

Agenda – Health and Social Care Committee

Meeting Venue:	For further information contact:
Hybrid – Committee room 5 Ty Hywel and video conference via Zoom	Helen Finlayson Committee Clerk
Meeting date: 7 October 2021	0300 200 6565
Meeting time: 09.00	SeneddHealth@senedd.wales

At its meeting on 23 September, the Committee agreed a motion under Standing Order 17.42(ix) to exclude the public from today's meeting

Informal pre-meeting (09.00–09.30)

1 COVID–19 recovery: evidence session with Dr Angharad Shaw and Dr Simon Williams

(09.35–10.15)

(Pages 1 – 31)

Dr Angharad Shaw, Lecturer, Department of Computer Science, Aberystwyth University

Dr Simon Williams, Senior Lecturer in People & Organisation, Swansea University

Research brief

Paper 1 – witness biographies

Paper 2 – written evidence from Dr Angharad Shaw

Paper 3 – written evidence from Dr Simon Williams

Break (10.15–10.20)



2 COVID-19 recovery: evidence session with Professor Gwyneth Davies and Dr Matt Morgan

(10.20–11.00)

(Pages 32 – 37)

Professor Gwyneth Davies, Professor of Respiratory Medicine & Respiratory Consultant Population Data Science, Swansea University Medical School
Dr Matt Morgan, Consultant in Intensive Care Medicine, Adult Critical Care Lead for Research and Development, Honorary Senior Research Fellow, University Hospital of Wales, Cardiff

Paper 4 – written evidence from Professor Gwyneth Davies

Paper 5 – written evidence from Dr Matt Morgan

Break (11.00–11.05)

3 COVID-19 recovery: evidence session with Professor Nicola Gray and Professor Mark Llewellyn

(11.05–11.45)

(Pages 38 – 43)

Professor Nicola Gray, Professor of Clinical & Forensic Psychology, Swansea University

Professor Mark Llewellyn, Professor of Health and Care Policy, Director, Welsh Institute for Health and Social Care, University of South Wales

Paper 6 – written evidence from Professor Nicola Gray

Paper 7 – written evidence from Professor Mark Llewellyn

4 COVID-19 recovery: consideration of evidence

(11.45–12.00)

5 Forward work programme

(12.00–12.15)

(Pages 44 – 50)

Paper 8 – Forward work programme

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Key issues: Dr Angharad Shaw

Dr Angharad Shaw

September 2021

1 Case numbers

We are at a place now where, I think, we have it in our power to send cases on a downward trend, that will be sustained. For the last few months we've apparently been working on a policy of containment, whereby we have been trying to keep numbers low enough that the health service is not overwhelmed. This is not a strategy that has been followed by most of our European neighbours, who have aimed to keep cases as low as possible (even though the Delta wave hit all of them). Regardless of the morality or practicality of the measures they have kept to (many of which we had in the past but have given up on), ultimately immunity has to be our way out of this. Immunity by infection will create a lot of suffering, and is unnecessary.

2 Children

Vaccinating children 12+ is the right thing to do, though I fear the government has yielded to pressure in making it not just voluntary, but very obviously optional. Whilst compulsion would be wrong, strong encouragement (e.g. sending vaccinating teams into schools, whilst allowing an opt-out) would have been more effective. We know that children are very significant spreaders, as well as suffering themselves (albeit to a lesser extent). And right now (as I write, 23rd September), cases are falling in all age groups apart from school age children. What this basically means is that it is now the children who are driving the pandemic on, in Wales.

3 The stages of Delta

There are a number of clearly distinct stages to the Delta wave, and there is a lesson in each of them for us. Together, I believe, they point the way forward.

1. End May to late July. Cases accelerating as Delta took over from Alpha as the dominant variant. Given the R_0 value of Delta is much higher than that of Alpha (roughly 7 to 4), there was little we could do to stop it initially, without doing the politically unthinkable and locking down again. But during this time we should not have relaxed restrictions (except I believe outdoor activities, which are far safer), yet we did. The rise was almost inevitable, but we were onto the vaccine programme, and it was going well. We were still over a month away from fully vaccinating down to 50 though. We needed to buy ourselves a bit more time, to slow the spread, but we failed to do that. In the second week of July, with cases still rising, the Welsh government announced masks would not be required in schools after the summer break. This was not sensible, and would come back to bite them, in September.

