfoddol Brenhinol ac mae'n helpu i wneud pobl hŷn yn wytnach a gallu byw'n annibynnol yn eu cymuned, tra bod y *Silver Line* yn darparu llinell gymorth gyfrinachol am ddim i bobl hŷn sy'n teimlo'n unig[17,18]. At hynny, mae'r *Campaign to End Loneliness* yn ategu nodau a chanlyniadau Heneiddio'n Dda a bydd yn cyflwyno prosiect yng Nghymru dan nawdd y Gronfa Loteri Fawr, sy'n cynnwys treialon yn ne-orllewin Cymru, i ganfod achosion sylfaenol unigrwydd ymysg pobl hŷn[19].

Gwasanaethau ac asedau cymunedol

14. Mae angen rhagor o gynlluniau a rhaglenni i roi sylw i unigrwydd ac unigedd sy'n broblem gynyddol. Fodd bynnag, nid yw'r ymyriadau hyn, a gyflwynir i raddau helaeth gan y trydydd sector, yn ddigon ynddynt eu hunain i roi sylw i lawer o'r rhesymau pam bod pobl hŷn yn mynd yn unig ac yn ynysig. Yr hyn sydd ei angen yw ymrwymiad o'r newydd i ddarparu gwasanaethau

[14] http://www.cadr.cymru/cy/index.htm
[15] http://www.contact-the-elderly.org.uk/about-us
[16] http://www.mensshedscymru.co.uk/
[17] http://www.redcross.org.uk/About-us/Media-centre/Press-releases/Regional-press-releases/Wales-and-western-England/British-Red-Cross-and-Royal-Voluntary-Service-improve-the-independence-of-older-people
[18] https://www.thesilverline.org.uk/
[19] http://www.campaigntoendloneliness.org/

cymunedol i bobl hŷn a phobl eraill yng Nghymru. Rwy'n sicr bod darparu bysiau cyhoeddus, toiledau, llyfrgelloedd, canolfannau dydd, dysgu gydol oes, meinciau mewn parciau, ayb. yn cadw pobl hŷn yn weithgar ac yn annibynnol yn eu cymunedau, a bod cael gwared ar y gwasanaethau hyn yn gwaethygu'r epidemig unigrwydd yng Nghymru. Mae toriadau mewn cyllid hefyd wedi effeithio ar Wasanaethau pryd ar glud ac mae'r dystiolaeth yn awgrymu bod y gwasanaeth yn llawer mwy na dim ond pryd o fwyd i bobl hŷn gan ei fod yn darparu i unigolion y cysylltiad cymdeithasol y mae gwir ei angen arnynt, yn enwedig y rheini sy'n methu â gadael eu cartref oherwydd diffyg cludiant, neu oherwydd anabledd neu salwch, ac mae'n wasanaeth ataliol hollbwysig arall[20].

15. Mae diogelu a gwella gwasanaethau cymunedol wedi bod yn un o'm blaenoriaeth ers tro byd ac mae'n un o'r meysydd blaenoriaeth yn fy Fframwaith Gweithredu. Fel yr eglurais yn fy adroddiad ar wasanaethau cymunedol yn 2014[21], rwy'n ymwybodol iawn o'r heriau ariannol enfawr sy'n wynebu Awdurdodau Lleol a bod gwasanaethau anstatudol, yr union wasanaethau y mae pobl hŷn yn dibynnu arnynt i fynd o gwmpas, wedi cael eu cau neu eu lleihau o ganlyniad i gyllidebau llai ac adnoddau prin. Erbyn dechrau 2017, ac yng nghyd-destun Heneiddio'n Dda yng Nghymru a Deddf Llesiant Cenedlaethau'r Dyfodol, mae angen gweithredu ar sut i ddiogelu ac ailgyflwyno gwasanaethau cymunedol cynaliadwy fel bod pobl hŷn yn llai tebygol o deimlo unigrwydd ac unigedd.

16. Mae'n hanfodol cronni asedau cymunedol a darparu gwasanaethau isel eu cost, uchel eu heffaith, ac mae atebion newydd, creadigol ac arloesol yn ofynnol, gwasanaethau sy'n gwneud pobl hŷn yn fwy gwydn ac yn helpu i leihau effeithiau niweidiol unigrwydd ac unigedd ymysg pobl hŷn. Mae Awdurdodau Lleol ac eraill eisoes yn cyflenwi cynlluniau arloesol, cost-effeithiol sy'n helpu i sicrhau nad yw pobl hŷn yn 'gaeth i'w cartrefi' a'u bod

[20] https://www.theguardian.com/social-care-network/2016/nov/08/meals-on-wheels-threat-council-cuts
[21] http://www.olderpeoplewales.com/wl/news/news/14-02-25/The_Importance_and_Impact_of_Community_Services_within_Wales.aspx#.WL7GTm-LTct

yn medru mynd allan, ymweld â gwasanaethau, ffrindiau a theulu, a bod yn rhan o weithgareddau cymdeithasol.

17. Drwy gyfrwng cynlluniau Heneiddio'n Dda yr Awdurdod Lleol rwy'n ymwybodol o arferion da, megis datblygu 'map gwres' yn Sir y Fflint i helpu i ganfod pobl sydd mewn perygl o fod yn unig, cyflwyno caffis dros dro mewn rhannau gwledig o Ynys Môn, a rhaglenni gweithgareddau i roi sylw i unigrwydd mewn cynlluniau gofal ychwanegol a chartrefi gofal yn Sir Gaerfyrddin, ac mae enghreifftiau pellach yn ofynnol ledled Cymru. Rwyf wedi dweud o'r blaen bod angen inni gydnabod a defnyddio ein cyfoeth o gyfalaf cymdeithasol yng Nghymru a chanfod ffyrdd o wneud gwell defnydd o'n sgiliau, ein gwybodaeth, ein profiad a'n seilwaith presennol sy'n cadw pobl hŷn yn iach ac yn weithgar yn ein cymunedau.

Sgiliau byw a gwneud pobl hŷn yn fwy gwydn

18. Yn ogystal â chreu a diogelu gwasanaethau ac asedau cymunedol, dylai datblygu sgiliau byw yn ddiweddarach mewn bywyd gael ei gydnabod fel ffordd arall o roi sylw i unigrwydd ac unigedd. Gall y 'digwyddiadau sbarduno' ym mywydau pobl arwain at newidiadau sydyn, gan eu gwneud yn fwy bregus ac yn fwy agored i unigrwydd. Gall colli partner, er enghraifft, gael effaith niweidiol ar fywyd rhywun, gan eu gorfodi i ddelio â materion ariannol neu gyfreithiol yr arferai eu partner ddelio â nhw, gan eu gwneud yn sydyn iawn yn agored i unigrwydd ac unigedd ac effeithiau cysylltiedig. Gall pobl hŷn sydd wedi colli eu swyddi hefyd deimlo effaith unigrwydd yn gyflym iawn, gan fod swydd nid yn unig yn gyflogaeth ond hefyd yn rhwydwaith cymdeithasol sy'n cadw pobl yn weithgar mewn cymuned benodol.

19. Yn dilyn Ymchwiliad y Cynulliad i Gyfleoedd Cyflogaeth i Bobl dros 50 yn 2015[22], rwyf wedi galw am ddatblygu agenda dysgu sgiliau byw ar gyfer pobl hŷn drwy gyfrwng Heneiddio'n Dda

[22] http://www.senedd.cynulliad.cymru/mgConsultationDisplay.aspx?ID=153

yng Nghymru. Byddai dull ‘cwricwlwm’ ar gyfer pobl hŷn yn cynnwys datblygu sgiliau ariannol, digidol a lles, gwella gwytnwch pobl hŷn a help unigolion i fod yn fwy parod am ‘ddigwyddiadau sbarduno’ yn ddiweddarach mewn bywyd.

20. Mae gwella sgiliau ariannol pobl hŷn, eu gallu a’u gwytnwch yn un o flaenoriaethau Heneiddio’n Dda yng Nghymru, a dylai’r ffocws hwn helpu i leihau effaith tlodi ymysg pobl hŷn a sicrhau eu bod yn dal i gyfranogi mewn gweithgareddau cymdeithasol, gan leihau’r tebygolrwydd y byddant yn teimlo’n unig neu ynysig o’r herwydd. Mae cynyddu nifer y bobl hŷn sy’n cael eu cynnwys yn ddigidol yn ffordd arall effeithiol o leihau unigrwydd, ac rwy’n ymwybodol o sut mae iPads, er enghraifft, yn gallu cysylltu pobl hŷn gyda ffrindiau a theulu, gan wella’u cysylltiadau a’r ymdeimlad o gynhwysiant mewn byd fwyfwy byd-eang[23].

21. Er bod sgiliau digidol yn bwysig i gysylltu â’r amcangyfrif o 35% o bobl hŷn yng Nghymru sydd wedi’u hallgau’n ddigidol[24], nid yw’n gallu cymryd lle’r cysylltiad â phobl na’r broses o ddatblygu sgiliau ‘meddal’ sy’n galluogi ac yn grymuso pobl hŷn i barhau i fod yn weithgar yn eu cymunedau. Gall gwella hyder pobl hŷn, ar ôl profedigaeth neu salwch hirdymor, er enghraifft, a chyfeirio pobl at grwpiau hunangymorth lleol, cynlluniau cyfeillio ar gyfer pobl hŷn a/neu rwydweithiau pontio’r cenedlaethau fod yn ffyrdd syml ond effeithiol o leihau effaith unigrwydd ac unigedd. Mae hefyd yn bwysig lleihau’r stigma sy’n gysylltiedig ag unigrwydd ac annog pobl hŷn i fynegi eu teimladau ac mae cael cymorth a chefnogaeth briodol hefyd yn hanfodol.

Casgliadau

22. Mae hwn yn Ymchwiliad sydd wir ei angen ac rwy’n glir bod angen gweithredu ar frys yn awr i roi sylw i unigrwydd ac unigedd, epidemig iechyd cyhoeddus cynyddol sy’n effeithio ar nifer

[23] https://www.fastcoexist.com/3047867/can-an-ipad-heal-loneliness-barcelona-wants-its-senior-citizens-to-give-it-a-try
[24] http://gov.wales/docs/dsjlg/publications/comm/160316-digital-inclusion-strategic-framework-cy.pdf

gynyddol o bobl hŷn ledled Cymru. Mae mynd i'r afael ag unigrwydd ac unigedd yn cael ei gydnabod yn araf fel un o'r blaenoriaethau, er hynny, mae angen gweithredu llawer mwy er mwyn deall ei achosion a datblygu ymyriadau rhagweithiol, ataliol sy'n helpu i sicrhau nad yw pobl hŷn yn teimlo unigrwydd ac unigedd yn y lle cyntaf, gan helpu'r unigolyn a'r pwrs cyhoeddus ar yr un pryd a chydnabod y bydd buddsoddi mewn gwasanaethau sy'n lleihau a lleddfu unigrwydd ac unigedd yn hanfodol er mwyn cyflawni ein huchelgeisiau llesiant yng Nghymru. Yn fyr, na all Gymru fforddio cael cenhedlaeth o bobl hŷn sy'n agored i effeithiau niweidiol, dinistriol a phellgyrhaeddol unigrwydd ac unigedd.

LI 19

Ymchwiliad i unigrwydd ac unigedd

Inquiry into loneliness and isolation

Ymateb gan: Bwrdd Iechyd Prifysgol Hywel Dda

Response from: Hywel Dda University Health Board

Consultation Response:
Inquiry into loneliness and isolation

Hywel Dda University Health Board (HDdUHB) is grateful for the opportunity to respond to the consultation on Inquiry into loneliness and isolation, please find our response below.

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

  Can lead to low mood with increased attendance at GP and access to primary and secondary MH services.
  Formal care services may be accessed and then retained at review as loneliness may manifest as an inability to cope alone.
  Poor confidence is often seen in older people who present in acute hospitals, e.g. following a fall. Living alone or in isolation can reinforce feeling of low confidence as not receiving validation from others or feeling like they have access to help in the event of a fall.
  .

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

  1. Community resources such as good neighbour schemes, befriending services, luncheon clubs, free public transport services, and intergenerational work have reported positive impact for some people, but where these have been developed in pockets and are not universal, awareness of schemes can be poor.

  2. Good, current information sources are needed to keep all informed of schemes in their areas. Need to consider the technology that is out there in the real world for say finding a takeaway in your local area and adapt this for community resources.

  3. Technology and “innovation” can be positive, but also can unintentionally impact on isolation, e.g. use of microwave meals instead of MOW being delivered or use of telecare alarm instead of someone popping in to check person is OK reduces the contacts people have with others. Future technologies and innovations, i.e social media, face time need to be considered in the round for their potential to increase isolation instead of decreasing it as may have been intended.

4. Proactive care, i.e. OT in primary care has demonstrated positive outcomes including working with people to increase participation in meaningful occupation and address loneliness at an earlier time. Recent case study from OT in primary care involved a referral regarding mobility but ended up with the individual declaring they were considering going into residential care, with loneliness being cited as one of the reasons. Information, advice and signposting to other community resources to address loneliness was part of the interventions provided by the OT.

5. The introduction of Third Sector Brokers or Community Resilience co-ordinators with the Health Board has been useful in undertaking baseline assessments of informal services within our communities and developing Dementia Friendly environments and partnership approaches. Their focus is on innovative approaches to building community resilience.

6. Providing single points of access for Information, Advice and Assistance, in line with the Social Services and Wellbeing Wales Act for the public that facilitates access to a directory of services in their local community e.g. DEWIS.

LI 20

Ymchwiliad i unigrwydd ac unigedd

Inquiry into loneliness and isolation

Ymateb gan: Cyngor Gofal Cymru

Response from: Care Council for Wales

Cyngor Gofal Cymru
Care Council for Wales
Hyder mewn Gofal - Confidence in Care

Health, Social Care and Sport Committee, National Assembly for Wales
Inquiry into loneliness and isolation

Care Council for Wales response

Sarah McCarty
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0300 3033 444

1. The Care Council for Wales is a Welsh Government-sponsored body responsible for the regulation and development of the social care workforce. In April 2017 we will merge with the Social Services Improvement Agency (SSIA) to become Social Care Wales with an expanded remit which includes research and improvement.

2. Since 2015 we have been responsible for commissioning training materials on the Social Services and Wellbeing (Wales) Act 2014, which has enabled us to develop a good understanding of the challenges and opportunities that lie ahead. Therefore, our response will concentrate on the current policy and the new legislative framework for delivering care and support, including services to tackle loneliness and isolation.

3. SSIA recently published a report called *The Anatomy of Resilience: Helps and Hindrances as we Age*[1]. The report found that "loneliness and isolation impact significantly on both physical and emotional health" (p11). The report notes that "it is important to distinguish loneliness from isolation, since they require different interventions: to tackle isolation, our approach might be to boost the number of contacts, for loneliness it may be more about boosting the quality of relationships" (p44). The report cites evidence that there are "greater risks of loneliness and isolation for men, people living alone, those who have been recently widowed, and for much older people" (p45). It is important to note that older people are not the only group affected by this problem.

4. We believe that it is important not to classify loneliness as a social care problem and the sole responsibility of social services departments. Rather, we believe that it is a challenge for all

[1] The Anatomy of Resilience: Helps and Hindrances as we Age, Social Services Improvement Agency, Cardiff, October 2015

of us, and that policies and actions are needed in communities and across services and sectors. For example, community networks (both geographical, interest and digital based) and the voluntary sector has an important role to play, as well as a range of public services including health, housing and leisure.

5. The Well-being of Future Generations Act should help in this regard, by encouraging co-operation across departments, partners and communities. Furthermore, the Social Services and Well-being Act encourages co-operation between communities, health, social services and the voluntary sector with its focus on:

    - prevention
    - person-centred care and support
    - care and support which looks at a person's assets
    - information, advice and assistance
    - staff skilled in the art of 'what matters to you' conversations.

6. The Social Services and Well-being Act is also important because of the importance it places on a person's assets. These assets include their social circle and community, which are crucially important when looking to tackle loneliness and isolation.

7. The Care Council has worked on the national training plan to support implementation of the Act. In particular it has produced materials on person-centred care and support and the importance of what matters to the person receiving care and support. We have published these resources on our Social Care Legislation in Wales Information and Learning Hub.

8. The Social Services and Well-being Act requires local authorities to assess the care and support needs of their populations. Loneliness and isolation have been picked up as an issue for older people in these assessments. As a result, we expect to see each of the social services regions addressing the issue through the regional area plans which stem from the assessments.

9. In tackling loneliness and isolation it will be important to consider the role which individuals, their friends and family, their community and local voluntary groups, and digital / interest communities can play. As loneliness is a societal problem it is important to consider a broad range of responses. Charities such as Cruse and Age Concern organise befriending schemes which have the potential to counter the worst effects of loneliness.

10. The importance of community resilience is referred to in our recently published Strategic Plan for Care and Support at Home. One of the key areas identified for action is that care and support at home needs to be built around communities. The strategy states that:

    > "Carers and families play a critical role in providing care and support at home. It's often a role that's not seen and can be lonely … We need to fully understand the resources in our communities. We need to support local communities to make the most of their strengths and connections. We have to use them, and build on them, to support health and well-being, particularly for the most vulnerable."

11. There are a number of other ways in which local communities could help tackle loneliness. For example, they could consider 'asset maps' which show which services and resources are available within a community. Local authorities will commission information, advice and

assistance services to help citizens to find support they need. These could cover a range of services from information about community activities to counselling services for those bereaved. Dewis Cymru currently has local information for North Wales, Cardiff, the Vale of Glamorgan, Rhondda Cynon Taf and Merthyr Tydfil and information for other areas will be added soon. A number of local authorities have introduced 'community connectors'. They work with individuals, groups and organisations across their local area to make it easier for people to find out what's going on and how they can get involved in social activities that could improve their wellbeing.

12. The Social Services and Well-being Act will also encourage local authorities to maintain and develop strategic support for voluntary sector services.

13. In summary, in tackling loneliness and isolation, society as a whole needs to place an emphasis on what communities and individuals can do, building community resilience and using the opportunities for co-operation provided by new legislation.

LI 21

Ymchwiliad i unigrwydd ac unigedd

Inquiry into loneliness and isolation

Ymateb gan: MS Society

Response from: MS Society

National Assembly for Wales Health, Social Care and Sport Committee inquiry into loneliness and isolation – Response from MS Society Cymru

Summary

MS Society Cymru welcomes the opportunity to provide feedback on the National Assembly for Wales' Health, Social Care and Sport Committee inquiry into loneliness and isolation.

Multiple Sclerosis (MS) is an incurable neurological condition, which affects approximately 4,900 people in Wales, and more than 100,000 people in the UK.

Around 85% of people with MS are diagnosed with Relapsing-Remitting MS. People with this kind of MS have distinct attacks of symptoms which then fade away either partially or completely. Many go on to have secondary progressive MS. It means they have a sustained build-up of disability, completely independent of any relapses. Primary progressive MS affects about 10 to 15% of people diagnosed with MS. Symptoms gradually get worse over time, rather than appearing suddenly.

1. Social isolation and loneliness among people living with MS

1.1. Social isolation and loneliness is a significant issue for people of all ages who are living with MS in Wales. In particular, people living with more progressive forms of MS have reported feelings of isolation as a consequence of their condition.

1.2. Social isolation among people living with MS can occur in all types of settings, from rural areas to larger urban conurbations. If someone cannot easily leave their house, they are at higher risk of being socially isolated whatever lies beyond their doors.

1.3. In 2014, the MS Society UK in collaboration with Plymouth University conducted research on social isolation among people severely affected by MS.[i] This study found;

1.4. Physical restrictions were the most commonly mentioned causes for social isolation. Participants described the difficulties they face in trying to get out and make or maintain contact;

1.5. "…the adventurous side of my spirit that used to take me out and about… because of various difficulties and physical constraints have made me isolated, 90% of what I do is in my own home environment".

1.6. "I'm in my home on my own for most of the week, and I've started to really struggle and feel unbearably lonely. I'm not able to get outside of my home on my own and only have 4 hours care a week".

1.7. For someone living with MS, the ability to leave their home and move independently is a complex undertaking. Whilst mobility aids can help to facilitate people living with MS to get around, many who use them report that they are often difficult to use and generally still require assistance from others.