Lesson learnt: It was a bad idea to ease restrictions whilst case numbers were rising, and whilst the vaccination rollout still had a fair way to go.

2. Second half of July. As schools wound down, and people went off on holiday, there was a noticeable fall in cases. Once again (as we had seen in the data during the firebreak lockdown) we had strong evidence that schools affect the overall case numbers.

Lesson learnt: Schools contribute significantly to the spread.

3. The month of August. Cases rose throughout the month, very steeply at times. It became fairly clear that what we were seeing was people coming back from holiday bringing it to their home communities. We'd seen in the summer of 2020 that tourism *into* Wales had far less effect on cases than some had feared, but we hadn't seen the effect of such large scale tourism going *out* of the country, and subsequently bringing it back home with them. Whether this was because many were travelling to places with high Covid cases, picking it up during transit (airports or flights), or were simply letting their guard down too much, is difficult to say. But the noticeably even distribution of case growth across Wales (the problems in the northeast excepted) shows that this was not an incoming tourism issue, rather an outgoing one. The vast majority of cases were in the younger age groups, many of whom had not been fully vaccinated at that stage, and some who were reluctant to do so.

Lesson learnt: Outbound tourism is a significant driver of cases, especially amongst unvaccinated young people.

4. First 10 days of September. At this point, cases started to fall. There were fewer young people returning from holiday, so the main driver of cases in August was removed. Schools returned, and for a few days cases continued downwards. The length of the downward trend was unexpected (indeed, Tim Spector of the Zoe app commented on that this week).

Lesson learnt: This reinforces the lesson from (3); removing the drivers reversed the rise.

5. The reversal of the brief downward trend was entirely predicted, as cases started to explode amongst school age children. In retrospect we see the reason for the longer downward trend was simply mathematical: cases rose in school age children from the date of return, but also fell in younger adults - as they got vaccinated and/or were not returning from holidays. Eventually the rise in cases in schools became so steep it negated the decline in other groups.

Lesson learnt: This confirms what we learnt in (2); schools have been a significant driver of the pandemic. It was also confirmed that saying masks would not be required so far in advance was not sensible.

4 Now

And right now, that is where we are. We have seen how, as the vaccination programme has rolled out from older to younger, case numbers in the corresponding groups have fallen. I believe that, as we continue the rollout to 12-17 year olds, we will see cases fall in that group too. There is evidence to suggest that vaccination could be of benefit down to 9 or 10 (possibly slightly lower), and if that were ever approved then that would also help ease the pressures driving the pandemic.

5 Our goal

Whatever the previous goals, I think we are within a fairly small distance from being on top of Delta. With cases falling now in all age groups apart from school age (except see §6), once we can reverse that with vaccination, we are nearly there. We should then see a sustained fall in cases. That's the point at which we have reached Herd Immunity, and done so the right way — by vaccination, not (primarily) by infection.

6 The elderly

There is a small rise happening right now in the very elderly. Whether this is because of waning immunity from vaccination (this is normal and expected), or because of hospital onset (frail

people more likely to be in hospital, hospitals becoming overstretched during the latest wave) is difficult to say. I suspect it's both. Whichever, this highlights the (now fairly urgent) need for boosters for those who received their vaccinations first, some of whom are around 9 months past vaccination now. And those who were first vaccinated with AstraZeneca will have less immunity than those vaccinated with Pfizer. I also note that deaths have been rising disproportionately in the last few weeks, and that is likely due to the same factors.

7 Vaccine passports

Evidence right now suggests strongly that we can beat Covid. But we need a high vaccine uptake, and to that end the Welsh government is right in introducing the "NHS Covid Pass". In fact, they might as well have called it a vaccine passport, because that is what it will get called I'm sure. Such a pass not only protects others at the venues being attended, but also encourages vaccination. I think the pass is a little weak (people will lie about a lateral flow result, regardless of the legality of doing so). The government needs to be bold on this, and remember that they have the backing of the Welsh people - at least, in comparison to those in England. Ultimately, to release all restrictions, we probably need around 85% immunity. That probably needs some cajolment for those who still, despite everything, think it won't affect them. And any politician who wants to placate the anti-vaxxers is on a dangerous slope.