1.8. Difficulties encountered with pavements, accessing buildings such as shop entrances and general accessibility issues etc. prevents people living with MS from accessing the outside world. Consequently, people living with MS are disabled by virtue of the fact that the built environment prevents them from accessing it and as a result are isolated in their own homes.

1.9. Whilst social isolation and loneliness affects people living with MS regardless of where they live, the issue is particularly compounded for those who live in rural areas.

1.10. A lack of accessible public transport substantively increases social isolation for people living with MS in rural areas. This is especially pertinent where a person has had to give up their driving licence or mobility vehicle as in the case for many who are going through the Personal Independence Payment assessment process and awaiting the outcome of an appeal.

1.11. Research conducted by the MS Society UK estimates that 1,489 people living with MS have had their mobility support downgraded since PIP started to replace DLA and up to 10,000 more people living with MS across the UK could lose out by the time PIP is fully rolled out. [ii]

1.12. Poor public transport can make it impossible to take up opportunities for social interaction. In addition, rural communities may also have fewer local opportunities for social interaction.

1.13. Another factor leading to isolation of people living with MS is toileting and incontinence. For many, self-catheterisation limits the amount of time for excursions away from home and can make even the shortest of car journeys become difficult.

1.14. Notwithstanding the lack of available public toilets, for many people who do try to find their way to a public toilet, many of those which purport to be ‘accessible’ are not fit for purpose.

1.15. For example, many people living with MS who are wheelchair users consistently report difficulties with being unable to manoeuvre their wheelchairs into the required space; sanitary/nappy bins and other furniture are frequently placed inappropriately and the accessible toilets being used as store cupboards.

1.16. An example of the difficulties encountered by people living with MS was highlighted by one of the participants in the MS Society study into isolation. The woman cannot easily change her shoes and tends to be in slippers at home which she can slip on and off. This is not something she can do with ease with other shoes. To perform the ‘pirouette’ as she calls it to use a toilet, she needs to take off her slippers and this is possible at home. However as she says, “I would go up to the shops but I don’t really want to out in my slippers. I can’t go to the toilet. I cannot put ordinary shoes on as I can’t get them off to do my pirouette in them”. As she is unable to put her shoes on and off by herself, she is unable to go to the toilet on her own and is therefore trapped within her own home.

1.17. An MS Society UK survey into the discrimination of people living with MS conducted in 2016 revealed that almost half (45%) of people with MS have experienced mistreatment or stigma because of their symptoms.[iii]

1.18. The most common experience is being accused of being drunk because they were having trouble walking (49%). While, 47% say they have received comments that they are exaggerating the extent of their MS because they 'look so well', 35% have been accused of wrongly parking in a disabled bay because they didn't appear disabled. Three quarters (73%) of people with MS say that living with the condition is more difficult when people treat them badly or stigmatise them because of their condition.

1.19. MS is a condition that is already unpredictable and challenging to live with and this stigma and misunderstanding is making life even harder for many of the 4,900 people living with the condition in Wales.

1.20. The survey results also showed that understanding family and friends can make a positive difference to those living with MS. Of those people living with MS who said they were supported during a difficult incident, 63% received help from a partner, 40% from immediate family and 34% from friends.

1.21. "MS means I have a poor sense of balance, and one morning I fell over in a busy marketplace. As I struggled to pull myself back up by grabbing onto wall, a woman walking past pulled her child away from me and said loudly "Disgusting drunk!" I was too stunned and upset to respond. My family and friends are a shield for me against misunderstandings and discrimination".

1.22. However, unpaid carers of people living with MS are also at high risk of social isolation. People with more progressed forms of the condition often require very significant levels of care and supervision, which severely limits opportunities for carers to maintain their social networks. People who provide unpaid care for people with complex neurological conditions like MS experience very high levels of stress and other mental health issues which both contribute to and can be exacerbated by social isolation.

2. The impact of social isolation for people living with and affected by MS is significant. Studies have suggested that depression is among the most common symptoms of MS and it is more common among people with MS than in the general population.

2.1. "I've started to feel really anxious and scared and I can't get past these feelings. I've developed bad depression and I've lost contact with friends".

3. Addressing the problem

3.1. Access to appropriate professionals is a key factor in addressing social isolation for people living with MS.

3.2. People living with the condition rely on the specialist expertise from a whole range of professionals including physiotherapists, occupational therapists, speech and language therapists, orthoptists, psychologists, continence and rehabilitation specialists who may be needed at different times to assess and treat symptoms effectively, and to prevent secondary complications from developing as a result.

3.3. The MS Society UK published findings from the 2016 My MS My Needs survey which showed that access to MS specialist services across Wales is patchy.[iv]

3.4. In 2017, MS Society Cymru will be launching a Big Lottery Funded project which will support 1,300 people living with and affected by MS in Wales. This project will offer support on a range of issues including access to social care, treatments, employment rights, mindfulness and welfare support. Such a holistic approach will go some way in combatting the difficulties faced by people living with MS and in conjunction with the local

activities organised by MS groups, will over time, reduce the prevalence of loneliness and social isolation among those who access the services.

3.5. However, reducing the impact of social isolation for everyone living with and affected by MS in Wales requires urgent action across a range of policy areas.

3.6. In addition to accessing appropriate health professionals identified above, social care has a vital role in reducing social isolation and loneliness. For people who live alone or are isolated within their family situation, and who find it difficult to go out, home care visits may be the only regular social contact that people have.

3.7. Greater access to direct payments would allow people living with MS to use the funds to do activities that are important to them, rather than having to fit into more traditional and increasingly limited service options.

3.8. Making communities more physically accessible to people living with MS would also have a significant impact on preventing and alleviating social isolation by making it easier for people to be out and about.

3.9. Challenging the stigma attached to disability especially hidden disability would also go a long way in creating a society that welcomes difference and enables people to venture out of their homes without fear of mistreatment.

3.10. Implementation of the Social Services and Well-being (Wales) and Future Generations Acts should ensure that commissioners of services have due regard to include initiatives to prevent and alleviate isolation and loneliness.

3.11. Isolation and loneliness can affect people living with MS in so many different ways. In order for the issues identified above to be fully addressed, the Welsh Government must also ensure that isolation and loneliness is embedded in all of its work.

3.12. The Framework for Action on Independent Living examines the barriers to equality and inclusion faced by disabled people in Wales, and the action needed to address them. It was developed following extensive engagement and consultation with disabled people across Wales and has a government-wide and cross-generational focus on barriers and actions for improvement.

3.13. The Framework supports the Welsh Government's Strategic Equality Plan and Objectives across portfolios and provides a detailed programme of action to tackle barriers to support disabled people so that they can live independently and exercise choice and control in their daily lives.

3.14. Given the extent of isolation and loneliness among people living with MS in Wales, it is clear that much more needs to be done to promote the 'inclusive and enabling society' as envisaged by the Framework. To this end, MS Society Cymru urges the Health, Social Care and Sport Committee to instruct the Welsh Government to ensure that the Framework for Action on Independent Living is fully adopted across all Welsh Government portfolios and by local delivery partners and stakeholders.

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[i] Robens et al, 2014. Social isolation amongst severely impaired people with multiple sclerosis (MS): choice, control and identity. Available here: file:///C:/Users/fmcdonald/Downloads/Robens%20et%20al%20Social%20Isolation%20in%20people%20with%20MS%202014%20(2).pdf
[ii] MS Society 2016 https://www.mssociety.org.uk/ms-news/2016/08/one-10-people-ms-could-face-disability-benefit-cuts

[iii] MS Society 2016 https://www.mssociety.org.uk/ms-news/2016/09/half-people-ms-have-faced-%e2%80%98unacceptable%e2%80%99-mistreatment

[iv] MS Society, 2016. My MS My Needs 2016: Access to treatment and health care. Technical Report. Available here: https://www.mssociety.org.uk/sites/default/files/MMMN%202016%20Technical%20report.pdf

LI 22
Ymchwiliad i unigrwydd ac unigedd
Inquiry into loneliness and isolation
Ymateb gan: Fforwm 50+ Cyngor Caerdydd
Response from: Cardiff Council 50+ Forum

Inquiry into Loneliness and Isolation

Please see below views of Cardiff's 50+ Forum members on what causes loneliness and isolation and what needs to be done to help overcome these.

Members discussed the topic and indicated that loneliness and isolation were not the same and indicated that they could be a personal thing with it being different from person to person. Member gave examples and indicated that whilst some people have outgoing personalities and are able to mix well, others find interacting with others difficult.

Members indicated that a host of evidence has been produced in recent years indicating the links between loneliness and isolation and health issues. They endorse this evidence and indicated how they have seen this in their own communities.

Members indicated that they either had experienced loneliness and isolation themselves or that they had friends or relatives who had. They indicated a range of reasons for why loneliness and isolation can be encountered these included:

- Bereavement
- Family moving away
- Not having family
- Being away from old neighbours / communities (due to downsizing / financial constraints)
- Being shy / not mixing / lack of confidence
- Loss of community spirit
- Loss of transport
- Reliance on public transport (especially in rural locations)
- Ill health (poor mobility, dementia, sensory impairments)
- Lack of Dr's appointments leading to greater ill health
- Retirement

- Fear of crime
- Community facilities closing (banks, community centres, post offices)
- Funding cuts to community organisations / groups
- Poor public footpaths resulting in fear of falling
- Lack of finances
- Lack of public toilets
- Lack of information of what is available / local activities
- Over reliance of ICT to promote opportunities (not all older people have access to or want to use ICT)

Members then discussed ways of overcoming loneliness and isolation these included:

- Planning for retirement, both financially and how to occupy time
- The promotion of volunteering opportunities
- The promotion of services giving financial / benefit take up advice
- Joining friendship clubs or other community based groups / activities
- The promotion of learning for fun
- Welsh Government / Local authorities to provide funding for voluntary organisations such as Age Connects or for Good neighbour schemes
- The provision and promotion of befriending services
- The provision of information about activities / groups available in local areas
- The provision of community / local transport
- The provision of public toilets
- Timely repair of pavements
- More sheltered/ community housing
- More intergenerational activities
- More job opportunities for older people (who want to work)

Members wanted to point out that many initiatives have previously been implemented and have been seen to be of benefit but due to lack of funding or the ending of grants initiatives have come to an end. This needs to end.

Consultation Response

Inquiry into Loneliness and Isolation

Health, Social Care and Sport Committee

March 2017

Introduction

Age Cymru is the leading national charity working to improve the lives of all older people in Wales. We believe older people should be able to lead healthy and fulfilled lives, have adequate income, access to high quality services and the opportunity to shape their own future. We seek to provide a strong voice for all older people in Wales and to raise awareness of the issues of importance to them.

We are pleased to respond to the Health, Social Care and Sports Inquiry into Loneliness and Isolation.

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

1. On March 2nd, Age Cymru launched a campaign against loneliness. As part of this campaign, we asked older people to share their experiences of loneliness and isolation with us. Throughout these conversations it became clear that the stigma surrounding loneliness is preventing people from asking for help, sometimes even from close relatives and neighbours. Consequently, it is likely that the number of people experiencing isolation and feelings of loneliness could be much higher that estimates suggest. Developing methods to identify people who are lonely, or who are at risk of becoming lonely, should be a priority for the Welsh Government.

2. Loneliness and isolation are a daily reality for many older people. It is possible to be isolated without being lonely and lonely without being isolated. 75,000 older people in Wales reported 'always or often' feeling lonely[1], while 68% of women were concerned about loneliness in older age.

3. In 2016, Age Cymru surveyed 200 people aged over 60 from across Wales. 23% of respondents admitted to feeling lonely. 24% of respondents said they were worried about falling over on slippery roads or pavements during the winter months. It is vital that the built environment enables, rather than prevents, older people taking an active part in their communities. Barriers in the built environment can exclude older people from becoming fully inclusive members of society. These can include pavements in a poor condition, car

[1] Age Cymru (2014) 75,000 over-65s in Wales say they are lonely. Press release.

parking on pavements and street 'clutter'; inadequate street lighting; a lack of seating in public spaces and a lack of public toilets.

4. Loneliness has complex causes, however there are practical actions that can be taken to address the issue. Being able to take part in community life, with good access to local services and facilities, is a lifeline for many older people. If an older person cannot get out and about locally they are at risk of poor health, less social contact with others and a reduced quality of life overall. There are already high levels of loneliness and social isolation amongst older people in Wales and an inaccessible built environment that deters people from taking part in community life can contribute to this.

5. Public and community transport are vitally important in helping older people to maintain independence and well-being. Such transport networks can ensure communities are well-connected and that services, facilities and amenities are accessible to older people. Without these, there is an increased risk that isolation and loneliness will impact upon people's well-being. It is essential that older people in all areas have the means to get out to buy food, get medical attention, get money and pay bills, and have social contact. These are basic features of a decent life and ought to be a high priority in transport policy.

6. Age UK recently published research that tested promising approaches to loneliness.[2] It found that people can become lonely due to a combination of factors including geographical isolation, inability to leave their home, being part of a seldom heard community, not knowing what resources and services are available locally and how they are relevant to their needs; or simply a lack of confidence to reach out.

7. There are also life stages when people are most at risk of becoming lonely and isolated including after retirement, bereavement, moving home or moving into residential care.

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

8. Research detailing the impact of loneliness on physical and mental wellbeing is growing. For example, evidence has linked loneliness with an increased rate of high blood pressure and cardiovascular disease. Lonely and isolated people are more likely to smoke, be overweight, eat fewer fruit and vegetables and skip medication.[3] Loneliness increases our chances of dying earlier and is linked to chronic conditions such as depression and dementia.[4]

9. However, the experiences of older people are often more effective in demonstrating the impact of loneliness. In response to a request for case studies, Age Cymru was contacted by a number of older people experiencing loneliness. The following text illustrates how people with caring responsibilities can be limited in their ability to improve their own situation. (Please refer to appendix 1 for further quotes from older people.)

[2] Age UK (2016) Testing promising approaches to loneliness. Available online @ http://www.ageuk.org.uk/Documents/EN-GB/services/loneliness/Testing_Promising_Approaches_to_Reducing_Loneliness_Report_2016.pdf?epslanguage=en-GB?dtrk=true

[3] Befriending Networks (2016) Loneliness in Scotland: A National Summit

[4] Befriending Networks (2016) *Loneliness in Scotland: A National Summit*

10. *I live with my son who has cerebral palsy. I'm his sole carer. I could go for days without speaking to a soul. I used to catch the bus just so I could have a conversation. I can leave my son home alone for several hours on the one day of the week he has support, but this is again a lonely time for me. The activities that I'd like to access are rarely on at the times I'm able to leave my son, but you've got to make the effort.*

11. *My son plays boccia and I run the local boccia club, which gives me the chance to meet people. I dropped into the club by accident and ended up running it. Volunteering with the club is one way I've expanded by life and it's been a phenomenal success. Volunteering is one way I've expanded my life and it's really helped with my health and wellbeing. Facebook is also a lifeline as it keeps me in touch with family and friends.*

12. In 2015, Age Cymru was commissioned by the Older People's Commissioner to interview people living with dementia and their carers from across Wales. Isolation and loneliness were a common theme in the interviews. Interviewees told us that there is a need for more befriending and respite services that respond to the needs of individuals[5]. However access to befriending projects in Wales is already scarce and evidence shows the situation is likely to get worse. For example, In Swansea a volunteer led befriending project that has been funded by the LA for over 10 years, is due to close by the end March of 2018 if not before.

13. Sensory impairments and physical disabilities can erode people's confidence in their ability to navigate the built environment safely and a fear of falling, especially during the winter months, can further exacerbate feelings of isolation and loneliness.

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

14. Many older people are capable of taking steps to alleviate loneliness by becoming involved in community activity; however, the current financial climate has led to the closure of many community services including adult learning classes, public libraries, day/community centres and third sector support services. It is inevitable, given the evidence of the impact of loneliness on health and wellbeing, that the withdrawal of opportunities for social interaction will increase pressure on NHS services. The Welsh Government must identify ways to encourage and develop community networks and activity so that older people are able to take steps to remain active and engaged.

15. Reducing loneliness can boost independence and reduce costs resulting in; fewer GP visits, lower use of medication, fewer stays in hospital, improved ability to cope after returning from hospital, reduced inappropriate admission to care homes and increased contribution of older people to society.[6]

Ways of addressing problems of loneliness and isolation in older people, including interventions to specifically address the problems and other projects with wider aims.

[5] Older People's Commission for Wales (2015) *Dementia – more than just memory loss.*
[6] Befriending Networks (2016) *Loneliness in Scotland: A National Summit*

Evidence for what works and the outcomes for older people in terms of health and wellbeing.

18 If schemes to target loneliness in older people are to be effective, they must involve older people at every stage, including planning, development, delivery and assessment.

19 Developing ways to target people who do not come into contact with mainstream service provision is important in preventing people from becoming lonely and experiencing long term consequences. A recent Age UK[7] study used a guided conversation, or motivational assessment, to understand older people's circumstances. Based on this, tailored support was developed which included; traditional befriending services, benefits advice, wellbeing information, transport, practical support and social engagement opportunities. Reducing loneliness is not always about encouraging more social engagement. Resolving other issues such as access to benefits helps people participate in activities, or helps them to help themselves, reducing their feelings of loneliness.

20 In November 2016, Age Cymru asked over 60s in Wales a series of questions about loneliness and potential solutions to the problem. Of those surveyed, 88 per cent said lonely older people do need more help and support, and of those:

- 70 per cent said free or subsidised transport to and from social events for older people would help tackle loneliness;
- 70 per cent said lunch clubs and social clubs for older people would help tackle loneliness;
- 70 per cent said regular visits from a friendly face for older people would help tackle loneliness;
- 58 per cent said a regular weekly phone call would help tackle loneliness.

Interventions to specifically address the problems and other projects with wider aims- Pimp My Uke

18 Pimp My Uke was an Age Cymru initiative and part of our Gwanwyn Festival. (Gwanwyn is a month-long national festival held across Wales in May each year celebrating creativity in older age.) Age Cymru, in partnership with Men's Sheds Cymru, provided Men's Sheds from across Wales with kits and materials to make their own ukuleles. They received musical tuition to learn to play their 'pimped' instruments. 150 members from Sheds all across Wales came together for a sharing event and performance at St David's Hall, Cardiff. It provided the first opportunity for all Sheds to come together and for some members it was the first time they had left their local community for a number of years.

19 The majority of Men's Sheds members are older men, who have experienced depression, isolation and other mental states which have impacted negatively on their lives. Taking part really increased the confidence of individuals; with new skills being discovered and a real and visible increase to the sense of wellbeing for those who took part.

[7] Age UK (2016) Testing promising approaches to loneliness. Available online @ http://www.ageuk.org.uk/Documents/EN-GB/services/loneliness/Testing_Promising_Approaches_to_Reducing_Loneliness_Report_2016.pdf?epslanguage=en-GB?dtrk=true

20 Older people attend adult community learning classes as a way of combating loneliness and Age Cymru was pleased to note that the Welsh Government has allocated a 13% increase in the allocation of funding for Adult Community Learning. Whilst many older people are able and willing to create and run their own informal learning groups, support from a local authority to market and develop the group can ensure its sustainability. Offering free access to local authority buildings can also help to ensure the groups remain financially viable.

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

21. If implemented in accordance with its aims, the Social Services and Well-being Act provides a framework to reduce loneliness across Wales. The drive towards a person-centred approach, including the facilitation of 'what matters' conversations, should provide an opportunity to identify people who are lonely or who are at risk of being lonely, and support them to find ways to improve their situation.

22. However, personal outcomes from these conversations must be effectively monitored and evaluated if they are to have real impact. In addition, Age Cymru remains concerned that financial constraints on local authority budgets are leading to the withdrawal of community services and an erosion of the community infrastructure and support that is vital to keep people active and engaged in later life.

23. The Act also introduced legislation that requires local authorities to work with partners to deliver preventative services. Again, if implemented well, the legislation should encourage new partnerships and ways of working that put older people at the centre of decisions that affect them.

24. Age Cymru is pleased to note that the Public Health Outcomes Framework, which is intended to support the Well-being of Future Generation Act's national indicators, includes a measure of people feeling lonely. Measuring levels of loneliness and its impact on an individual should enable local authorities to develop services and ways of working that can create more cohesive and connected communities.

Appendix

Older people's experiences of feeling lonely.

The important thing is as soon as you can is to get out and about to places because the best way to meet new people is through your interests. But there are times when it's not easy to meet people and when you start to get isolated there's a sort of doom hanging over you. It's as if you're an alien and people know you haven't spoken to anyone for the last for two, but it doesn't last forever.