8 Our global responsibilities

We are suffering Delta because this new variant emerged, from India. We suffered Alpha because that variant emerged from Kent. In Britain as a whole, we have more cases per head than anywhere else in Europe. And by putting vaccinated people up against a dangerous virus, we run the risk of being the source of yet another variant; maybe one with greater vaccine escape. We can take the chance that it won't happen, but we have a responsibility not just to ourselves but to the international community to make sure we are not the source of the next worldwide wave of Covid. If for no other reason, that should be enough to say that a policy of keeping cases just under the level the NHS can cope with is morally wrong.

9 Long Covid

Data from the Zoe app suggest that although the vaccine reduces the chance of Long Covid developing in an infected person, it only does so by around 50%. That means that we can expect to see many more cases of Long Covid emerging from the Delta wave. For context, we've had around 125,000 cases since the start of June. From that we are looking at many thousands of cases of Long Covid. And there is very little help available in Wales for sufferers.

10 Ongoing

Defeating Covid in the long term means maintaining a high enough immunity amongst the population that cases brought in from elsewhere will not spread. A strategy needs to be developed. This is likely to involve boosters, as vaccine immunity will wane.

A virus that kills people is not a clever virus. Killing your host is never a good idea. Ultimately, the strain that wins out is the one that produces mild symptoms and keeps the host alive. There are other coronaviruses that simply cause a cold. In the end, maybe we will get lucky, and such a mutation will emerge in Covid.

Written evidence submitted by Dr Simon Williams (Swansea University) to the Senedd's Health and Social Care Committee meeting (7th October 2021)

Key messages

Our Swansea University research, as well as other research conducted in and beyond Wales, on public attitudes to the coronavirus pandemic suggests the following key priorities over the coming years:

- Vaccination uptake. Maximising uptake (and reducing hesitancy) of COVID-19 vaccines in young adults and children and of COVID-19 booster vaccinations and flu vaccinations in relevant (vulnerable) groups remains a key priority.
- Adherence to future COVID-19 measures. Clear guidance and practical support will be essential to maximise adherence to future COVID-19 non-pharmaceutical (behavioural) mitigation measures if any need to be re-implemented. This includes: Ensuring adequate self-isolation support; encouraging and enabling employers to institute isolation and home-working practices when needed; providing clear messages over new, particularly Wales-specific, mitigation measures.
- Mental health impacts of the pandemic. Investing in identifying and supporting mental health recovery following the pandemic in the short term will likely yield significant health and economic benefits in the longer term.
- Health and social care staff shortage. Ensuring an adequate supply of well-qualified staff is essential in order to provide necessary social care services in Wales. To do so, understanding the reasons for the under-supply of social care staff will need to be properly understood and addressed. Likely factors include perceived low pay and perceptions of the status and nature of the role. The impact of the pandemic on the workforce needs also to be better understood.

Vaccination uptake

High uptake of COVID-19 vaccines in young adults and children, and high uptake of COVID-19 booster vaccinations and flu vaccinations in relevant (vulnerable) groups are all essential in order to minimise future mortality and morbidity from both COVID-19 and flu. Maximising vaccine uptake is therefore also a way to minimise ongoing pressure on the health service in Wales.