When you lose someone close to you everybody's happy to help for a while, but you need to be a bit cheeky and ask for what you want.
Betty, 96, Cardiff

My husband was diagnosed with dementia two and a half years ago and has been in a care home for the last year. He's happy and I'm happy for him to be there and I love being with my husband and holding his hands - it's the happiest time of my life, but I have reached the lowest point in my life.

I had little or no help available from social services when my husband was diagnosed with dementia and I am living through it now and suffering from loneliness and depression.

My son also died 12 years ago and I am practically emotionally dying. I am not in a good place. I don't want pills, I want company. I'm struggling to keep going.
Jane 84, Cardiff

I lost my husband two years ago from bowel cancer. He passed away 10 weeks after his diagnosis. The only person in see now is Sainsbury's when they bring me my shopping every Thursday, and that's been that way for two years.

I take dog for a walk every morning, but I find the day tremendously long. Apart from the dog, the TV is my main form of company and I have it on almost all day.
Nancy 62, Swansea

Many years ago, I lost my daughter when she was 15 and I experienced a lot of isolation and anger when she died. You need to feel wanted - we all need to be needed and there's much the individual can do and we have a lot to offer whatever our age.

Isolation can hit all types of people - it can happen to anyone, but when you're down the only way is up.
Donna, 70, Bangor

LI 24

Ymchwiliad i unigrwydd ac unigedd

Inquiry into loneliness and isolation

Ymateb gan: Parkinson's UK

Response from: Parkinson's UK

Health Social Care and Sport Committee
Loneliness and Isolation Inquiry
Response from Parkinson's UK

Introduction and context

1. Parkinson's UK strongly welcomes the Committee's Inquiry on loneliness and isolation, which is a major issue for people living with Parkinson's in Wales. We would like to emphasise that loneliness and isolation can be a problem for people of any age.

2. Most people living with Parkinson's in Wales are aged over 50. However, some people are diagnosed much younger. For younger people diagnosed with Parkinson's, it can be doubly isolating to have a condition that is commonly associated with older people.

3. Our response is informed by our work with some of the 7500 people in Wales who have Parkinson's and their unpaid carers, families and friends.

4. This also reflects published research that shows that people with Parkinson's typically report very sharp increases in social isolation as their condition progresses, with a very negative impact on quality of life.[12]

1. Scale and Causes

5. Parkinson's UK believes that loneliness and isolation can occur in all types of settings, from remote and rural settings to urban areas and all points in between. Social isolation can affect people living in a range of situations, from people with Parkinson's who live alone, to people who live in residential care or with partners or family members with whom they have minimal social interaction. If someone cannot easily leave their house, they are at higher risk of being socially isolated whatever lies beyond their doors.

6. Rural areas that have a lack of public transport can increase social isolation, particularly when a person has had to give up their driving licence due to the progression of Parkinson's. Poor public transport can make it impossible to take up opportunities for social interaction.

7. Rural areas also have fewer local opportunities for social interaction, and some voluntary sector initiatives find it prohibitively expensive to offer support to small numbers of people living in remote and rural settings, which can mean that people who live rurally are additionally disadvantaged.

2. Impact of isolation and loneliness

8. In addition to the factors that put anyone at risk of social isolation, people with Parkinson's often have specific symptoms that can contribute to social isolation. As the condition progresses, these symptoms typically worsen.

9. For example:
   - Problems with mobility makes access to buildings and travelling difficult
   - "Wearing off", where medication stops working, and people have extremely limited mobility until the next dose takes effect, has a major impact on people's ability to be away from their home or in social situations
   - Mental health symptoms including apathy, depression and anxiety are very common and can prevent people from maintaining social networks
   - Pain and fatigue have a significant impact on people's ability to be social
   - Cognitive impairment and dementia make it much more difficult for people to socialise
   - Communication issues, including lack of clarity of speech, quietness, slowness of speech can make conversation difficult
   - Many people find it embarrassing that they experience unpleasant and visible symptoms such as drooling, excess sweating, incontinence, tremor, swallowing issues, involuntary movements, changes in gait and facial masking.
   - Some people with Parkinson's have mistakenly been accused of being drunk in public. People with Parkinson's report that other people's attitudes and misunderstandings about their condition can have an enormous impact.

10. Parkinson's is a very complex and difficult condition to live with. People whose Parkinson's symptoms include depression, apathy and anxiety will often experience more severe symptoms if they are isolated.

11. It is also likely that the serious health impacts of loneliness will apply to people with Parkinson's as to the rest of the population, making it even harder to live well with the condition, and placing people at risk of poor health related to loneliness.

12. Unpaid carers of people with Parkinson's are also at high risk of social isolation. People with more advanced Parkinson's often require very significant levels of care and supervision, which severely limits opportunities for carers to maintain their social networks. People who provide unpaid care for people with complex neurological conditions like Parkinson's experience very high levels of stress and other mental health issues which both contribute to - and can be exacerbated by - social isolation.

13. All of these factors have a major impact on individual outcomes, but also carry financial costs. These include increased risk of hospital and care home admission, and increased use of non-emergency NHS care and social care services.

3. Ways of addressing loneliness and isolation

14. Parkinson's UK supports around 30 local groups in Wales, which offer friendship and a range of activities to people affected by Parkinson's. Many people affected by Parkinson's find it extremely helpful to meet with others in a similar situation, and sharing experiences can "normalise" some of the stigmatised and embarrassing symptoms so that people feel less isolated.

15. In addition, many of our local groups enable people to come together to sustain activities that can improve health and wellbeing. Exercise classes, dance classes and walking groups are very popular. They are particularly important considering the growing evidence that exercise may help to slow the progression of Parkinson's, but the social aspect is what enables people to maintain these activities.

16. In Cardiff, the "Live Loud" group brings together people living with Parkinson's in an informal setting to improve their speech together so that they can reinforce their learning and maintain the improvement over time. Some of our groups also offer regular activities like singing and day trips and additional projects to meet local needs are being developed with volunteers in our North and South Wales Local Development teams.

17. Our free and confidential Parkinson's Local Adviser service provides one-to-one information and support to people with Parkinson's, their families and carers across Wales. This may include benefits advice, emotional support and links to local and other services. Our Parkinson's Local Advisers come across many people affected by Parkinson's who are socially isolated, and commonly refer these clients to their local Parkinson's UK groups, the Parkinson's UK online forum, and to services provided by other organisations within their area.

18. Befriending services are very effective and popular, and people affected by Parkinson's often ask to be put in touch with people to offer this kind of social support. However, there are huge gaps in provision throughout Wales.

4. Policy Solutions

19. Parkinson's UK believes that reducing the impact of loneliness and isolation will require action across a range of policy areas.

20. **Social care** has an important role in reducing social isolation. For people who live alone or are isolated within their family situation, and who find it difficult to go out, home care visits may be the only regular social contact that people have.

21. Parkinson's UK believes that a shift in home care is needed, so that the importance of developing a human relationship between workers and clients is both recognised and accommodated within care packages. 15 minute care visits, and care that is solely task orientated, do not allow relationships to develop between clients and care workers. In addition, clients need consistency of carer workers to develop understanding, trust and social relationships.

22. For people who live in care homes, and are well enough to do so, care visits and trips are needed, along with activities that can enable residents to build relationships with each other.

23. **Social support initiatives including befriending, buddying schemes and other social activities.** The importance of this work as a preventative intervention which reduces dependence on statutory services needs to be recognised so that cash-strapped local authorities can justify supporting these types of projects where they are managed by third sector organisations.

24. Accessible communities

Making communities more accessible to people with Parkinson's could also have a major impact on loneliness and isolation by making it easier for people to be out and about in their communities, in terms of the physical environment and transport.

25. Parkinson's UK believes that this should include:
    - More places to adopt the dementia friendly communities model, both in terms of raising awareness of the issues that people with dementia face, but also creating built environments and services that are easier to use for people with dementia
    - Buildings, pavements and public spaces that are accessible to wheelchair users and other disabled people.
    - Accessible public transport, including both vehicles and stations
    - Accessible public toilets, including toilets that have space and equipment to enable them to be used comfortably by people with serious impairments, or who need to accompanied by a carer

26. **Creating a society that welcomes difference, including older age and disability** Parkinson's UK would like to see people living in a country that values older and disabled people, and is welcoming and understanding. We are concerned that the "scroungers" rhetoric around welfare benefits has legitimised negative attitudes to disabled people.

27. We believe that more should be done to address society's fears around aging, frailty and dementia. We want to make sure that the voices and experiences of older, frailer people – including disabled people and those with long term conditions and dementia - are heard by policy makers, and by society.

5. About Parkinson's

About 7500 people in Wales have Parkinson's.

Parkinson's is a progressive, fluctuating neurological disorder, which affects all aspects of daily living including talking, walking, swallowing and writing. People with Parkinson's often find it hard to move freely. There are also other issues such as tiredness, pain, depression, dementia, compulsive behaviours and continence problems which can have a huge impact. The severity of symptoms can fluctuate, both from day to day and with rapid changes in functionality during the course of the day, including sudden 'freezing'. There is no cure.

For further information, please contact Rachel Williams, Campaigns, Policy and Communications Officer for Parkinson's UK in Wales, [redacted], telephone [redacted].

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[2] Forsaa, E. B., Larsen, J. P., Wentzel-Larsen, T., Herlofson, K. and Alves, G. (2008), Predictors and course of health-related quality of life in Parkinson's disease. *Mov. Disord*., 23: 1420–1427.

LI 25

Ymchwiliad i unigrwydd ac unigedd

Inquiry into loneliness and isolation

Ymateb gan: Cyngor Gwasanaeth Gwirfoddol Castell-nedd Port Talbot

Response from: Neath Port Talbot Council for Voluntary Service

Neath Port Talbot Council for Voluntary Service

Supporting, promoting and developing the local voluntary sector

Cyngor Gwasanaeth Gwirfoddol Castell-nedd Port Talbot

Cefnogi, hyrwyddo a datblygu y sector wirfoddol leol

Health, Social Care and Sport Committee
Inquiry into loneliness and isolation

1. Neath Port Talbot CVS is the County Voluntary Council and a Charitable Company set up to promote, support and develop the Third Sector in Neath Port Talbot. This response provides examples of the causes of isolation and loneliness, as well as projects which address these problems.

2. The Social Services Volunteering Scheme provides volunteer befrienders to reduce loneliness and isolation for adults with long term physical disabilities and older people. This service has seen a massive increase in referrals from Social Services, from 62 in 2015 to 156 in 2016. The increase in need appears to coincide with the reduction in provision of local authority services such as day centres, which has left many people who previously used these services without companionship or opportunities to socialise with their peers.

3. The Family Support Volunteering Project matches volunteer befrienders with vulnerable families to provide support with issues such as low self-esteem and confidence, social isolation, and coping skills. A high percentage of the referrals involve single parent households where domestic violence has resulted in low self-esteem and mental health issues. Anxiety and depression have led to withdrawal and isolation which impacts upon the children's quality of life. Many families live in isolated communities offering few social opportunities for single parents who lack confidence and this is exacerbated by limited public transport from rural areas to access social facilities within the towns.

4. The Community Links Project, funded through the Big Lottery Fund AdvantAGE Programme, aimed to improve the health and wellbeing of older people primarily over 65, by reducing social isolation, through volunteer befriending and new initiatives to meet unmet need. Reviews with the

beneficiaries of one to one befriending highlighted that 94% felt less lonely, 76% reported improved health and wellbeing, 76% reported their confidence had improved, and 100% reported an improvement in quality of life as a result of the project.

5. Through the Community Links Project, a number of initiatives were developed that provide examples of the way loneliness and isolation can be addressed. Furry Friends developed from an informal group of dog walkers that extended its membership and support network through social media. The initiative has encouraged physical activity, facilitated new friendships and introduced older people particularly to Facebook. The group has over 190 participants, with over 50% being older people. Members of the group have increased their social interaction and experienced a positive boost to their health and wellbeing.

6. A lunch club was developed in a valley community with attendees having access to free community transport as a lack of transport was cited by many as a contributing factor to isolation.

7. The Big Sunday Lunch was developed with NPT Homes around their sheltered housing complexes as it was recognised that, despite living in sheltered housing, many still felt isolated and missed Sunday dinners and sharing a meal with others. The initiative brought people together on a monthly basis and aimed to develop ongoing social networks. Free transport was provided to reduce the barriers to involvement. 100% of those completing a quantitative survey stated that their social interaction had increased, with 91% establishing a circle of support.

8. The following case studies highlight the impact the Community Links Project has on individuals. B was 85 years old when he met his volunteer. The death of his wife and deteriorating health had led to increased isolation; having to give up driving because of epilepsy also compounded his situation. Despite trying to stay positive, B found himself feeling very down on occasions. Having a volunteer has done him “the world of good.” The increased activity has improved B’s mobility and he no longer has to use a stick whilst out. B said “I think it improves everybody if you can get out of the house and meet people. You come back to the house and feel more light-hearted.”

9. D started volunteering at an Amman Valley nursing home when he was 85 and had recently lost his wife, having been her carer for many years. He and his wife had been very active in the community. D knew that he was still missing her, but felt that he now needed more purpose to his life. D is a very sociable, chatty gentleman as well as a Welsh speaker, skills and

qualities that he was able to bring to his volunteering. D was initially placed to visit a resident of the nursing home on a one to one basis, but it became apparent that D knew many of the other residents, and he began to visit up to fifteen residents, spending more than three hours there, enabling them to use their language of choice. D felt volunteering gave him a "lifeline." In turn, he has become an invaluable asset to the nursing home, and has continued volunteering since the project ended.

10. Neath Port Talbot CVS undertook a small public survey on loneliness and isolation at Neath Port Talbot Hospital in October 2016. Respondents felt that living on the outskirts and in rural areas meant that there was little information on what is happening in the local area and the broader county and region. A lack of available public transport, especially in the evenings, to access social activities was also identified as a cause of isolation and loneliness. It was felt that widows/ers and those experiencing bereavement were vulnerable to loneliness and isolation. Older people were also mentioned as being at risk of feeling lonely and isolated, as a result of a reduction of cessation of family contact. Those with chronic conditions or limited mobility were also felt to be at risk of loneliness and isolation. Respondents also felt that loneliness and isolation could impact on any age group.

11. In terms of addressing the problems of loneliness and isolation, the respondents felt that improvements to public transport could be a possible solution along with coffee mornings for the recently bereaved, volunteer befriending, and the improved provision of information on local services and activities. There was also a feeling that if providers of domiciliary care were allowed and able to spend more time talking and communicating with people who are isolated and lonely, that this would be of benefit.

12. The views of 40 service users over 50 years old experiencing mental ill health were collected during the period October 2015 to January 2017. The closure of community services has led to an increase in isolation and loneliness. If the courses and groups that are still active ran more frequently and for longer, people would feel more involved and connected. People felt there were not enough services, especially out of hours, in Neath Port Talbot. Peer mentoring or befriending were recognised as providing a way to move away from isolation and towards entering into groups and social activities. Five service users stated that daily support with daily living tasks would help them with their mental health issues. Lack of motivation, isolation and being unable to do daily tasks left them feeling depressed and disempowered. Having practical help within the home and support to go to appointments would improve their mental health and reduce isolation.

13. People felt that a lack of free counselling services, lack of understanding of mental health issues, a lack of interest, and no-one willing to take time to listen to service users caused further isolation and loneliness. 25 people felt in order to get proper support with their mental health they needed to be in crisis. Anxiety, depression, loneliness, low self-esteem and low confidence affected people but were not being seen as a priority by the 'system'.

14. Transport is frequently raised as an issue which exacerbates loneliness and isolation. Neath Port Talbot has valley communities where access to public transport is poor especially for those with mobility issues. Even in urban areas people have difficulty accessing transport as in many instances they cannot get to the bus stop. There are two community transport providers in Neath Port Talbot, which provide a number of different services. Community transport is provided to enable older people, many of whom live alone, to access the weekly Croeserw Bingo Group in the Afan valley. This social activity reduces isolation and keeps attendees mentally active. Other examples include weekly shopping trips, where individuals have door to door service and assistance with their shopping; "Eat, chat and shop", where individuals are picked up, taken shopping and then go for a meal somewhere on their way home; and dedicated swimming sessions, where the pool is hired for private use and transport is also provided.

15. Isolation isn't limited to older people. There are also lots of young people that lack the confidence and ability to access services, many of whom do not have access to transport. The Neath Port Talbot CVS BBC Children in Need Project provides volunteer befrienders who support to vulnerable young people aged 16-18. The following examples highlight the impact of volunteer befriends on young people.

16. 17 year old C was referred by the Child and Adolescent Mental Health Service (CAMHS). Due to a past incident, C was too frightened to leave her home and was suffering with anxiety and depression. When she turned 18, her support with CAMHS ended and she was referred to adult services. This caused further anxiety as C found it difficult to get to her appointments. A volunteer provided a listening ear for C to be able to offload her worries. Together they went to appointments and C has now been able to go on to college and get herself a part time job.

17. J lives in the Afan Valley. He suffers from depression and anxiety and has been home schooled for a year. Other than a younger sibling, he has no engagement with any other children. His mum, who also suffers with poor mental health, does not drive and public transport is an issue for residents

of the Afan Valley. There is also little community activities for them to engage with locally. The family appear to be isolated due to their location.

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LI 26

Ymchwiliad i unigrwydd ac unigedd

Inquiry into loneliness and isolation

Ymateb gan: Cymdeithas Cwnsela a Seicotherapi Prydain

Response from: British Association for Counselling and Psychotherapy

BACP Written Submission to the Health, Social Care and Sport Committee Inquiry into Loneliness and Isolation

1. Introduction

The British Association for Counselling and Psychotherapy (BACP) welcomes the opportunity to contribute to this important inquiry. Loneliness and isolation has significant impact on physical and mental health and is a leading cause of anxiety and depression, as well as increased suicide rates, particularly for older people. Loneliness reduces life expectancy, increases the risk of premature death by a quarter[1] and is said to have an effect on mortality that is similar to smoking 15 cigarettes a day[2].

More than 75% of women and a third of men over the age of 65 live alone. Without the means to leave their homes, or with fewer visits from community workers and service providers, an increasing number of older people will feel lonely and isolated resulting in damaging effects to their mental health[3]. Age Cymru's 2014 omnibus survey further highlights the scale of the challenge in Wales, where over 75,000 older people "*always or often*" feel lonely, and 14% of respondents reported feeling "cut off from society"[4].

BACP are the leading professional body for counselling and psychotherapy in the UK, with over 44,000 members, and 1,800 members in Wales. Our practitioner-members are based in a range of settings in Wales, including the NHS and third sector, providing therapy to clients with a wide range of presenting issues. BACP recognises the critical role that counselling and psychotherapy can play in helping to manage the adverse mental health effects of loneliness and isolation and our written evidence focusses on this important aspect of the inquiry.

2. The link between loneliness and isolation and depression

2.1. The link between loneliness and isolation and depression is well evidenced and documented. Loneliness has been found to increase the symptoms of depression beyond what can be explained by initial levels of depressive symptomatology[5]. Whilst loneliness predicts changes in depressive symptoms, depressive symptoms do not predict changes in loneliness. Loneliness remains the significant predictor of changes in depressive symptomatology[6] . Loneliness has also been found to be a significant predictor of anxiety[7].

2.2. There is a clear correlation between old age, isolation and depression. People over 65, particularly older women, are more prone to depression than any other age group in Wales.[8] Depression affects around 22% of men and 28% of women aged 65 years and over[9].

[1] Age UK, *No one should have no one*, December 2016

[2] Welsh Government, Ageing Well Wales, 2014-19

[3] Older People's Commissioner for Wales, The Importance and Impact of Community Services within Wales, February 2014

[4] Age Cymru and Age UK, *TNS Omnibus survey*, April 2014

[5] (Cacioppo, Hughes, et al., 2006; Green et al., 1992; Hagerty & Williams, 1999; Heikkinen & Kauppinen, 2004; Wei, Russell, & Zakalik, 2005; cf. Weeks et al., 1980. Full details in Annex A

[6] Cacioppo, J. T., Hawkley, L. C., and Thisted, R. A. (2010). Perceived Social Isolation Makes Me Sad: 5-Year Cross-Lagged Analyses of Loneliness and Depressive Symptomatology in the Chicago Health, Aging, and Social Relations Study, Psychology and Aging, 25(2):453–463

[7] Muyan, M., Chang, E. C., Jilani, Z., Yu, T., Lin, J and Hirsch, J. K. (2015). Loneliness and Negative Affective Conditions in Adults: The Journal of Psychology, 150:331 – 341

[8] Audit Commission in Wales. (2004). Developing Mental Health Services for Older People in Wales. Retrieved from http://www.wales.nhs.uk/documents/MHSOP-20report.pdf

[9] Health and Social Care Information Centre. (2007). Health Survey for England, 2005: Health of Older People. Retrieved from http://www.hscic.gov.uk/pubs/hse05olderpeople

2.3. However, despite the high numbers suffering it is estimated that 85% of older people with depression receive no help at all from the NHS and remain undiagnosed and untreated[10]. Furthermore, untreated depression is the leading cause of suicide amongst older people, with men living alone at particularly high risk[11].

2.4. Whilst we understand the inquiry's focus on older people, it is important to also highlight the other vulnerable groups who are at risk of isolation, such as teenagers and young unemployed adults, recently retired people, new mothers, immigrants and people with physical disabilities and learning disabilities. We also reflect their needs in our recommendations.

3. The role of psychological therapies in tackling depression

3.1. In line with the findings of Hill and Brettle (2004; 2005), counselling and psychotherapy are effective interventions for people experiencing psychological distress, particularly for anxiety and depression. The outcomes for older people are equivalent to that of younger populations.

3.2. The most recent IAPT report in England found that outcomes for Older People who access psychological therapies are good, with recovery rates of approximately 60% in the over 65's, compared with under 50% in the general adult population. Within this outcomes for a range of psychological therapies were found to be comparable, including cognitive behavioural therapy (CBT), counselling for depression (CfD), and interpersonal psychotherapy (IPT).

3.3. Whilst not covered by the remit of the inquiry we urge the Committee to also consider the role and impact on carers of older people. In Wales, 370,230 people provide unpaid care, some 12% of the population. Census data found that carers in Wales who are providing high levels of care were three times more likely to suffer ill health than non-carers.[12]

4. Barriers to accessing psychological therapies for older people

4.1. Whilst older people consult their GP almost twice as often as other age groups, only one in six older people with depression discuss their symptoms with a GP[13] and only 15% receive the specialist mental health care they need.[14] There are a number of reasons for this.

4.2. Older people may present with non-specific symptoms such as malaise, tiredness or insomnia rather than disclosing depressive symptoms. In addition, physical symptoms, including pain, are common and the primary care clinician may feel these indicate organic disease. Older people sometimes have beliefs that prevent them from seeking help for depression, such as a fear of stigma or that antidepressant medication is addictive[15].

4.3. Older people from black and minority ethnic backgrounds often do not see mental health services as appropriate. People from different ethnic groups may present with culturally specific idioms of distress. This may lead practitioners to overlook psychological distress and focus solely on the physical aspects of the presentation[16].

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[10] Smyth, C. (2014). Depression in old age 'is the next big health crisis'. Retrieved from: http://www.thetimes.co.uk/tto/health/news/article40572

[11] Primary Care Mental Health Forum, Management of Depression in Older People, June 2014

[12] Welsh Government. (2011). Carers Strategies (Wales) Measure 2010: Guidance issued to Local Health Boards and Local Authorities.

[13] Age Concern, Promoting mental health and well-being in later life: a first report from the UK Inquiry into Mental Health and Well-Being in Later Life. London: Age Concern/Mental Health Foundation, 2006

[14] Smyth, C. (2014). Depression in old age 'is the next big health crisis'. Retrieved from: http://www.thetimes.co.uk/tto/health/news/article40572

[15] Primary Care Mental Health Forum, Management of Depression in Older People, June 2014

[16] Primary Care Mental Health Forum, Management of Depression in Older People, June 2014

4.4. Primary care practitioners may lack the necessary consultation skills or confidence, to correctly diagnose later life depression, or may see the symptoms as part of the ageing process[17]. GPs often feel unsupported due to the lack of availability of psychological interventions and or a lack of knowledge of associated services in their local areas.[18]

5. Government Support to tackle Loneliness and Isolation

5.1. BACP is supportive of the commitment that the Welsh Government made to secure the mental health and wellbeing of all of its people, as signalled in the *Well-being of Future Generations (Wales) Act 2015* and through the publication of *Taking Wales Forward*[19], which includes an important commitment to "*Help people live healthy and independent lives*" with a big focus on building resilience for the whole population while also supporting those with the greatest health need and poorest health outcomes.

5.2. This commitment is further exemplified through the *Ageing Well Wales Programme* (2014-19), which fully recognises the grave physical and mental health impacts of loneliness and isolation and highlights this as a priority area for intervention. Beneath this flagship national policy, *Local Ageing Well Plans* have been produced by every Local Authority in Wales. Whilst we support the will of local areas to design services they need, the quality and status of plans is diverse. Whilst most clearly highlight the need to tackle mental health challenges associated with loneliness and isolation, only a small number of these focus on tackling depression by ensuring older people get access to appropriate therapies. We would particularly like to highlight Bridgend and Merthyr Tydfil as well developed examples.

5.3. BACP is also supportive of the Welsh Government's flagship Mental Health Action Plan - *Together for Mental Health*, and its identification of loneliness and isolation as critical areas for Government intervention. We are supportive of the measures proposed under priority 5.2 and in particular, we welcome the proposal for a national/cross departmental approach to reduce loneliness and isolation among those at risk of mental health problems. We look forward to supporting the development of the proposed cross-government Loneliness and Isolation Strategy, recently announced by the Minister for Social Services and Public Health.

5.4. Alongside the above policies, which broadly focus on reducing physical exclusion, we would have liked to have seen greater emphasis on talking about the barriers that people face, particularly many older people, to secure adequate treatment for the mental health symptoms of loneliness and isolation. We have provided a small number of recommendations, in Section 6, which aim to address these challenges.

6. Recommendations

6.1. BACP proposes the following recommendations to inform an improved approach to managing the challenges highlighted in our evidence as well as the development of the Welsh Government's awaited Loneliness and Isolation Strategy.

6.2. Our evidence demonstrates that psychological therapies have a key role to play in tackling the negative mental health impacts of loneliness and isolation. However, it simply isn't good enough that 85% of older people with depression in the UK receive no access to the support they need to live with dignity. We call on the Welsh Government to show real leadership in ensuring that older people in Wales get better support and access to appropriate talking therapies.

6.3. We are pleased to see that the stigma toward mental health is improving in Wales, as evidenced by the 2017 Time to Change Survey, where 4.7% more people indicated a positive attitude to Mental

[17] Rabins P (1996). Barriers to diagnosis and treatment of depression in elderly patients. American Journal of Geriatric Psychiatry 4: 79–84.
[18] Burroughs H, Morley M, Lovell K et al (2006). 'Justifiable depression': how health professionals and patients view late-life depression – a qualitative study. Family Practice 23: 369–377.
[19] Welsh Government, Taking Wales Forward, November 2016

Health over the past five years[20]. However, stigma remains a significant barrier for many older people and people from BME communities to get the support they need. We call on Welsh Government to do more to improve awareness with vulnerable groups and communities and we believe this should be at the heart of the new Loneliness and Isolation Strategy.

6.4. Public Health Wales NHS Trust, has a key role to play through its Healthy and Well Communities Programme, to support community and third sector organisations to develop collaboration approaches to tackling loneliness and isolation. Alongside this we would like to see a commitment to ensure local Health Boards are providing adequate access to psychological therapies, as well as ensuring appropriate links are being made to *Local Ageing Well Plans* to ensure a joined up approach.

6.5. Whilst we welcome the development of *Local Ageing Well Plans* that meet the specific needs of local communities, the quality and status of these is mixed and only a very small number provide adequate provision to tackle the serious mental health challenges associated with loneliness and isolation. We believe the Department has a key role to play in ensuring best practice is spread across each Local Authority to ensure older people get access to appropriate therapies and support to their mental health needs across the length and breadth of the Country.

6.6. There needs to be a greater understanding of the impact of loneliness on mental health within GP and social services, together with better awareness of the positive impact of psychological therapies – ensuring that mental health assessments take better account of the impact of loneliness, and that people are directed to receive the appropriate support they need.

6.7. Healthcare providers and commissioners in Wales need to focus on developing services which support all those groups at greater risk of social isolation, such as teenagers and young unemployed adults, recently retired people, immigrants and people with physical disabilities and learning disabilities, so that individuals can be offered support at an early stage, reducing the chance of their developing chronic loneliness with all its ensuing and costly physical and mental health problems.

7. Contact Details

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Ymchwiliad i unigrwydd ac unigedd

Inquiry into loneliness and isolation

Ymateb gan: Cymdeithas Ponthafren

Response from: Ponthafren Association

Ponthafren Association

Consultation - Inquiry into Loneliness and Isolation National Assembly for Wales - Health, Social Care and Sport Committee

Submission from Ponthafren Association.

1.0 The following submission is in response to the first two points raised ie,

- the **evidence for the scale and causes** of the problems of isolation and loneliness, including factors such as **housing**, transport, community facilities, **health and wellbeing services**;
- the **impact** of loneliness and isolation on older people in terms of **physical and mental health and wellbeing**, including whether it disproportionately affects certain groups such as those with dementia;

1.1 Ponthafren Association is a registered charity operating out of our Wellness and Learning Recovery Centres in Welshpool and Newtown, offering support to people with mental health issues and those experiencing isolation and loneliness.

1.2 We provide a facility where people can relax, access support, including support from their peers and participate in a wide range of workshops, activities and courses, as well as providing an out-of-hours counselling and crisis service. We direct people to other organisations and specialist support services in the county. Many of our members have a range of psychiatric conditions and personality disorders. Some self-harm or are involved in substance misuse, others are involved in the criminal justice system, have been offenders in the past, or are homeless. Many have dual diagnosis, where their mental health issues are compounded by a learning disability or alcohol / drug dependence.

1.3 We follow a holistic approach to recovery, supporting individuals with a person-centred planning approach and offer a service to address both mental and physical well-being as the two are interlinked. We provide training and activities that help people to:

- Understand and manage their mental health condition
- Build skills and develop confidence
- Support independent living
- Seek employment or training opportunities

Ponthafren's direct relationship to people affected by Loneliness and Isolation: many of our members, due to their mental health issues, experience loneliness and isolation. This can cause an inability to engage in mainstream activities due to lack of confidence and low self-esteem. Some are unable to talk to their family and friends about the issues they are facing on a daily basis and this can cause them to become disengaged from their pre-existing support networks. Some of our members have become long term unemployed or have retired and have become disengaged from their local community.

Ponthafren's relationship to services for people with dementia: we offer support for people who care for people with dementia and people in the early stages of dementia. All of our services are accessible to the above groups. The majority of our staff and volunteers are all Dementia Friends trained. We have played an integral role in the development of Newtown as Dementia

Friendly Community and sit on the steering group. Our staff and volunteers provide regular activities for a local carers of people with dementia group and work very closely in partnership with CREDU providing a monthly carers group.

3.0 **Policy Framework**

3.1 National Assembly for Wales …. http://www.cpa.org.uk/cpa-lga-evidence/Merthyr_Tydfil_County_Borough_Council/Ageing_Well_in_Wales_Programme.pdf

3.2 In line with the Powys Ageing Well Plain we aim to help achieve improvements in the quality of life for our members across the following aspects of the Ageing Well programme's priorities.
In delivering these priorities, our vision is that we work with people who use our services and their families to make sure older people in Powys:

- Have the opportunity to take part in social activities and be included in the community, to maintain their well-being;
- Are given relevant information, so that they have an increased choice and control over what matters to them;
- Have greater access to health and social care which is close to home and can meet their needs;
- Experience a good quality of life; and are safe from abuse and neglect.

http://pstatic.powys.gov.uk/fileadmin/Docs/Adults/Integration/Powys_Ageing_Well_Pan_2016-2019.pdf

3.3 Ponthafren Association recognises that Loneliness and isolation are not the same thing: the causes of loneliness are not just physical isolation and lack of companionship, but also sometimes the lack of a useful role in society. Many of our service users experience this because of their mental health issues make them feel less worthy or unable to continue to play an active role in society because of the stigma that surrounds their 'condition' or their personal lack of confidence and self-esteem.

Whilst social isolation is an objective state – defined in terms of the quantity of social relationships and contacts – loneliness is a subjective experience. Loneliness is a negative emotion associated with a perceived gap between the quality and quantity of relationships that we have and those we want. Ponthafren offers people the opportunity to engage with their peers and participate in meaningful activities that are requested by our memberships. We offer a range of life skill courses, such as Confidence Building, Resilience skills, Conflict Management and Emotional well-being. We also offer a range of physical activities such as low impact exercise, a walking group, Zumba and Tai Chi.

4. **Evidence**

4.1 Our membership during 2016 peaked at 592 members out of the North Powys population of approximately 63,000.

4.2 The age breakdown of our 2016 membership is as follows with the average age of our members being 47.8 (Powys average 45.1, Wales average age 41.4)

1	0 - 4	231	25 - 49
1	5 - 9	159	50 - 64
1	10 - 14	123	65 - 89
31	15 - 19	0	90 plus
45	20 - 24	592	Total

4.3 Our 2016 membership is represented in the following categories:

76	Older People	45	Physical / Sensory Disability
29	Elderly Mentally Ill	2	Carers
227	Adult Mentally Ill	25	CYPP
3	Learning Disability	185	Other (No health problems)
		592	Total

261 of our members do not declare any health grounds on their membership form which implies that their main reason for attending is in order to address isolation or loneliness. Of course, many people in the other categories might also suffer from isolation or loneliness.

4.4 We run a very successful counselling service which is free to our members at the point of access. This service had the following referrals during 2016:

158	Self	7	Montgomeryshire Family Crisis Centre
66	GP	6	Kaleidoscope (Drug & Alcohol service)
21	1:1 Recovery scheme	6	Probation service
15	Community Mental Health Team	17	Other
14	Counsellor referral	310	Total

4.5 The age breakdown of the referrals to the counselling service is as detailed below:

19	15 - 19	15	65 - 89
41	20 - 24	0	90 Plus
172	25 - 49	11	No age recorded
52	50 - 64	310	Total

The average age of the referrals is 39.7

4.5 One of the questions that we ask all counselling clients is “Do you feel less stigmatised and more a part of the community?” the 62 responses were as follows:

- Yes 42
- No 8
- Neutral 11
- Did not answer 1

4.6 We also offer group life-skills courses and asked the participants “Do you feel less stigmatised and more a part of the community?” the 120 responses were as follows:

- Yes 93
- No 11
- Neutral 11
- Did not answer 5

5. **Impact of loneliness and isolation on older people in terms of physical and mental health and wellbeing**

"At Ponthafren we have found that engagement in purposeful activity can make a profound impact on older people who have lost their way and become socially isolated, their family, and the community within which they live."

Case Study
One gentleman who had recently retired felt that he had lost his standing in the local community, he felt that he no longer played an important role in his local community. He had no knowledge of mental health issues and did not realise the negative impact his behavior was having on his relationship with his wife. He went on our accredited volunteer course and became a volunteer driver for us. He also joined the local gym with our support and now accesses that on a regular basis. He admits that this is not necessarily for the exercise but for the social interaction with others he meets there. This has enabled his wife to have time on her own and for her to interact with her own group of friends. Whereas prior to his accessing our services he wanted to be around her continuously, which was having a negative impact on her mental health and wellbeing. She felt isolated from her friends and unable to socialize.

6. **Impact of loneliness and isolation on the use of public services**

"At Ponthafren we have found that lonely people have more cause to use public services, particularly social care and health, than other people. Lonely members are more likely to:

- visit their GP
- Use accident and emergency services
- Report incidents to Police

We have experienced all the above with many of our members, but now the accident and emergency services will refer and signpost people to ourselves, which is positive''.

Case Study
One of our members who is 50 years of age would repeatedly make calls to the Police to report incidents, when they attended the scene they were finding that the person just wanted to talk and have company. They frequently called out the emergency services at weekends and in the evenings to say they had taken an overdose or were having chest pains to try to get admitted to hospital. A Police Community Support Officer made a referral to our service so that the person was able to increase their social network and gain appropriate support. The person has now attended life skills courses, which include resilience skills, this has enabled them to deal with issues that they are experience and talk more freely about them to their peers.

7. **Positive impact of Digital inclusion**

"At Ponthafren we have found that by accessing digital technology it has led to increased social interaction and had a positive impact on a personas Mental Health and Wellbeing. The person becomes less socially isolated due to them being able to be in touch with a wider social network, on line and also through meeting others on the courses and in our centres."

Case Study
One lady who was 70 came to our basic computer course and our ‘learn to use a mobile phone’ course because she had family in in numerous places around the UK. She was unable to communicate with them on a regular basis and felt very isolated and excluded from their lives. She felt that going to the local college was too daunting for her, but being in a small group with people of a similar age and similar lack of knowledge gave her the confidence to learn skills that were completely alien to her. She now Skypes her family, texts and emails and is also on social media. She can see pictures of her grandchildren and keep in regular contact with them, whereas previously she was unable to see her family growing up and felt totally disconnected from them.

8. **Benefits of ‘Whole Community Working**

‘’ At Ponthafren we have found that the effect of volunteering on depression among the older members encourages social integration, it also encourages people to play an active role in other areas of society, increases their social circle and makes them feel valued again.’’

Case Study
One of our volunteers is 67 years of age facilitates our Outreach group in a nearby town. This group is made up of people who are over 60 years of age and would otherwise be very isolated in their community because of their mental health issues. This volunteer has recently had physical health issues as well as mental health issues, but one of the driving factors surrounding his recovery was the thought of getting back to volunteering again and supporting the group. Volunteering has increased his social network. He feels he is valued and this has had a positive impact on his life, whereas prior volunteering he had been made redundant from a job with the local authority and had become withdrawn and in his words 'lonely and without purpose'.

9. **Stigma**

Because of the stigma surrounding mental health issues, a lot of our members have detached themselves from their families and friends, either because they feel ashamed and unable to talk about their issues as they feel a burden to society, or because their family and friends do not understand what they are feeling. The majority of our members are on benefits and would not be able to afford a counsellor. Waiting lists for NHS Counsellors and Psychiatrist are long in Powys. We are able to offer our members counselling free at the point of access, which then enable them to talk about their issues. We also offer life skill courses in a group setting or on a one to one basis.

By being able to get involved in meaningful activities with others, increases peoples self-esteem and confidence and be less responsive to stigma attached to their mental health issues. We offer people a safe pair of hands in a non-judgmental way, which enable stigma to be less of an issue.

We also offer physical activists which include Zumba, Walking groups, beginners running, swimming and low impact aerobics. All of these activities can be isolation fighters. They can give people a reason to get up in the morning and get out to meet others.

Due to stigma, we see that it is hard for our members to retain friendships and make meaningful friendships with others, until they gain confidence and greater understanding about their own mental health issues that they are experiencing.

Some of our members have become depressed because of loneliness and some have become lonely because of their mental health issues.

Please see embedded voice recordings from three of our members below who tell their story:

Please double click the below icons to open the sound files in your default program:		
Interview 1	Interview 2	Interview 3

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2. Loneliness as a Public Health Issue: The Impact of Loneliness on Health Care Utilization Among Older Adults: (2014)
Kerstin Gerst-Emerson, PhD, and Jayani Jayawardhana, PhD
http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2014.302427

3. http://www.ageuk.org.uk/documents/en-gb/for-professionals/evidence_review_loneliness_and_isolation.pdf?dtrk=true

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Ymchwiliad i unigrwydd ac unigedd
Inquiry into loneliness and isolation
Ymateb gan: Macmillan Cymorth Canser
Response from: Macmillan Cancer Support

Inquiry into Loneliness and Isolation

The Response of Macmillan Cancer Support to the Health, Social Care and Sport Committee's Consultation

Contact:	Greg Pycroft, Policy Officer (Wales) Email: [redacted] Tel: [redacted]
Date created:	March 2017

1. Introduction

1.1 Macmillan Cancer Support welcomes this opportunity to contribute to the inquiry into Loneliness and Isolation

1.2 In Wales, 19,000 (WCISU Feb 2015) people are diagnosed with cancer every year and more than 130,000 people are currently living with or beyond cancer, almost 4.5 percent of the population. By 2030 it is expected that 250,000, almost eight percent of the Welsh population, will have been affected by a cancer diagnosis and one in two of us will be affected by cancer at some point in our lives.