Uptake in young adults currently lags behind that of older age groups in Wales.¹ Our research has helped identify a number of barriers and facilitators to uptake, including in young adults, such as: the role of convenience (drop-ins) and the role of misinformation.¹ COVID-19 rates remain very high amongst school-age children.² Although policy changes have removed the burden of COVID-19 absenteeism due to self-isolation of close contacts or bubbles,³ COVID-19 vaccines for children are a way to reduce the risk of both school absence *and* illness in those children who are themselves infected with COVID-19. It is likely that in the foreseeable future, COVID-19 vaccines will also be approved in use for children aged 5-11 in a number of countries, presumably including the UK.⁴ Our research suggests that parents are hesitant over the decision of whether to vaccinate their children, and so government and public health communication will need to understand, recognise and

¹ <https://research.senedd.wales/research-articles/vaccine-hesitancy-in-wales/>

² <https://phw.nhs.wales/topics/latest-information-on-novel-coronavirus-covid-19/>

³ <https://gov.wales/schools-coronavirus-guidance>

⁴ <https://www.pfizer.com/news/press-release/press-release-detail/pfizer-and-biontech-announce-positive-topline-results>

address the causes of hesitancy, including concerns over potential long term side-effects and uncertainty over the extent to which children can catch and are affected by COVID-19.⁵ Our research also found that sentiment to flu and COVID-19 booster jabs was generally positive, but concerns were raised, for example over whether or not the jabs were safe to take simultaneously – something that public health communication can help to reassure.⁶

Adherence to future COVID-19 restrictions

Our research has also looked at the factors behind adherence and non-adherence to COVID-19 non-pharmaceutical measures.⁷ Overall, adherence has been high in Wales and the UK generally throughout the pandemic.⁸ However, data suggests that adherence had recently been declining through spring and into the summer.⁹ Our research found that ‘alert fatigue’ was a common problem – where people struggled to ‘keep up’ with rules that changed frequently and often varied across the four nations.¹⁰ As such, going forward, if measures are to be re-introduced, it is important to consider: (1) That adherence may not be as high as in previous phases of the pandemic; and (2) that communicating the measures and their rationale are clear (especially if different to UK guidance) and mixed-messages are avoided. Our Swansea University study commissioned by Senedd Research found that people had variable knowledge of the potential financial and social and emotional supports available during self-isolation.¹¹ Research is ongoing in collaboration with Public Health Wales. Self-isolation of positive cases remains a crucial way of minimising spread, and ongoing financial and social support needs to be in place, particularly for those more socially and economically vulnerable in society. Longer term, employers need to be supported to enable workers to self-isolate and/or work-from-home when sick or symptomatic.

Mental health impacts of the pandemic

Early on in the pandemic, we found that social isolation and distancing were having significant impacts on people’s mental health and wellbeing, and particularly those who were in for example low- or insecure-income occupations⁶ Although people’s mental health and wellbeing has generally improved over the past few months as the measures have been relaxed,⁷ stress and anxiety remain a problem, and the full and long-term impacts are unknown. Research, including our own, will follow these impacts. However, providing early funding and services to support those most affected by the pandemic (including those with prior mental health conditions) will be essential. One particular priority should be children and young people. We know that early identification and support for early emotional and mental health problems can mitigate or prevent longer-term illness (including potentially serious mental ill-health) in the longer term (something that can be cost-effective).

Health and social care staff shortage

The pandemic has both impacted and highlighted some deficits in the social care system. The social care staff shortage is an immediate priority. Future planned research will explore: (1) How much of a priority people think social care reform should be for the Welsh Government; and (2) whether public perceptions of social care work has changed following the pandemic. The workforce shortage can be offset by incentivising and training staff through improved pay and other benefits and in improving working conditions.

⁵ <https://www.medrxiv.org/content/10.1101/2021.07.28.21261252v1>

⁶ <https://psyarxiv.com/hyxm5/>

⁷ <https://bmjopen.bmj.com/content/10/7/e039334.abstract>

⁸ <https://phw.nhs.wales/news/week-74-how-are-we-doing-in-wales-public-engagement-survey-results/>

⁹ <https://www.covidsocialstudy.org/results>

¹⁰ <https://www.gov.uk/government/publications/spi-b-behavioural-and-social-considerations-when-reducing-restrictions-10-february-2021>

¹¹ <https://research.senedd.wales/research-articles/coronavirus-how-can-test-trace-protect-be-improved/>

Agenda Item 2

Health and Social Care Committee briefing, 7 October 2021

Professor Gwyneth Davies, Professor of Respiratory Medicine & Respiratory Consultant
Population Data Science, Swansea University Medical School.