1.3 The good news is that survival rates are steadily improving and many people recover. On average 70 percent[1] of Welsh residents diagnosed with cancer can expect to survive at least one year. However, despite this positive news we find that loneliness and isolation are unwelcome experiences of too many people living with cancer.

1.4 From our own research into the subject, a first for people with cancer. A significant proportion of people diagnosed with the disease in the UK, one in four[2], will lack the basic support of family and friends during their treatment and recovery. They face loneliness and isolation during the toughest fight of their lives.

1.5 A more recent Macmillan/YouGov survey found that 12% of people with cancer in Wales – an estimated 15,000 people have no close friends to talk to about their cancer[3].

1.6 At Macmillan Cancer Support we believe no-one should face cancer alone. We understand that people choose to deal with cancer in different ways, but for those who can manage by

[1] Welsh Cancer Intelligence and Surveillance Unit Official Statistics 2012 data. Published 10 April 2014
[2] Macmillan Cancer Support. (2013) "Facing the Fight Alone: Isolation among cancer patients." p6
http://www.macmillan.org.uk/documents/aboutus/mac13970_isolated_cancer_patients_media_reportfinal.pdf
[3] Macmillan Cancer Support. (2017) Press release: Hundreds of thousands of people with cancer have no close friends to talk to

themselves there will be many more people with cancer who simply have no-one to turn to. Being diagnosed with cancer is bad enough; facing it in isolation is worse.

2. Isolation, Loneliness and People Living with Cancer

2.1 Macmillan's UK-wide research on isolation[4], published in 2013, sought to capture and appraise the scale of isolation among cancer patients. Doing so allowed us to better understand issues around isolation and shape as suite of recommendations to support those in need.

2.2 For Macmillan isolation has two main dimensions; first there's emotional isolation, the feeling of loneliness and being alone. Secondly there's physical isolation, being cut off from services and people, or not being able to do things that a person used to do pre-diagnosis.

2.3 We were able to draw a range of findings from the first-ever research into the number and profile of people with cancer in the UK. 1,700 people and 150 healthcare professionals were surveyed about the amount of support patients receive during their treatment and recovery, and what effect this has on their physical and emotional well-being.

2.4 **While we knew that isolation and loneliness was faced by cancer patients the scale of the problem is striking.** One in four people we surveyed reported a lack of support from family and friends during their treatment and recovery. One in fourteen people (representing 7% of people with cancer) received no help whatsoever, facing cancer completely alone. There is slight regional variation – offering contrasts, perhaps, between urban and rural regions. 12% of Londoners with cancer reported complete isolation, while the figure drops to 5% in Wales[5].

2.5 We also found that we could categorise isolation in a range of ways. We identified five categories of isolation, and identified further issues within each category, and the groups of people with cancer most commonly affected. The five categories of isolation[6] are:

Category of isolation	Isolation issues	Which groups may be particularly affected?
Emotional isolation	Low self-esteem caused by **change of appearance** as a result of cancer Low sex drive or **lack of intimacy** creating a barrier between partners **Lack of family and friends** to support **Depression and anxiety** caused by cancer, its treatment and other long-term effects Depression and loneliness caused by **bereavement** due to the death of someone with cancer	People with some head and neck cancers People who have had a mastectomy People with lymphoedema People who have had treatment to the pelvic area People in treatment phase and directly post treatment The bereaved/widowed
Financial isolation	**Can't afford to do social activities** or holidays **Can't afford to pay for transport** to and from activities/treatment or **can't afford to buy mobility aids** to get out and about	People of working age People with dependents (children and elderly parents) People with complex financial situations (mortgages, pensions, insurance)

[4] Macmillan Cancer Support. (2013) "Facing the Fight Alone: Isolation among cancer patients."
[5] Ibid p9-10
[6] Macmillan Cancer Support (2013) "Isolation amongst people affected by cancer – a dossier of evidence on issues and solutions" Powerpoint presentation. Macmillian Cancer Support: London. slides 9 and 10

	Carer can't afford cover to allow them to go out (respite care)	People on low fixed incomes
Physical/ practical isolation	**Limited or no means of transport** or **lack of mobility aids** or **rural isolation** **Carer needed for practical support** (carer is isolated) **Feeling ill** as a result of chemo/radiotherapy **Cancer-related fatigue** **Long-term side effects** stopping patient from doing 'normal' things (e.g. colostomy bag) **Dying alone**	Those in rural locations The vulnerable elderly Those in lower socioeconomic groups Those actively going through treatment Those with debilitating long-term side effects (e.g. from bowel cancer) Those in care homes
Information-related isolation	**Peers/carers/families don't understand so don't know what the patient is going through** **Lack of information for making the patient feel like no one else is going through the same thing ("going through it alone")** **Lack of out of hours services**	**Children with cancer** **People with rarer cancers** **People with learning disabilities** **People at transition points of care**
Cultural & spiritual isolation	Isolation caused by **language barriers** **Stigma and taboo** discussing cancer for certain religions/ethnic groups	Minority ethnic groups where English/Welsh is not first language People with sensory disabilities – eg deaf and hard of hearing, blind and partially sighted, etc

2.6 Three in five people (58%) said that the reason they lacked family and friend support was that they were too busy to help or lived too far away. Two in five people (41%) of people said that they preferred to deal with their cancer on their own (the cancer may have been relatively mild) and did not want any support in the first place. However, a similar number said they did not know where to turn, thought there was no-one who could help them or felt too tired of ill to do anything to support themselves[7].

2.7 A third of healthcare professionals did not always ask if a patient has support from family or friends, this increased to almost a half of GPs[8].

2.8 We found that overall women were more likely to be isolated than men[9] and cancer patients aged between 35 and 55 were least likely to have support at all times. Fewer than half of these patients said they were fully supported during treatment and recovery, compared to two-thirds of those aged 55 or over[10].

2.8 The negative effects of isolation on cancer patients are very concerning. People skip meals and fail to eat properly at home; some are unable to wash themselves properly, and do

[7] Ibid p6
[8] Ibid p7
[9] Ibid p7
[10] Ibid p9

household jobs such as cleaning. Isolation also contributes to people living with cancer not being physically active and contributes to mental illness[11].

2.9 Almost half of healthcare professionals made a link between isolated cancer patients and a real struggle to get to and from hospital, worryingly affecting the outcomes of treatment. More than half of healthcare professionals say that isolated cancer patients make poorer treatment decisions, even choosing to skip treatment altogether[12].

2.10 Our research also identified clinical studies that link isolation with negative clinical outcomes in specific forms of cancer - notably breast[13]; colorectal[14]; and ovarian[15].

2.11 We continue to monitor and survey the cancer patient experience to identify isolation and loneliness; it continues to inform Macmillan's "Not Alone" campaign[16]. Isolation remains an unfortunate feature. Our 2016 Macmillan/YouGov survey found that 12% of people with cancer in Wales – an estimated 15,000 people have no close friends to talk to about their cancer.[17].

3. Reducing Isolation Amongst People Living with Cancer

3.1 On the back of its 2013 research Macmillan made a number of recommendations to improve the outcomes of isolated cancer patients. These were directed at the key agents for change, notably the cancer patient; friends and family; and healthcare professionals.

3.2 First, our recommendations acknowledge that patients have a role in helping themselves become less isolated. Recognising that isolation can have a real and negative impact on personal health and well-being is an initial step to speaking to healthcare professionals and need being recorded. Patients may end up being signposted or supported to overcome isolation, whether via services provided Macmillan; social services or other registered charities[18].

3.3 Second, we recommend that friends and family of those living with cancer continue to talk to cancer patients about their condition or treatment since it's unlikely to increase their distress. We also suggest that friends and family make themselves acquainted with the materials - available online and elsewhere - that can help with and inform conversations. Finally, if people find conversation too hard we also recommend friends and family find other ways to remain close, through other forms of practical help

3.4 We finally recommended that the third group, healthcare professionals, are made aware of the impact of isolation on the general health and well-being of cancer patients, and that allowances are made for people who happen to lack support. Greater awareness of alternative forms of support would also mean that patients can be signposted, and make full use of, other suitable services should the need be identified[19].

3.5 The Recovery Package, which was led by Macmillan, is a series of key interventions which, when delivered together can greatly improve outcomes for people living with and beyond cancer.

[11] Ibid p11
[12] Ibid p11
[13] Kroenke C H et al. Social Networks, Social Support, and Survival after Breast Cancer Diagnosis.Journal of Clinical Oncology. (2006). 24(7): 1105–1111. http://jco.ascopubs.org/content/24/7/1105.full
[14] ii Nausheen B et al. Relationship Between Loneliness and Proangiogenic Cytokines in Newly Diagnosed Tumors of Colon and Rectum. Psychosomatic Medicine. 2011. 72(9): 912–916. http://www.psychosomaticmedicine.org/content/72/9/912.abstract
[15] Lutgendorf S K et al. Social Influences on Clinical Outcomes of Patients with Ovarian Cancer. Journal of Clinical Oncology. 2012. 30(23): 2885–2890. http://jco.ascopubs.org/content/30/23/2885.full
[16] Macmillan Cancer Support. (2017) http://www.macmillan.org.uk/about-us/what-we-do/our-ambition/not-alone-campaign.html
[17] Macmillan Cancer Support. (2017) Press release: Hundreds of thousands of people with cancer have no close friends to talk to
[18] Macmillan Cancer Support. (2013) "Facing the Fight Alone: Isolation among cancer patients." p12
[19] Ibid p13

3.6 The recovery package is made up of the following elements

- A Holistic Needs Assessment (HNS) which results in a written plan at key points of the care pathway
- A treatment summery completed at the end of each acute treatment phase and sent to the GP
- A cancer care review to discuss the patients' needs
- Access to an education and support event focussed on health and wellbeing to prepare a person for the transition to supported self-management.

3.6 These key interventions provide opportunities for the healthcare professional/key worker to identify isolation and loneliness and co-produce appropriate support that meets the needs of the cancer patient. We welcome the reference to the Macmillan Recovery Package within the Cancer Delivery Plan[20] and look forward to working with the Wales Cancer Network to deliver consistent application across Wales.

3.7 As the source of cancer policy direction in Wales the recently refreshed Cancer Delivery Plan can be commended for continuing to place the delivery of more patient-centred care at its core[21]. While isolation is not explicitly referred to in the plan, isolation will be tackled through the consistent delivery of key actions, including; access to welfare benefits advice; a common Macmillan recovery package; providing services as locally as feasible[22]; allocation of a named key worker; and supporting people at the end of their treatment, when they leave the acute phase – thereby avoiding people feeling unsupported and isolated[23]. Macmillan supports these key actions and is committed to supporting their implementation across Wales.

For any further information regarding this response, please contact Greg Pycroft, Policy Officer, Wales – [redacted] or [redacted].

[20] Welsh Government (2016) "Cancer Delivery Plan for Wales 2016-2020: The highest standard of care for everyone with cancer". p14 http://gov.wales/docs/dhss/publications/161114cancerplanen.pdf

[21] Ibid p3

[22] Ibid p14

[23] Ibid p13

LI 29
Ymchwiliad i unigrwydd ac unigedd
Inquiry into loneliness and isolation
Ymateb gan: Prosiect Eden
Response from: The Eden Project

Dear Sirs /madam

We would like to submit good practice community led solutions to reducing loneliness within wales.

Eden Project Communities - The Big Lunch

Eden Project Communities is the home of The Big Lunch, an idea from the Eden Project, funded by the Big Lottery. In 2016 7.3 million people took part in The Big Lunch, the UK's annual get-together for neighbours. This year on 17 and 18 June, as part of The Great Get-Together weekend, we're hoping for even more.

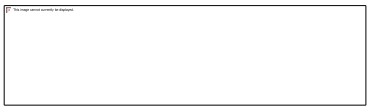
Since 2009, millions of people have been stepping out from behind closed doors to join The Big Lunch; to have fun, share food and enjoy conversations with their neighbours. As a result new connections are made and over time friendships blossom. Neighbourhoods are where we have our homes but we know that for many people, even home can be a lonely place, for anyone of any age.

The Big Lunch works to build connections between people in the places where they live so that neighbours become a vital source of support, rather than a bitter reminder of how lonely we are. The Big Lunch has joined the Jo Cox Commission on Loneliness, because we believe place matters and working together through this collaboration we can help drive positive social change that will help reduce the number of people suffering feelings of loneliness in their neighbourhoods and homes.

We know:

People make 20 connections on average when they take part in community activities
For 1 in 20 people, talking with a neighbour is the highlight of their day
1 in 8 people involved in community activities go on to exercise together
1 in 8 people involved in community activities go on to do something cultural together

Loneliness is a mismatch between the relationships we have and those we want. It is our internal trigger, letting us know it's time to seek company, just as hunger lets us know it's time to eat.



Anyone at any age can be lonely — even busy people, even you — whether alone or in a group, at work or at home with family.

Loneliness is a sign that something needs to change. Loneliness harms us as individuals and it harms our neighbourhoods and communities. Research has shown that lacking social connections is as damaging to our health as smoking 15 cigarettes a day (Holt-Lunstad, 2015).

Loneliness, like confidence and fragility, can come and go, often taking us by surprise.

Isolation however, is often where there is no choice but to be alone. Some people seek solitude, but few choose to be lonely or isolated, primarily because it isn't good for us.

Lonely people are often excluded from the opportunities many of us take for granted. They may find their self-worth, confidence and trust reduce, decreasing their access to new opportunities and to meeting new and different people in ordinary everyday situations. And yet it is from these that we develop new relationships, experiences, insights, interests, hobbies and hopefully new friendships.

Even home can be a lonely place. Neighbourhoods are where we have our homes and they affect how we feel. Our neighbours can be both a vital source of support or a reminder of how lonely we are.

There are things we all can do within our neighbourhoods to enable ourselves and others to feel more supported and less lonely.

Earlier this year we commissioned research to look at the value of connected communities.

The Cost of Disconnected Communities in Wales: £2.6 billion per year
Social isolation and disconnected communities could be costing the Welsh economy £2.6 billion every year, a new study has found.

The research has been commissioned by Eden Project initiative The Big Lunch and funded by the Big Lottery to examine the impact of community-led initiatives on societal welfare and on the economy in each area of the UK.

The research reveals the annual cost to public services in Wales of social isolation and disconnected communities, including:

Demand on health services: £427 million
Demand on policing: £10 million
The cost of stress and low self-esteem: £8 million

Disconnected communities are linked to a loss of productivity, with a net cost to the Welsh economy of over £1 billion every year.

According to the research, which was carried out by leading economics consultancy the Centre of Economics and Business Research (Cebr), neighbourliness already delivers substantial economic benefits to Welsh society, representing an annual saving of £2.13 billion in total.

The saving comes from sharing between neighbours, an increase in social connection and reductions in the demands on public services such as healthcare, social care, welfare and the environment.
It also includes the productivity benefits associated with a happier and healthier workforce: a net gain to the Welsh economy of £601 million.
The study shows that an increase in neighbourliness – where members of the community share their time, interests, ideas and resources with each other - helps to ease demand on public services by providing locally run alternatives, such as neighbourhood watch schemes and local litter picks. In Wales, the saving to public services currently equates to £264 million.

It also reveals that neighbourliness has a huge welfare value, with £1.26bn saved each year in Wales through neighbours sharing resources and services such as childcare, pet sitting, DIY and transport, and borrowing tools and household equipment.

Becoming more connected with the community has also been shown to have a positive influence on people's health and the report estimates that social cohesion currently saves £254m in reduced demand on health services in Wales – and could potentially grow to £681m if everyone in Wales got to know their neighbours and became more involved in community activities.

"The Big Lunch study reveals that the financial benefits to individuals and wider society are enormous, highlighting more reasons than ever for communities to come together. Getting to know your neighbours through an initiative like The Big Lunch will bring you joy and happiness, and will also help you, Wales and the UK as a whole to save money."

The report is a combination of qualitative research and quantitative data – the latter garnered via a survey carried out by Cebr for the purposes of the study.

The survey found that, on average, 97% of people in the UK believe that community projects have a positive impact on society as a whole, and 96% believe that the cost of running key community services is higher if the community is not connected and if people are lonely or socially isolated.

Cebr director Oliver Hogan said: “With our report we have established the cost to society of disconnected communities. Our starting point is that community involvement can act to reduce loneliness and isolation and encourage positive change within communities. There is a lot of existing research on loneliness, so this study was shaped to provide a perspective on the costs imposed on society by disconnected communities.

“We found that, by increasing social capital, reducing isolation, and enhancing social inclusion, community activities and events lead to improvements in health, educational performance and socioeconomic circumstance. As such, they can help redress the balance between the need for and provision of public services and reduce the demands on those services. However, an element of the overall improvement in societal welfare also translates into productivity gains, both to the Welsh and to the UK economy through a happier and healthier workforce.”

Why The Big Lunch is great for communities

Over 70% of attendees feel The Big Lunch is good for the community
94% of attendees believe The Big Lunch will have a positive impact on their community
88% of organisers feel better about their neighbourhood as a result of hosting a Big Lunch
65% of people who organise a Big Lunch go on to do more in their community
74% of people who do The Big Lunch feel an increased sense of community
38% of people who do The Big Lunch feel a surge in their own self esteem

The Big Lunch is one of the most significant and well known initiatives of the Eden Project, an educational charity working to connect people with each other and the living world.

Started in 2009 and made possible by the Big Lottery Fund, The Big Lunch is an annual event held in June encouraging people to have lunch with their neighbours in a simple act of community, friendship and fun. Designed to build stronger and better connected communities, the initiative aims to improve the lives of the individuals involved while also easing the demands on public services and delivering productivity gains to employers.

In Wales, over 185,000 people took part in The Big Lunch in 2016. Samantha Evans, the Eden Project's Community Network Developer in Wales, said: "We wanted to understand the impact of community-led initiatives like The Big Lunch, outlining the benefits to individuals' health and well-being, and the economic impact too. Existing research suggests that people feel happier, safer and more content when they live in connected communities and know their neighbours.

Thank you for your time and consideration, and the commitment the Assembly is making calling for an inquiry into loneliness

Yours Sincerely

Tracey Robbins

Eden Project Communities

UK Delivery Manager

Tracey joined Eden Project Communities early 2016 from her previous role as Policy and Research Manager for Neighbourhoods at the Joseph Rowntree Foundation.

For 5 years Tracey led the Neighbourhood approaches to loneliness programme, for JRF, a place based action research programme working with local people to explore what causes and reduces loneliness within four different neighbourhoods across 2 cities and more importantly to do something about it.

Tracey's career has focussed on asset based community development approaches, health wellbeing and social care within the voluntary and community sector for 20 years. Using action research and participatory technics to work directly with individuals and groups to bring about change, develop opportunities and redress imbalances.

Many of those years were voluntary, becoming a practitioner as well as an advocating the needs of communities, on local, regional, national and international forums.

For 9 years she has worked voluntary with individuals, communities and organisations to develop, co-ordinate and manage new initiatives - working locally to meet the needs of communities and strategically in developing and evaluating services.

Tracey has also blogged about her experience on loneliness and helps offers to connect with this ever increasing issue. More information including a free resource pack to down load can be found here:

http://www.thebiglunch.com/

http://www.thebiglunchers.com/index.php/2016/03/home-can-be-a-lonely-place-but-not-if-you-open-your-door-to-the-big-lunch/

http://www.thebiglunchers.com/index.php/2016/05/with-a-big-lunar-lunch-everyone-can-come-to-the-table/

http://www.jrf.org.uk/work/workarea/neighbourhood-approaches-loneliness

You can follow Tracey on twitter @TraceyJRobbins

Inquiry into loneliness and isolation

Stonewall Cymru's response

Background
Stonewall Cymru is Wales's leading lesbian, gay, bi and trans (LGBT) equality charity. We were founded in 2003, and we work with businesses, public bodies, schools, the Welsh Government, the National Assembly for Wales and a wide range of partners in communities across Wales to work towards our vision of a world where lesbian, gay, bi and trans people are accepted without exception.

Overview

1. Stonewall Cymru welcomes the opportunity to respond to this important inquiry by the Health, Social Care and Sport Committee into loneliness and isolation.
2. Lesbian, gay, bi and trans (LGBT) people are more likely to grow old with less robust support networks. They are also less likely to access support services due to fears of discrimination, lack of understanding and poor-quality care. This combination of factors means that LGBT people (especially older LGBT people) are often highly vulnerable to isolation and loneliness.

Scale and causes of isolation and loneliness

3. The *Trans Mental Health Study* (2012) found that on a scale from one (never feeling isolated) to seven (constant isolation) the mean score of trans respondents was 3.9, reflecting a high level of isolation among trans people.
4. Stonewall's research *Lesbian, Gay and Bisexual People in Later Life* (2011) found that the life experiences of lesbian, gay and bi people differ from those of straight people in ways that render them much more vulnerable to isolation and loneliness as they grow older.
5. Older lesbian, gay and bi people are less likely to have children, less likely to see family members at least once a week, and more likely to live alone than their straight counterparts. Gay and bi men over 55 are almost three times as likely to be single as straight men.
6. It also found that older lesbian, gay and bi people are much more likely to rely on friends for care, support and social contact. However, many noted the difficulties in relying on friends for care who are also getting older and facing increasing support needs themselves. Furthermore, providing informal care without adequate support is a common cause of isolation and loneliness for carers.

Impact on mental and physical health and wellbeing

7. *Lesbian, Gay and Bisexual People in Later Life* also found that isolation and loneliness were likely to have negative effects on mental and physical wellbeing.

8. Lesbian, gay and bi older people were more likely than their straight peers to drink alcohol more often and more likely to have taken drugs in the last year.
9. Lesbian, gay and bi older people who were single were also more likely to smoke, to have taken drugs in the last year and to rate their mental health as poor than those in a relationship.
10. The *Trans Mental Health Study* also found high rates of self-harm, suicidal ideation, and other indicators of poor mental health and wellbeing among trans people, along with high levels of drug and alcohol use.

Public services

11. *Lesbian, Gay and Bisexual People in Later Life* found that lesbian, gay and bi people were nearly twice as likely as their straight peers to expect to rely on external services as they get older, including GPs, social services and paid help, and many of those surveyed identified that their lack of other support mechanisms would increase their own reliance on health and social care services.
12. Despite this, three in five lesbian, gay and bi older people believe that social care and support services would not be able to understand and meet their needs and many do not feel comfortable disclosing their sexual orientation to health and social care professionals including care home staff, paid carers and social workers.
13. Many of those surveyed identified fear of discrimination or a lack of acceptance as being the cause of their concerns, and Stonewall Cymru's *Unhealthy Attitudes* (2015) research found that one in five health and social care staff in Wales have heard their colleagues make negative remarks or use discriminatory language about trans people, and one in ten have witnessed colleagues express the dangerous belief that people can be 'cured' of being lesbian, gay or bi.
14. It also found that just one in twenty patient-facing health and social care staff have received training on the health needs of LGBT people.
15. The expectation of poor-quality care increases anxiety and further undermines the mental health of those who are isolated: seven in ten lesbian, gay and bi people over 55 were concerned about needing care in the future.
16. It also leads to people delaying seeking help for their needs until it becomes absolutely necessary, when they require much higher levels of care. This undermines preventative approaches aimed at supporting and facilitating continued independent living and therefore entrenches isolation and increases the cost of care provision.
17. Finally, many LGBT people in care may not disclose their sexual orientation or trans status to care workers, and if they live in residential care or in shared accommodation, to other residents. This increases levels of isolation and loneliness, as it means that people feel less able to be themselves and to talk freely about their lives and experiences with those they spend time with.

Addressing problems of loneliness and isolation

18. An essential intervention in combatting loneliness and isolation among LGBT older people will be to ensure that all health and social care staff receive training on the care needs of LGBT people and to transform residential homes and specialist

housing into spaces where LGBT older people feel confident that they can be themselves and be treated with respect and dignity.

19. As part of this, the Welsh Government should work with the newly-established Social Care Wales and the Care and Social Services Inspectorate Wales to ensure that embedding LGBT-inclusive practice is an essential component of the work to improve care services across Wales.
20. Furthermore, the Welsh Government should explore innovative models of care provision for LGBT older people by continuing to work with Disability Wales to develop cooperative models for people receiving direct payments, and exploring the potential of sheltered accommodation provision for LGBT people. These provisions recognise the close connections between of the need for care and support and the need for community and social interaction and are often identified by LGBT older people as options that would alleviate their concerns about receiving care.
21. Social groups provide an important opportunity for people to socialise and make friends in the community. Welsh Government should continue to work with local authorities and third-sector organisations to ensure a range of opportunities to socialise remain available to older people across Wales.
22. For many LGBT people, it is important to find community with other people who are LGBT and who might share experiences with them. It is particularly important therefore that social groups and community organisations for LGBT people that are accessible to older people are supported.
23. Stonewall Cymru's Information Service serves as a database for these groups across Wales, and should be signposted as a resource to those who run groups, as well as to those who work in professional roles across social services and wellbeing so they can inform people experiencing loneliness of the opportunities available in their area.

Further reading

Hiding who I am: The reality of end of life care for LGBT people (Marie Curie, 2015)
Unchartered Territory: A report into the first generation growing older with HIV (Terrence Higgins Trust, 2017)
NISCHR Report on LGB residential care (Swansea University, 2013)
Trans* Ageing and Care Project (Swansea University, forthcoming)

Further information

For further information, contact:
Crash Wigley
Policy and Campaigns Officer
Stonewall Cymru
[redacted]

LI 31

Ymchwiliad i unigrwydd ac unigedd

Inquiry into loneliness and isolation

Ymateb gan: National Community Hearing Association

Response from: National Community Hearing Association

HEALTH, SOCIAL CARE AND SPORT COMMITTEE:

INQUIRY INTO LONELINESS AND ISOLATION

1. The National Community Hearing Association (NCHA) represents community hearing care providers in Wales. NCHA members are committed to good hearing for all and have an excellent record of outcome, safety and patient satisfaction.

2. **People with unsupported hearing loss are at greater risk of loneliness and isolation**. Our response highlights
   - the scale and impacts of unsupported hearing loss in Wales, and
   - what the government and NHS can do to support people with hearing loss and therefore to reduce the risk of isolation and loneliness.

HEARING NEEDS AND THE IMPACT OF HEARING LOSS

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

3. **Hearing loss affects half a million people in Wales**. Unmet hearing needs are a major and growing public health challenge[1]. Hearing loss is the 5th leading cause of years lived with disability in Wales[2] and one of the most common long-term conditions in older people. Age-related hearing loss is the single biggest cause of hearing loss and the main reason people visit hearing services. As the population grows older more people will develop a hearing loss and the demand for hearing care will increase exponentially.

4. **Unsupported hearing loss increases the risk of loneliness[3] and isolation**[4]. Quality hearing care reduces these and other risks, and helps people to stay healthy and independent for longer. This is also why investing in hearing care can reduce pressures on health and social care[5].

5. All other UK counties now recognise hearing loss as a major public health challenge and acknowledge its impact on isolation and loneliness, for example
   - NHS England's Action Plan on Hearing Loss states "*In older age, hearing loss becomes a major challenge and people with hearing loss can find it difficult to follow speech without hearing aids and are at greater risk of social isolation and reduced mental*

well-being. Social isolation has an effect on health and in older people there is a strong correlation between hearing loss and cognitive decline […]"[6].

- The Scottish Government, See Hear Strategy notes: *"Hidden and/or untreated sensory loss leads to a withdrawal from social interaction. To a person with dementia, for example, failure to recognise and respond to a sensory loss will result in greater isolation, will generate behaviours that can be misinterpreted as symptoms of advancing dementia, and will lead to a consequent failure to respond appropriately to basic physical needs."*
- Northern Ireland's Action Plan noted, *"Untreated hearing loss can lead to isolation for an individual with a negative impact on personal relationships, employment, social life, and ultimately mental health. More than half of people over the age of sixty have some degree of noticeable hearing loss."*

Wales is therefore an outlier and today the only home country yet to take hearing loss seriously. Therefore this major public health issue that has a profound impact on individuals and their social networks, and that increases the risk of social isolation and loneliness, remains unaddressed.

6. There is now an opportunity to bring about positive change and give Welsh people with hearing loss the same opportunities as people in other parts of the UK. Wales can deliver this through its own Action Plan on Hearing Loss. Open public engagement and an evidence-based approach to meeting the hearing needs of the population would of course challenge existing models of care, especially those that are based on the interests of institutions and the professions, but failing to take action now will only add to the public health burden and associated costs on both individuals and the health and care system in the future.

HEARING CARE IN WALES

7. The vast majority of people with hearing loss have age-related hearing loss, for which there is no medical cure. These patients require support from non-medical adult hearing services, often referred to as audiology or the adult hearing service. The UK NHS is unique in that these non-medical hearing services continue to be provided in hospital settings, whereas in the rest of the world they are provided in the community. There are few services more suited for community provision and yet still delivered in acute hospital settings – e.g. the main reason for visiting hospital hearing services is to have a hearing aid repaired or to collect batteries. This is contrary to the '*Setting the Direction: Primary & Community Services Strategy Delivery Programme*' which states the ambition to
   - deliver the majority of health care needs in the community (p.5)
   - commission high quality and convenient services for local people (p.4-5)
   - provide community-based services across Wales that are reliable and accessible irrespective of where people live (p.6), and
   - provide a system that ensures the right treatment and care is providers to the right patient at the right time in the right place by the right person in the right way" (p.13).

8. Patients therefore have to travel considerable distances for a non-medical care that can be delivered locally and closer to home. The need to travel further to access hearing services

is known to reduce compliance with and benefit from hearing aids[7]. This means there are physical barriers to accessing hearing care in the first instance and thus significant unmet need, and additional barriers to accessing ongoing care which can have an adverse impact on outcomes. This in turn means more people are still likely to be at risk of isolation and loneliness, a situation driven largely because services have not adapted to population needs and preferences.

WHAT CAN BE DONE?

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

9. There are two policy interventions the Welsh government can support in order to reduce the risk of loneliness and isolation

   - **Use evidence and data to plan services**. The NHS Wales Planning Framework 2017/20 states that local health needs assessments should be based on robust analysis with a focus on quality improvement and reducing health inequalities[8]. Here the evidence will highlight significant unmet hearing needs across Wales and opportunities to address inequalities and improve quality of services, and this will in turn help reduce the risk of isolation and loneliness.

   - **Utilise the existing qualified workforce and community locations**. Hearing care professionals in Wales, despite registration with the Health and Care Professions Council (HCPC), are often unable to offer NHS hearing care from community-based locations. At the present time only people with the ability to pay can access these community-based services. This is not the case in the English NHS, where there is a more equitable service and people are able to access NHS hearing care closer to home and free at the point of use. If the NHS in Wales is to meet unmet hearing needs, and deliver services closer to home it should allow qualified and registered Welsh hearing care professionals to offer NHS hearing care from the community-based locations from which they operate, in the same way their counter parts in England are able to.

10. Unsupported hearing loss increases the risk of loneliness social isolation. Hearing care in Wales needs to transform from a hospital based to community-based service if Wales is to support people to age well. Making this shift will improve access, and long-term outcomes. A community-based model of hearing care will also align with the Well-being of Future Generations (Wales) Act 2015 and help reduce the number of people at risk of loneliness or isolation.

[1] NHS England (2015), Action Plan on Hearing Loss, p.12
[2] Vos, T et al (2015), Global, regional, and national incidence, prevalence, and years lived with disability for 301 acute and chronic diseases and injuries in 188 countries 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. The Lancet
[3] Cacioppo JT, Hawkley LC, Norman GJ, Berntson GG. Social isolation. *Ann N Y Acad Sci*. 2011;1231:17-22
[4] Hidalgo, J. L. et al. 2009. Functional status of elderly people with hearing loss. *Archives of Gerontology and Geriatrics,* 49(1), pp. 88-92
[5] Monitor (2015), NHS adult hearing services in England: exploring how choice is working for patients, p.6

[6] NHS England (2015), Action Plan on Hearing Loss, p.8
[7] Reeves, D.J. et al., 2000, Community provision of hearing aids and related audiology services, Health technology assessment, vol. 4, no. 4The survey had a 77% response rate in Wales. The original paper can be found here: http://www.journalslibrary.nihr.ac.uk/__data/assets/pdf_file/0008/64817/FullReport-hta4040.pdf
[8] NHS Wales (2016) Planning Framework 2017/20, p.36-37

NATIONAL ASSEMBLY FOR WALES, HEALTH, SOCIAL CARE AND SPORT COMMITTEE INQUIRY INTO LONELINESS AND ISOLATION

SUBMISSION FROM THE BRITISH GERIATRICS SOCIETY

Introduction

1. The British Geriatrics Society (BGS) is the professional body of specialists in the healthcare of older people in the United Kingdom. Our membership is drawn from doctors practising geriatric medicine including consultants, doctors in training and general practitioners, nurses, allied health professionals, researchers and scientists with a particular interest in the care of older people and the promotion of better health in old age. BGS has 3,500 members who work across England, Scotland, Wales and Northern Ireland. In Wales our members play a key role in acute hospitals and the community in delivering effective healthcare for older people.

2. BGS welcomes the opportunity to present this written submission to the Committee's Inquiry. We have noted the Committee's specific interest in evidence for the scale and causes of loneliness and isolation, and its impact on health and social care services, together with evidence of what works in addressing the issues. Our submission focuses on the loneliness and isolation experienced by older people in Wales.

Evidence for the scale and causes

3. There are clear links between age and loneliness. ONS analysis of statistical data on wellbeing shows that people age 80 and above are the most likely to report high levels of loneliness (29%)[i]. The evidence of loneliness in later life, and the link between isolation and loneliness, is extensive and well documented, for example, by Age UK in their evidence review of loneliness in later life[ii].

4. We know that the scale of loneliness and isolation is likely to grow, given that its likelihood increases with age. The number of people aged 65 and over living in Wales is projected to increase by 292,000 (44%) between 2014 and 2039[iii]. We are therefore pleased that the Committee is conducting its Inquiry and recognises the need for a strategic approach to addressing this crucial issue now.

5. There is evidence that rural poverty is a contributing factor in social isolation[iv]. Wales has a relatively large rural area and high levels of poverty compared to the UK average which suggests that older people who also experience rural poverty may be at greater risk of loneliness and isolation. In 2011, almost 30% of the rural population in Wales was aged 60 or above, compared to 21% for urban areas[v].

6. Living environment. Lack of access to transport and appropriate housing are key factors that contribute to isolation amongst older people. Difficulty in accessing transport, whether because of limited public transport or fuel poverty, is likely to impact disproportionately on older people, and can present challenges in accessing primary and acute health care. A recent review of housing for older people in Wales concluded that "the housing environments in which we age can play a determining role in ensuring that people remain engaged in their local communities and maintain a sense of autonomy and independence".[vi] Living environment is one of the key determinants in enabling older people to be discharged from hospital without delay and in regaining the ability to live independently.

7. Health status is a significant factor that contributes to people becoming disconnected from social groups[vii]. Many older people who BGS members work with have complex and multiple conditions, which can make it difficult to maintain social connections and participate actively in the community and in activities that are meaningful to them. For those older people who are in good health and are 'ageing well' many will be caring for a spouse or close relative: Carers UK research found that 8 out of 10 carers have felt lonely or socially isolated as a result of looking after a loved one[viii] .

Impact of loneliness and isolation on use of health and social care services

8. The impact of loneliness and isolation is well evidenced and its impact on use of health and social care services is significant[ix]. People who are lonely are more likely to:

- visit their GP
- use medication
- have more falls and need long term care
- move into residential care
- use accident and emergency services[x]

9. There is evidence that loneliness has an effect on mortality that is similar to smoking 15 cigarettes a day, and is associated with poor mental health, cardiovascular disease, hypertension and dementia.[xi]

10. Many of the older people who BGS members work with are living with frailty: between a quarter and a half of all people aged 85 and above are estimated to be frail. This means that they are at risk of dramatic deterioration in their physical and mental wellbeing after an apparently small event which challenges their health[xii]. Being able to maintain social contact makes a significant difference to the health of older people living with frailty. The extent to which older people are able to maintain independence, and therefore have less need of social care, is in part dependent on their social networks, and support from family and friends

11. There is a two way relationship between social isolation and dementia: people who are socially isolated are more likely to develop dementia, and people who have dementia and are more likely to become isolated and reduce or stop engaging with their social networks. Either way, the consequence is an increased likelihood of needing support from health and social care services.

12. Delayed discharge from hospital is exacerbated for older people who are socially isolated, and the likelihood of re-admission to hospital is greater without the support of family and friends. It is also greater when there are difficulties in accessing intermediate care: we know that waiting times to access intermediate care have increased significantly in the last three years as a result of a capacity gap, and that one third of the people waiting for

intermediate care support are waiting in an acute bed[xiii]. Whilst there isn't clear data to show the full impact of delays in accessing intermediate care services, our view is that there may be a disproportionate impact on older people who are lonely or isolated.

Addressing problems of loneliness and isolation – evidence for what works for older people's health and wellbeing

13. There is strong evidence and clear guidance on the provision of high-quality care and services for older people. The King's Fund report, *Making our health care systems fit for an ageing population* provides comprehensive information on what we know works well. This includes both major and minor interventions, for example, "adequate treatment for 'minor' needs that limit independence such as foot health, chronic pain, visual and hearing impairment, incontinence, malnutrition and oral health … have significant benefits on older people's well-being and independence" [xiv] Without such interventions the risks of loneliness and social isolation, and of greater deterioration of health, may require more acute, resource intensive health and social care.

14. Comprehensive Geriatric Assessment (CGA) is a holistic, multidimensional, interdisciplinary assessment of an individual by specialists of many disciplines in older people's health care. It includes as a core element an assessment of the social support networks available to the person, and their level of participation in activities which are of significance to them. Research shows that use of CGA in hospitals increases independence, thus contributing to an individual's capacity to engage with their social networks[xv]. Alongside this the provision of a regular holistic medical review by GPs is an essential component in the range of support required to promote health and wellbeing in older people with frailty, and enable them to maintain social networks.

15. Health services provided by multi-disciplinary teams are essential in meeting older people's health and social care needs. BGS and the Royal College of GPs recently published a report on innovative approaches in practice, *Integrated care for older people with frailty*[xvi] which shows the benefits of GPs and geriatricians working together, with access to the vital services provided by other professionals, including nurses, therapists, pharmacists and social workers. It provides case studies of how it is possible to deliver improved health outcomes for older people, economic benefits and greater levels of staff satisfaction. Key features of these case studies include:

- person-centred care
- continuity of care
- proactive approaches which use:
    - the electronic Frailty Index to identify patients at risk of frailty
    - Comprehensive Geriatric Assessment (CGA)
    - care plans for multiple eventualities
- strong communication and collaboration

16. When a hospital admission has been necessary, good discharge planning and post-discharge support are essential[xvii]. There is evidence that post-discharge follow-up telephone calls are a cost-effective method of improving outcomes for older people who are socially isolated. They help prevent readmissions to hospital and can also help to identify older people experiencing loneliness and social isolation, meaning that support can be put in place"[xviii]

17. The British Geriatrics Society has developed tools based on our members experience and expertise in meeting the health care needs of older people. These include:

- **Comprehensive Geriatric Assessment**. Further information about CGA is available at: http://www.bgs.org.uk/cga-managing/resources/campaigns/fit-for-frailty/frailty-cga
- **Fit for Frailty** Parts 1 and 2, provide advice and guidance on the care of older people living with frailty in community and outpatient settings, and on the development commissioning and management of services for people living with frailty in community settings. There is some evidence that focusing community services on those with frailty rather than on those 'at highest risk of hospital admission' might improve quality of patient care and reduce hospital bed usage. http://www.bgs.org.uk/fitforfrailty-2m/campaigns/fit-for-frailty2/fff2-campaign/fff2-lite-vn
- **The Silver Book** provides practical advice on safe and effective emergency care of older people in an acute setting. It sets out standards of care and recommendations for policy makers which are based on integrated health and social care services delivered by interdisciplinary working with a person centred approach as the only means for achieving the best outcomes for frail older people. http://www.bgs.org.uk/silverbook/campaigns/silverbook

Current policy solutions to loneliness

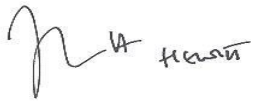
18. BGS members in Wales recognise and value the framework of support for older people that has been developed in recent years, including the Wellbeing of Future Generations (Wales Act) 2015, the Ageing Well in Wales initiative, and the introduction of the Better Care Fund with its encouragement to local authorities to ensure that their plans include action to address loneliness and isolation.