Background

Lockdown was associated with the largest drop in COPD attacks and severe asthma attacks ever seen in Wales/Scotland/UK

Early in the pandemic, asthma and COPD were identified as potential risk factors for hospital admission and death from COVID-19, and since the majority of exacerbations are associated with respiratory viral illnesses, it was expected that such exacerbations might increase.

However, our work has recently shown that lockdown was associated with the largest drop on severe asthma attacks ever recorded in the UK (1). There was a drop of 30% in asthma exacerbations resulting in emergency hospital admission in Wales and a 41% drop in Scotland (Figure 1), compared with national averages from the last 5 years (pooled reduction 36%, incidence rate ratio, IRR: 0.64, 95% CI: 0.49 to 0.83, p value 0.001). Reassuringly there was no significant change in asthma deaths. In Wales, a large spike in GP prescriptions for inhaled and oral steroids was seen in the week leading up to the first national lockdown (March 23 2020), suggesting that improved self-management may provide one explanation for the reduction in asthma attacks (spikes of 120% and 130% prescriptions for inhaled and oral steroids). In England, Shah and colleagues report a significant drop in severe exacerbations managed in primary care with oral steroids following lockdown (2).

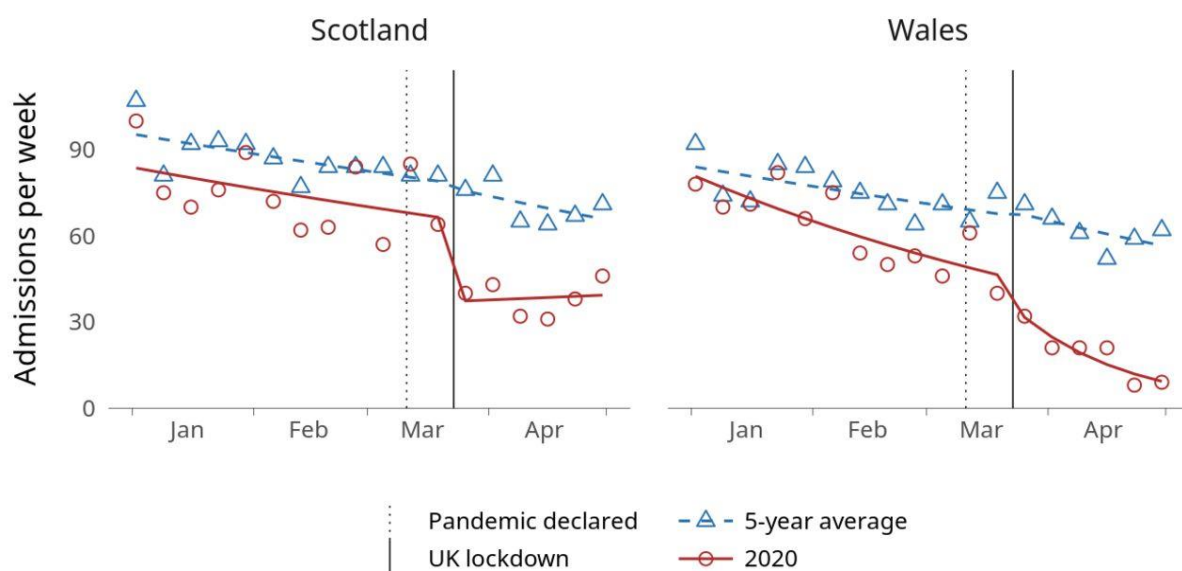


Figure 1: Weekly count of emergency asthma admissions in Scotland and Wales in 2020 and 5-year average (points) in addition to modelled trend lines.

We also showed that lockdown was associated with the largest drop in COPD attacks ever seen across Wales and Scotland (3). We found a 39% reduction in GP consultations and a 48% reduction in hospital admissions for COPD following the introduction of the first national lockdown (Figure 2). Reassuringly, we also found no evidence that deaths due to COPD have increased during lockdown.