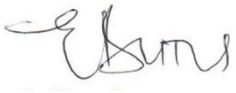
19. However, we believe that greater investment in implementation is required if the intention of these initiatives is to be more fully realised.

20. We believe that part of the solution to loneliness and social isolation amongst older people in Wales lies with speeding up the journey towards increased integration of primary and acute care, and of health and social care services. Our view is that this shift can only be achieved in practice with increased investment to support implementation.

21. We recognise that the re-design of services for older people, so that they are genuinely person-centred and co-ordinated around older people's individual needs, is the only effective means of ensuring maximum benefits from such investment. BGS is therefore keen to share its experience and expertise and engage with, the Assembly, the Welsh Government and others in the statutory and voluntary sectors who share our aim of promoting better health for older people in Wales.

We would be more than happy to attend an oral evidence session if that would be helpful. Please do not hesitate to get in touch.





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Royal College of Psychiatrists
Consultation Response

DATE: **10 March 2017**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Suicide

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

Alcohol

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

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

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

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

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

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

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

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

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

Professor Keith Lloyd
Chair, RCPsych in Wales

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

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Ymchwiliad i unigrwydd ac unigedd

Inquiry into loneliness and isolation

Ymateb gan: Marie Curie

Response from: Marie Curie

Marie Curie – Health, Social care and Sport Committee Inquiry into loneliness and isolation, consultation response

Introduction and scale of the problem

We welcome the opportunity to respond to the National Assembly for Wales' Health, Social Care and Sport Committee's call for evidence into loneliness and isolation. We want to highlight the issues of social isolation for people who have a terminal illness and the social difficulties around death, dying and loss that can exacerbate this.

At Marie Curie we're here for people living with any terminal illness, and their families. We offer expert care, guidance and support to help them get the most from the time they have left.

The number of older people in Wales' population is growing; people aged 85 and over make up around 2.5% of the Welsh population and this is projected to increase by 87.2% by 2030[1]. This shifting demographic, coupled with an increasing average life expectancy means that people are living longer and with more complex needs than before, often with multiple long-term conditions. We also know that the number of people dying each year is anticipated to have risen by 9% by the same time.

Many of these people will be living with a terminal illness. By that, we mean they will have reached a point where their illness is likely to lead to their death. Depending on their condition and treatment, they may live with their illness for days, weeks, months or even years after this point.

Marie Curie is the UK's biggest provider of care for people living with a terminal illness outside the NHS. Our mission is to help people living with a terminal illness and their families make the most of the time they have together by delivering expert care, emotional support, research and guidance.

Across the UK we have nine hospices (including one in Penarth) and around 2,000 community nurses spread across the UK (including around 150 in Wales).

Our hospice in Penarth cost £3.4m to operate during 2015/16 of which £1.4m (42%) came from NHS/Govt funding with the rest coming from fundraising/charitable donations. During 2015/16 our hospice in Penarth provided 9,497 days of care to 472 individual patients.

Our nursing service in Wales cost £3.7m to run during 2015/16 of which £1.8m (49%) was funding from NHS/Govt funding, with the rest coming from charitable donations. Across Wales in 2015/16 our nurses delivered a total of 88,914 hours of care to 2,424 patients.

We run a Helper service in Wales. This service is managed by Marie Curie employees but delivered by volunteers. They are very carefully recruited, trained and supported to offer to companionship, support and friendship to people at the end of their lives. Each helper works with one individual. The resources to run the Helper service come entirely from charitable donations. The Helper service currently operates in Cardiff, Vale of Glamorgan and Rhonnda Cynon Taf with plans to further roll out across more of Wales.

[1] www.MarieCurie.org.uk/Atlas

Many people who have a terminal illness will need some support or companionship from other people. Whilst the NHS/Social Services can provide some of this, charity and other third sector providers are needed too.

We cannot look at one aspect of loneliness and isolation, we need to be able to look at cause and effects of the issue. Often this cannot simply be separated.

We know ill health can contribute to social isolation, through physical and mental manifestations in many illnesses. In the case of terminal illnesses, the rate of disease progression is often unpredictable and impaired communication has the potential for an increasingly significant impact on personal relationships and interactions – which we know can lead to increased loneliness and social isolation.

Communication is crucial to addressing and mitigating these effects. We know that communication is important in end of life care. For example, advanced care planning is essential to ensure that people with terminal illnesses have their physical, psychological, social, and spiritual needs assessed and their care planned in a way that meets their wishes. Ensuring that these conversations are held and that care plans are agreed is an important element in reducing the likelihood of loneliness and social isolation. However, we also know that the shared experience and emotional support provided by meeting other people in a similar situation can also reduce isolation.[2] We need to be able to support people to be able to interact with others who understand what they are experiencing, in addition to providing social support, such as befriending, that counteracts social isolation and loneliness.

Impact of loneliness & isolation

For people living with a terminal illness, there are often multiple barriers to getting the care and support that they need. This is particularly evident in remote and rural settings and people in these communities often do not have the same access to care and support services at the end of life as those living in more densely populated areas. As expected they are more likely to be physically and geographically isolated than those living in urban settings. Terminally ill people in rural areas experience barriers to care that include a lack of appropriate transport, physical and social isolation, a limited out of hours services and limited staff resources and specialist services. [3]

A significant proportion of the Welsh population lives in smaller settlements: nearly 20% live in villages of less than 1,500 persons compared with 10% in England. Wales also has a relatively low proportion of its population in large settlements: only 26% live in urban areas with a population over 100,000; in comparison, nearly 40% of the English population live in urban areas larger than the largest in Wales. Another feature of the settlement pattern in Wales is the share of the population living in the sparsest rural areas: 15% compared with only 1.5% in England.[4]

We know that the physical and mental deterioration often associated with dementia can often lead to social isolation, depression, and carer burden – especially if there are no community support networks. It is important to remember that Dementia remains a terminal illness. There is also evidence to suggest that men living with dementia are less likely to seek and receive the help and support they need although initiatives such as the 'Men's Shed' programme are part of the means to address this issue.

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[2] Caring about Dying: Palliative care and support for the terminally ill a guide for donors and grant-makers
[3] https://www.mariecurie.org.uk/globalassets/media/documents/policy/campaigns/equity-palliative-care-uk-report-full-lse.pdf
[4] Welsh Assembly Government (2005). *Rural Development Plan for Wales, 2007 to 2013: The Strategic Approach*. pp. 61–63.

It was encouraging to find that a joint event held between Marie Curie and Alzheimer's Cymru recently in Llanelli engaged well with men, suggesting that gender is not necessarily a barrier to accessing help but that the way in which it is designed and provided needs careful thought.

Addressing problems of loneliness & isolation

There are three specific Marie Curie programmes that which helps deal with loneliness & isolation:

2.1 Caring for Carers

Caring for a loved one with a terminal illness can be both physically and emotionally challenging and at times, financially stressful. Research has shown that becoming a carer increases the risk of loneliness.[5] Carers and family members are at increased risk for depression and social isolation as well as physical illness and injury related to the demands providing care. Additionally, research has also shown that social isolation is often among the symptoms of grief following bereavement. The onset of loneliness can happen gradually and this is often exacerbated by specific life events, especially one associated with loss or bereavement.[6]

Every month in our Penarth Hospice we run an event called 'Careers Café' this is a very informal event where cares can come in for a tea or coffee either as a respite break or to seek advice from both Marie Curie staff and/or from other cares or from former careers who attend.

As mentioned a similar event began in Llanelli in October 2015, run in conjunction with Alzheimer's Cymru.

2.2 Helper programme

The Marie Curie Helper Service provides one-to-one emotional support, companionship and information about relevant local services to people living with terminal illnesses, and their families and carers through the use of volunteer helpers.

The Helper service specifically aims to:

- Fill the gap in meeting the emotional support needs of terminally ill people, and those of their carers
- Provide carers with support to enable them to continue caring
- Reduce social isolation faced by some terminally ill people and their carers
- Support people throughout the terminal phase of their illness, usually within the last 12 months of life

Our Helpers visit people in their homes, offering a few hours of their time each week to provide company and support to people with a terminal illness, and their families and carers, to help them to cope with more confidence. This service is available from the time of a person's terminal prognosis and for their families after bereavement.

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[5] ibid
[6] http://www.iriss.org.uk/resources/preventing-loneliness-and-social-isolation-older-people

The Marie Curie helper service is relatively new and currently operates across Cardiff, The Vale of Glamorgan and in the Rhondda Valley. Over time we hope to expand this when resources and volunteers allow.

2.3 Information and Support line

Launched in March 2015, Marie Curie's Information and Support line (0800 090 230) offers free support, help and advice for patients, relatives and carers regarding terminal illness, death and dying as well as bereavement/support. 9,936 calls were received in the 2015/16 financial year, whilst most of the calls where for general support and practical day-to-day care matters 17% were for emotional support and 6% for help with bereavement.

Many of the calls have been from people just looking for someone to talk to (these calls come from both people who are terminally ill and relatives/carers) rather than enquiring about a specific problem. The call centre has received calls from people with a terminal condition who are phoning up simply to let others know how they're doing.

Loneliness and isolation with regards to Palliative Care

Whilst the remit for the consolation does not specify specific scenarios, Marie Curie would like to draw the committee's attention to the following:

Loneliness and Isolation is also an increased risk factor in people not receiving palliative care when they need it. Research shows that there are significant differences between palliative care patients and people who die without access to palliative care[7].

Therefore, we need to ensure that everyone with a terminal illness gets the care they need, when they need it. Recent research in primary care has shown that 1 in 4 people and up to 8 out of 10 non-cancer patients with a terminal illness are not accessing palliative care and those that do are getting it very late into their care. Often support for people earlier than the last weeks of life is patchy, as is bereavement aftercare. Lack of access to professional and support services can cause complex social and psychological issues for people and their families.[8]

For more information please contact:

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LI 35
Ymchwiliad i unigrwydd ac unigedd
Inquiry into loneliness and isolation
Ymateb gan: Relate Cymru
Response from: Relate Cymru

relate
the relationship people

Inquiry into loneliness and isolation

Relate Cymru evidence submission to the Health, Social Care and Sport Committee inquiry into loneliness and isolation

Contact: [redacted], [redacted]

Relate Cymru, 47 Walter Rd, Abertawe (Swansea), SA1 5PW

About Relate Cymru

1. Relate is the UK's leading relationship support charity, and we work to build stronger relationships for individuals, couples, families, workplaces and communities in Wales. We deliver services across Wales from delivery centres in Cardiff, Swansea, Aberystwyth, Brecon, Carmarthen, Llandrindod Wells, Corris, Crickhowell, Bridgend, Haverfordwest, Bangor, Wrexham, Llandudno, and Rhyl, and our services include relationship counselling (including specialist relationship counselling for people living with cancer and their families), family counselling, children and young people's counselling, help for domestic violence, sex therapy, child contact services, and other support. Based in this experience of delivering counselling and other services to families and children and young people, as well as our research, we are submitting evidence to this inquiry from our recent research into the quality of social relationships across the country.

Impacts of loneliness

2. The evidence showing the impact of loneliness and isolation on individuals and communities is considerable – and continues to grow. Research shows that experiencing loneliness and isolation can affect us in multiple ways.

3. **Physical wellbeing**

   The physiological impact of loneliness is stark, and is linked to:

   - defective immune functioning; [1]
   - higher blood pressure; [2]
   - increased risk of developing coronary heart disease and stroke; [3]
   - increased risk of obesity.[4]

Research also shows us that experiencing feelings of loneliness can be a sad vicious cycle - not only is it linked to higher likelihood of certain illnesses, research also shows that feeling lonely also makes us more likely to develop additional behaviours bad for our health, such as smoking and being less active.[5]

4. **Psychological wellbeing**

Loneliness and social isolation are also associated with psychological factors too, which in turn impact on physical health:

- Loneliness is linked to lower self-esteem and limited use of coping methods,[6] and social isolation is linked to reduced self-efficacy.[7]
- Studies also indicate that poor social relationships may double the risk of depression: researchers found that 14% of adults who have very poor quality social relationships will come to experience depression later in life, compared to seven per cent of adults with high quality relationships.
- Previous research by Relate with New Philanthropy Capital found that an increased number of social relationships is associated with higher reported personal wellbeing.[8]
- A recent study from Oxford University even goes so far as to suggest that our friendships may be a more effective painkiller than morphine. People with higher numbers of friends and more social interactions experienced higher release of endorphins, and were therefore found to have a higher pain tolerance.[9]

5. **Community wellbeing**

The quality of relationships with neighbours also plays an important role in wellbeing:

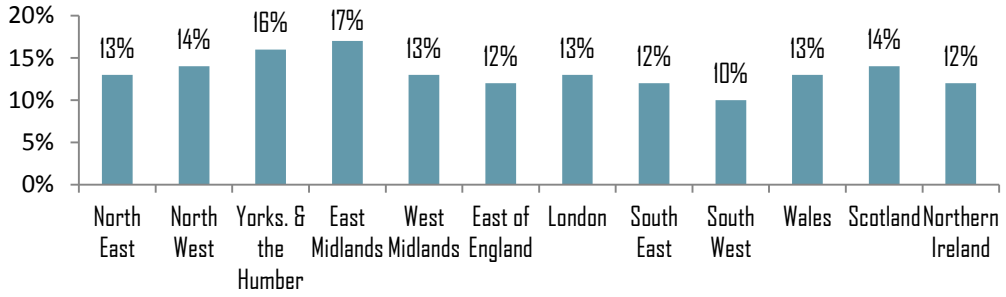
- Research has found that subjective wellbeing is affected by relationships with neighbours.[10]
- The National Survey for Wales found a clear correlation between individuals' life satisfaction and the extent to which neighbours reported helping each other out: 42% of people who strongly agreed their neighbours helped each other out also reported high life satisfaction (9/10 out of 10) compared to just 27% of people who strongly disagreed.[11]
- Research suggests that relationships with neighbours may be particularly important for older people: studies find that that social cohesion, people's sense of belonging to their community, and any changes in these factors are predictive of wellbeing, and strengthening relationships among neighbours particularly improves older adults' wellbeing.[12]

Relate research on social relationships in Wales

6. Our latest research report – launched on 1st March 2017 - *You're not alone: The quality of the UK's social relationships,* examined our social relationships and presented findings from our *The Way We Are Now* survey of over 5,000 people from across the UK. Evidence of the scale of loneliness was sadly striking. In Wales, and on average across the UK, more than one in eight (13%) people said they do not have a single close friend.

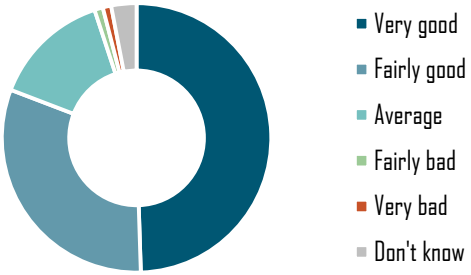
This UK average has increased since 2014/15, when one in ten people said they had no close friends.

Figure 1: People who have no close friends



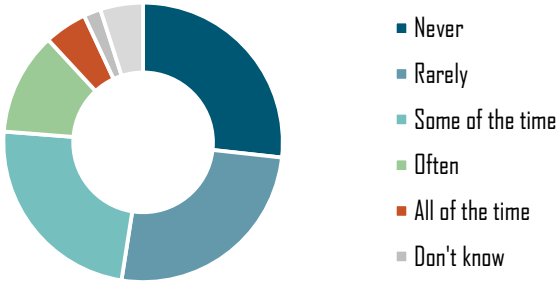
7. Most people in Wales (80%) enjoy good relationships with their friends and for half (50%) these relationships are reported to be very good.

Figure 2: Quality of relationships with friends in Wales



8. Over two-fifths of people in Wales (41%) said that they felt lonely at least some of the time in the two weeks prior to the survey, and almost a fifth (17%) said that they feel lonely often or all of the time.

Figure 3: Feelings of loneliness in Wales



9. Wales was the most neighbourly region in the UK, with 58% of people saying they have good relationships with their neighbours.

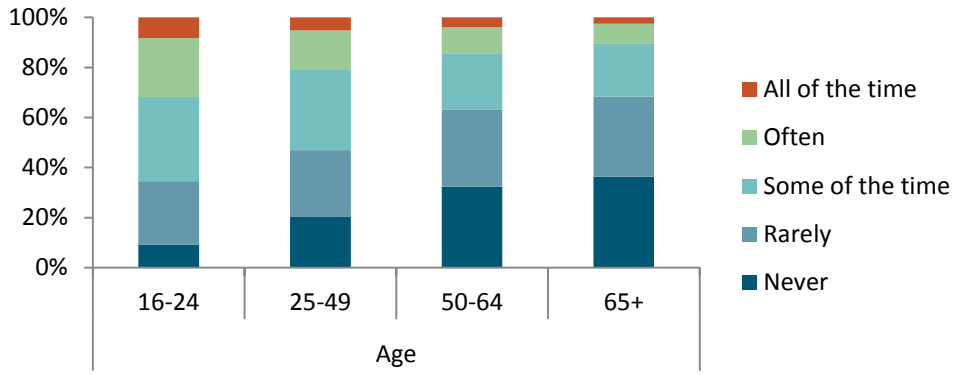
10. Across the UK, the impact of loneliness and isolation on personal wellbeing was evident:

    - People with no close friends were two-and-a-half times as likely to say they feel down, depressed or hopeless either often or all the time (31 per cent) as those with four or more close friends (13 per cent);
    - Two out of five of those with no friends were more likely to say they never or rarely feel good about themselves;
    - People with very good friendships were almost twice as likely to never feel down, depressed or hopeless as those that reported having average quality of friendships; and
    - People who had good relationships with their neighbours were more likely to feel good about themselves, and less likely to feel down, depressed or hopeless.

11. Our research also demonstrated that other factors intensify feelings of loneliness and isolation. We identified a clear difference in feelings of loneliness between people who are disabled or who live with a long-term health condition and those who are/do not. Among people who said their day-to-day activities are limited 'a lot' in this way, 55% said they feel lonely at least some of the time, whereas for people who were not limited by disability or a long-term condition this was 42%. And looking only at those who said they feel lonely either often or all of the time, people limited a lot by disability or a long-term condition are twice as likely as those not limited in this way to report feeling lonely often or all the time (30% compared to 15%).

12. Although public discourse and service provision tends to focus on loneliness experienced by older people, we found that it was the *youngest* respondents who were most likely to report feeling lonely. In our sample, among those aged 16-24, almost two-thirds (65%) said they feel lonely at least some of the time, and almost a third (32%) feel lonely often or all the time. Among people aged 65 or over, however, just 32% said they feel lonely at least sometimes, and just 11% feel lonely often or all the time.

Figure 4: Feelings of loneliness by age



13. We also observed a similar pattern with respect to age and relationship quality as we did with friends – older respondents reported better relationships with their neighbours. Among people aged 65+, 78% said their relationships with neighbours were good,

compared to 50% of people aged 25-49, and 35% of people aged 16-24. These patterns mirror the findings of the recent research by the British Red Cross at the end of 2016, which similarly found that among respondents aged 16-24, 32% said that they often or always feel lonely, and which found that public perceptions of loneliness (which centre on older people) do not match up with the reality.

Policy implications

14. Our data showed that social isolation and loneliness is a widespread issue that affects people of all demographics, and can have damaging impacts on health and wellbeing. Given the importance of social relationships, it is vital that policy makers take action to tackle the causes of loneliness, and work to ensure that support is made accessible to those most vulnerable. In particular, we would recommend:

- The Welsh Government issues guidance to commissioners and local health boards and local authorities to ensure that the quality and strength of people's social relationships becomes a core pillar of health and wellbeing strategies;
- Local policy makers and Directors of Public Health consider the best way to gather data on social connections to inform planning and commissioning of services which are responsive to local needs;
- Commissioners commit to building the evidence base and build evaluation into programmes to tackle loneliness, increasing understanding of what works for whom – loneliness affects people from all ages and all walks of life, and one size may not fit all;
- Public Health Wales investigates the causes and effects of loneliness (both for individuals and wider society) in younger people in particular, and how to overcome it; and
- Commissioners ensure that everyone has timely access to counselling and other therapeutic services to respond to loneliness and mitigate the impacts on health and wellbeing.

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LI 36

Ymchwiliad i unigrwydd ac unigedd

Inquiry into loneliness and isolation

Ymateb gan: Cymdeithas Cludiant Cymunedol

Response from: Community Transport Association

Community Transport Association

Response to the Health, Social Care and Sport Committee Inquiry into Loneliness and Isolation

Introduction and Executive Summary

1. In all parts of the UK, on every day of the year - including Christmas Day – thousands of community transport staff and volunteers are helping people to stay independent, participate in their communities and to access vital services and employment.
2. Community transport is about providing flexible and accessible community-led solutions in response to unmet local transport needs, and often represents the only means of transport for many vulnerable and isolated people. Significant user groups are older people and disabled people with a majority of services and projects working in rural areas.
3. Using everything from minibuses to mopeds, typical services include voluntary car schemes, community bus services, school transport, hospital transport, dial-a-ride, wheels to work and group hire services. Most services are demand-responsive, taking people from door to door, but a growing number are offering scheduled services along fixed routes where conventional bus services are not available.
4. As community transport works to a different business model to commercial passenger transport services It is always run for a social purpose and community benefit, but never for a profit - it often a more reliable and resilient way of ensuring a broader range of transport needs can be met.
5. The Community Transport Association is the national body working with the providers of community transport helping them to remain relevant and responsive to key areas of public policy and make a big difference for people and families in the communities they work in.
6. In Wales, community transport providers provide trips to many socially isolated individuals. Their services make a huge different to how people feel about their own loneliness and sense of isolation. In compiling our response we have surveyed members across Wales to gather their views, and ensure that their lived experience is at the heart of this work.

Based on members views we have a number of recommendations that we would like the Committee to consider:

7. The Welsh Government should work closely with the providers of community transport to better understand the transport needs of lonely and isolated people.
8. The Welsh Government should work with CTA to help community transport operators in Wales to develop new relationships with healthcare providers, and provide a broad range of services to members across Wales.
9. The Welsh Government should support a training programme for community transport operators to identify a greater range of needs and provide effective signposting to health and social care services.

Community Transport's Role in Alleviating Loneliness and Isolation

10. Community transport operators across Wales work with some of the most isolated communities in the country. Their footprint tends to be rural, and the demographic of service users tends to be older people and often people with disabilities.
11. In our surveying to look at the scale of the work community transport does to alleviate isolation, we heard from community transport operators who work to alleviate isolation as part of their day-to-day activity, as well as groups who have been engaged in specific project work across the country. Specific projects includes running luncheon clubs supported by county councils, the creation of Wheels to Meals schemes, projects funded by charitable umbrella bodies concerning specific projects, as well as the employment of staff specifically to work on areas of isolation.
12. Owing to their specific focus on inclusivity and accessibility, community transport works with individuals who struggle to access other forms of transport. In particular, CTA's latest State of the Sector Report for Wales found that 94% of community transport organisations reported that their service included older people, 84% of services provided transport to people with disabilities, and 60% to people living in rural areas.
13. Around 60% of community transport organisations in Wales are membership-based or have passengers registered to use their services. There are approximately 140,000 individuals and 3,500 groups registered to use community transport services[1].
14. In our recent survey, our members told us that they see the alleviation of isolation and loneliness as key to everything they do. They spoke about how their services are;

- "'for people who have no other means of getting about."
- "'a lifeline to many rurally isolated, lonely individuals."
- "doing our utmost to carry out requests of lonely people for transport."
- "indispensable as a hands on service which alleviates isolation and loneliness."

15. In addition, members who responded to our survey are regularly monitoring the impact they have on alleviating loneliness and isolation. They found their passengers stated they would have no other way of getting out if it wasn't for community transport: one single car scheme reported making 70 vital trips in a four month period, while one member spoke to us about specific funding they were awarded in recognition of the work they were doing around alleviating social isolation.
16. It is clear from the survey responses we have gathered that there a large number of older people, and people with disabilities, across Wales whose levels of loneliness and isolation are extenuated by Wales' disperse population and predominantly rural geography but which is alleviated by the work of community transport

[1]http://www.ctauk.org/UserFiles/Documents/In%20Your%20Area/Wales/State%20of%20the%20Sector%20Wales%20English%20version.pdf

Supporting Community Transport to Support Isolated and Lonely People in Wales

17. Our members across Wales also provided us with feedback on how their relationships with other agencies, such as public services, other passenger transport organisations, and charities and community groups, impact their ability to alleviate isolation and loneliness in their communities.

18. They informed us that they work closely with a number of sectors including health, and children and young people. In particular, a number of respondents were keen to emphasise that they worked closely with local councils.

19. One of the unique things about community transport is the positive relationships that develop between service providers, and service users. Many of the respondents noted that they work closely with their users to provide a service that is tailored to their needs, helping them to feel comfortable in using community transport services.

20. **We recommend:** that the Welsh Government work with CTA to reach out to community transport providers and further discuss the ways in which their unique services alleviate loneliness and isolation in their communities.

21. Many organisations suggested to us that their work could be more impactful if they enjoyed a better relationship with their local day centre and GPs surgery. We have seen a benefit of this relationship with Hackney Community Transport (HCT) in England and their CCG programme. Through developing a close relationship between HCT, their local CCG, and their local Council for Voluntary Service, they have been able to provide access to health and social setting which in turn have promoted emotional and physical wellbeing.

22. **We recommend:** that the Welsh Government work closely with the CTA in Wales to support organisations to develop these relationships which will in turn allow service users to access a broader range of opportunities.

23. Finally, community transport operators can often be a key support to many lonely people with the community transport journey providing a key means of social interaction.

24. **We recommend:** that the Welsh Government provides support delivering training to community transport operators to signpost service users to other support they need, either in a medical, or social setting.

Conclusions

25. It is clear that community transport not only plays a key role in alleviating loneliness and isolation, particularly for older people in rural communities, but that community transport operators can provide a unique insight into the lives of those who suffer most acutely from loneliness and isolation.
26. The work our members do throughout Wales is an invaluable lifeline to thousands of people. Without these services people would be unable to get around, to get to medical and social appointments, and ultimately to live their lives to the full.
27. In particular, the survey of our members demonstrates that they consider a key part of their role to provide social opportunities for people in their community. With their particular emphasis on providing inclusive and accessible transport, providing social opportunity to some of Wales' most isolated citizens is truly at the heart of everything they do.
28. We hope that the above submission provides a useful insight into the extensive work that community transport operators do in providing inclusive and accessible transport to lonely and isolated people across Wales. In addition, we hope the Health, Social Care and Sport Committee consider our recommendations as useful mechanisms to help support the already vital work that is going on throughout Wales.

For further information contact should be made to:

Tim Cairns

Acting Director for Wales

[redacted]

Cardiff & Vale of Glamorgan
INTEGRATED HEALTH & SOCIAL CARE PARTNERSHIP

National Assembly for Wales Inquiry into Loneliness and Isolation -
Response from Cardiff and Vale of Glamorgan Regional Partnership Board

1. The Cardiff and Vale of Glamorgan Regional Partnership Board includes representation from the two local authorities, Cardiff and Vale University Health Board, WAST, third sector providers and carer representatives.

2. The Board recognises that as our population is increasingly ageing, more and older people are dealing with loneliness and isolation across our region. However, we also recognise that it isn't just older people who are dealing with this issue. Our response to this inquiry will provide some evidence from some of the services that operate across Cardiff and Vale of Glamorgan.

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

3. Tackling social isolation and loneliness – across our population, but especially older people - has been identified as one of the key themes in the Cardiff and Vale of Glamorgan Population Needs Assessment which will be published by 31st March 2017.

4. A Local Government Association report, Combating Loneliness[1], published in January 2013 lists a number of potential risk factors for loneliness, including:
   - living alone
   - poor health
   - being aged 80+
   - loss of friends
   - having no access to a car/ never using public transport. in Wales, two-thirds of single pensioners have no car, and so reliable local transport is extremely important as people get older[2]
   - living in rented accommodation
   - living on low income or on benefits as main income
   - having no access to a telephone

5. There is significant anecdotal feedback from the City of Cardiff Council's case management teams that the older people that they are supporting are reporting that loneliness is a significant issue for them. It also appears that the higher the level of need/ disability, the more loneliness is a factor for them.

6. It is not just older people who are affected by loneliness. It is also an issue for younger people with disabilities, especially where they lack opportunities to engage with their

[1] Local Government Association (2013) Combating Loneliness: A guide for local authorities. Available at: http://www.local.gov.uk/documents/10180/7632544/L15-431+Combating+loneliness+-+a+guide+for+local+authorities/b4b88757-2623-4696-ae04-565892a58909 [accessed 23/02/17]
[2] Older People's Commissioner for Wales(2013) "A Thousand Little Barriers" http://www.olderpeoplewales.com/Libraries/Uploads/A_Thousand_Little_Barriers_1.sflb.ashx [accessed 14/02/17]

communities and/or peer groups. Also young adult carers in a recent study by the Carers Trust reported that they can often feel isolated from their peers and sometimes reluctant to tell others about their situation, for example teachers, which can lead to isolation and not receiving the support they need[3].

7. Parents can be affected by loneliness, with a survey by Action for Children in 2015 finding that nearly a quarter felt lonely and cut off from friends and other sources of support.

8. Poor access to appropriate transport is reported as a major contributing factor to increasing people's isolation and sense of loneliness. Even within urban areas it can be difficult due to poor mobility or disabilities, or too far for people to get to a bus or train station. In rural areas the problem is even more apparent. Some individuals have reported through the case management teams that they have experienced a lack of understanding/consideration on the part of bus drivers of their needs which adds to their reticence about using public transport. Although there are voluntary transport schemes, these are limited and often oversubscribed, and have to be booked in advance. This can be a real problem for older people, especially if they have memory issues. A recent survey by Age Connects Cardiff and the Vale found that older people cited lack of transport as one of the barriers to being able to access services.

9. The survey carried out by Age Connects Cardiff and the Vale with 248 older people also highlighted other common issues which are contributing to loneliness and isolation:-
   - The overwhelming factor for making life better for older people is having regular contact with others, particularly of their own age
   - Lack of opportunities to get out and about
   - Transport was a key issue
   - Personal support and care for carers
   - Support to go out
   - Readily available information and advice services
   - Someone to turn to when help is needed

10. A particular contributory factor in Cardiff is its multicultural nature, as there is growing awareness of a kind of cultural loneliness, for example where people only speak their native language, and their religion makes it difficult for them to go to mixed groups.

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

11. Social isolation and loneliness for older people can be associated with both mental and physical health and wellbeing[4]. There can be an impact upon cognitive decline for some

[3] Carers Trust (2013) Young Adult Carers at School: Experiences and Perceptions of Caring and Education. Available at: https://professionals.carers.org/sites/default/files/young_adult_carers_at_school-8_11_13-1_proof_4_final.pdf [accessed 09 Feb 2017]

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older people. Research by the Campaign to End Loneliness[5] summarised that the effect of loneliness and isolation on mortality is comparable to the impact of well-known risk factors such as obesity, and has a similar influence as cigarette smoking.

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

12. Being isolated can impact upon older people's ability to access services, which can then impact upon their health and wellbeing. In Cardiff, the Independent Living Officer team has noted that many older people they support may come up against motivational barriers or concerns around leaving the house which can impact upon their ability or confidence to access services or activities which could help address their loneliness. The team make referrals to the Day Opportunities Team who will work with an older person to help them overcome these barriers.

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

13. In Cardiff and the Vale of Glamorgan, a number of initiatives to address the problems of loneliness and isolation have been delivered by Age Connects Cardiff and the Vale. The 'Friendly AdvantAGE' programme – a partnership project comprising Glamorgan Voluntary Services, Cardiff Third Sector Council (C3SC), Age Connects Cardiff and the Vale, Scope Cymru and Dinas Powys Voluntary Concern – exists to reduce the social isolation and increase the confidence of older people in Cardiff and the Vale of Glamorgan. It does this in various ways by using a combination of staff and volunteers to befriend and reach out to isolated people and encourage them to become more involved with their families, friends and communities. The programme is essentially a project coordinating five 'local' befriending projects. In an evaluation of Friendly Advantage, of the people who said they were lonely at baseline, 84% said as a result of being involved in the project their social interaction and well-being had increased.

14. The Healthy and Active Partnership Programme delivered by Age Connects reported that over a 4 month reporting period of 86 clients, 78% of clients show an improvement in their experience of loneliness. This has been measured by using the Campaign to End Loneliness Measurement Tool. The Senior Health Shop provides older people with a place to go to meet others, gather information and take part in activities, and 82% of people say that attending has reduced their isolation or loneliness.

15. Extra Care schemes have proved an effective solution for many people to address loneliness and isolation; access to onsite care and support enables people to access activities and become involved. For older people who move to extra care housing, there is emerging evidence that social lives and relationships strengthen, consequently lowering the risk of

[5] Campaign to end Loneliness http://www.campaigntoendloneliness.org/threat-to-health/ [accessed 13/02/17]

loneliness[6]. In one local Extra Care scheme in Cardiff, there are close links with the neighbouring high school and the tenants regard this intergenerational contact as invaluable.

16. In the Vale of Glamorgan, an Extra Care scheme has been running for three years jointly commissioned in partnership with Social Services, Housing and Supporting People. There are care and support services on site and people undertake a unified assessment and will have needs to enable access to the scheme. A panel meets on a regular basis to assess new applicants and to agree lettings when there is a vacancy. Most people who come into the scheme state they had been isolated in the community and the scheme has addressed this. This scheme is used as a community hub for people who are isolated to meet and make networks, they have regular coffee mornings and information sessions for people who still live in the community.

17. The City of Cardiff Council's Independent Living Service has been established to support people to find their own solutions to issues in order to defer or negate their need for statutory services. Fundamental to the work of this multi-disciplinary team approach is the provision of information, advice and assistance and the early identification of outcomes. Through the use of better outcome conversations all Independent Living Officers and Contact Officers discuss loneliness and social isolation with clients. If loneliness or social isolation are identified by the Officer, conversations would become about interests that the service user may have. Tools such as DEWIS and knowledge of groups and 3rd Sector organisations would then be used to assist the service user. Independent Living and First Point of Contact do not just limit assisting the service user concerned but will also consider the issue of loneliness and social isolation on other members of the household and carers who often experience loneliness but lack local knowledge to gain respite.

18. As highlighted above, the multicultural nature of Cardiff can create a kind of cultural loneliness, for example where people only speak their native language, and their religion makes it difficult for them to go to mixed groups. The Day Opportunities Team has provided the catalyst for them to get together, with the use of an interpreter and enabled people to become friends, provide peer to peer support for each other and attend groups together. Between April and December 2016, Preventative Services have helped remove 171 people from Social Isolation, through the provision of information, advice and assistance in accessing services, activities and groups that enhance the service user's wellbeing.

19. There are a range of voluntary/ community groups which can help older people address loneliness and isolation, including lunch clubs, choirs, exercise classes and gardening clubs. Recent additions to the Cardiff and Vale area are 'men's sheds', which offer a social space for men to meet and undertake practical activities together. One of the members of a Shed in Cardiff, who is suffering from early on-set Alzheimer's, has shared that attending the Shed has revitalised him and given him meaning and purpose once more. Members of Sheds in other areas of Wales that have been running for longer have credited Men's Sheds with saving their lives, having previously had suicidal thoughts.

[6] Housing LIN (2013) What role for extra care housing in a socially isolated landscape? Available at: http://www.ilcuk.org.uk/images/uploads/publication-pdfs/What_role_for_extra_care_housing_in_a_socially_isolated_landscape.pdf [accessed 8th March 2017]

20. The Vale of Glamorgan Council delivers a range of Supporting People projects which support older people to remain in their own accommodation. The Council has retendered the Supporting People Older persons floating support schemes recently and as part of these schemes asked providers to specifically target older people isolated in the community. They have been working with the 50+ Coordinator to identify ways in which to meet and engage isolated people and offer them support. The Council are also undertaking a series of talking workshops with older people around the commissioning of future joint services and have been working with Cardiff on a regional proposal. There are Step down schemes run from sheltered accommodation and an Accommodation Discharge Coordinator who works with people in hospital to find them suitable accommodation on discharge.

21. The provision of good communication and information, highlighted as a key theme in 'Ageing Well in Wales' is proving effective in supporting people to engage and define their own outcomes and solutions. Fundamental to this approach is the provision of information, advice and assistance and the early identification of outcomes. There have recently been some developments of projects which are taking the approach of early intervention and the need to support the older person to identify their own needs and outcomes.

22. The Wellbeing4U project, delivered by United Welsh Housing Association operates a team of Wellbeing Coordinators based in GP practices. They receive referrals from GPs of people needing support for a range of issues, from finance to social isolation, and are able to signpost and support people to access services that can help them address isolation if this is something that is highlighted during their conversations. Some clients the team have worked with have received support to enable them to have adaptations made to their home to enable them to remain living independently, had referrals to befriending projects, and been supported to access the Senior Health Shop. The crucial elements in the work of this team is the ability to intervene at an early stage, and engage the older person in conversations to understand the full extent of their needs and put in place a personalised response.

23. A final point to make with regard to addressing loneliness is the role that volunteering can play. People who volunteer often make local connections, and take part in activities with other people, therefore this can help to reduce their isolation and make them less lonely[7].

Contributions to this response received from:-
Age Connects Cardiff & the Vale
City of Cardiff Council, Adult Services
City of Cardiff Council, Independent Living Service
Vale of Glamorgan Council, Housing Services
United Welsh Housing Association
Cardiff & Vale UHB
Cardiff Third Sector Council

[7] Campaign to end loneliness 'Volunteering: an answer to tackling isolation and loneliness?' http://www.campaigntoendloneliness.org/uncategorized/volunteering-an-answer-to-tackling-isolation-and-loneliness/ [accessed 08 Feb 2017]

LI 38
Ymchwiliad i unigrwydd ac unigedd
Inquiry into loneliness and isolation
Ymateb gan: Cymdeithas Llywodraeth Leol Cymru a Cymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol
Response from: Welsh Local Government Association and Association of Directors of Social Services

Inquiry into Loneliness and Isolation

Introduction

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

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

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

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

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

6. Given the population predictions, where we will see large increases in the number of older people living alone, particular in the 85+ age range, the issue of loneliness and social isolation is likely to continue to be a significant issue for public services and partner organisations to respond to. All of this takes place against a background of severe financial challenges facing public services in the delivery of services.

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

Scale, Causes and Impact

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

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

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

- **Being active**: being able to participate in interests and pleasures which give meaning to life.

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

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

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

14. One of the biggest challenges for youth services in engaging young people, for example, is the 'pull' of social media which can lead to more young people isolating themselves in bedrooms, which can cause a number of issues – inability to socialise and form relationships, depression, anxiety/agoraphobia, lack of exercise and obesity. Work

pressures for parents can also compound this as parents are not able to spend as much time with their children – or, in the case of a recent Children's Society report, 'Troubled Teens: A study of the links between parenting and adolescent neglect' many teenagers are left to their own devices too early at home.

Ways of Addressing Problems of Loneliness and Isolation

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

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

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

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

19. A key part of the Social Service and Well-being (Wales) Act is the production of regional population assessments. Whilst the assessments are still in development and are yet to be finalised the emerging findings suggest that loneliness and isolation is being recognised as an issue. Importantly, concerns around the impact of loneliness and isolation are not confined to older people and it is seen as an issue across a number of other groups, including:
    - People with a physical disability
    - People with a sensory impairment
    - Minority ethnic groups with a social care need
    - Adult mental health, specifically dementia for some regions
    - People with a learning disability
    - People with autism and the parents of children and young people with autism
    - Care leavers
    - Young carers
    - Veterans
    - Victims of physical and sexual abuse (victim isolation)

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

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

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

Current Policy Solutions / Opportunities

23. All 22 Welsh Local Authorities have signed up to the Dublin Declaration on Age friendly cities and communities, making a commitment to work towards the creation of Age

Friendly communities. Local Government has also been involved in the Ageing Well in Wales Programme from the beginning, with the WLGA working with the Commissioner's Office in establishing the Programme, building on a similar campaign undertaken in England. We are supportive of the key strands of the Programme – creating age friendly communities; tackling loneliness and isolation; preventing falls; developing dementia supportive communities; and addressing employment and skills needs for older people. Progress on these 5 areas of work will lead to measurable improvements to the quality of life of older people, with local authorities taking a key role in supporting this work. It will be important for local authorities to work closely with local communities and partner organisations to consider how services can be delivered in the future, during a time of severe public spending constraint, by doing things differently.

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

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

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

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