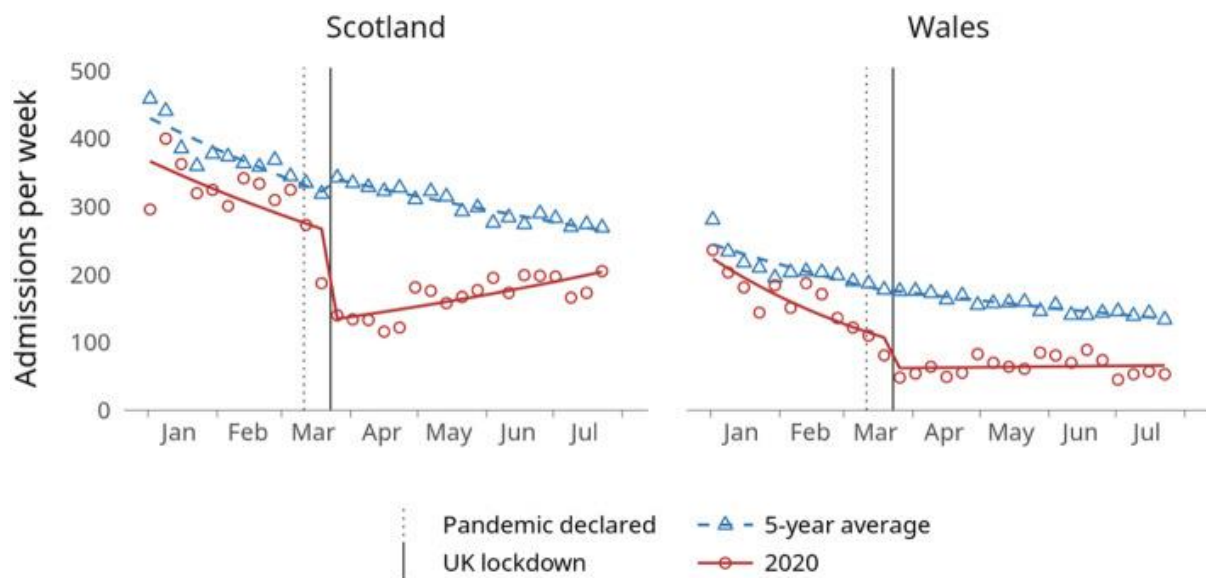


Figure 2: Weekly count of emergency COPD admissions in Scotland and Wales in 2020 and the corresponding 5-year averages (2015–2019, points) in addition to modelled trend lines.

Our research team at Swansea University Medical School worked in partnership with researchers at the University of Edinburgh’s Usher Institute to access data from the SAIL databank and Public Health Scotland. We performed interrupted time series analyses and compared weekly trends of events for the first 18 weeks of 2020 with the national averages over 2015–2019. We looked at a single change point at week 13 (when the first UK lockdown was announced on 23 March) to see how trends changed.

These are observational studies, and as such, can’t establish cause. However, there are several potential explanations for the substantial reduction in exacerbations seen in lockdown. These factors include changing behaviour due to lockdown measures leading to reduced circulation of respiratory viruses - the most common triggers for acute exacerbations of COPD and asthma - and reduced outdoor air pollution. Other factors include improved self-management and treatment adherence, driven by patient concerns during the pandemic and shielding by a subset of patients. Avoidance of healthcare settings due to fear of COVID-19 is likely to have played a part but it is reassuring to note that there was no increase in asthma or COPD deaths that would be feared if those with severe attacks were avoiding seeking the urgent treatment they needed. A study in South Korea – where there was thorough social distancing, personal hygiene, and universal use of face masks – showed a significant decrease in hospital admissions for influenza, pneumonia, COPD, and asthma as an unintended benefit of these measures (4).

These findings have far-reaching implications because a reduction in COPD and asthma-related admissions increases healthcare capacity and resources to treat people with COVID-19. Further investigation based on these results could also support the drive to reduce pollution levels. Beyond the pandemic, it is hoped that the findings will support an improved public health message to facilitate effective self-management of asthma and COPD and to reduce the transmission of respiratory infections through better hygiene and other precautionary measures.

The key question now is how can we harness any positives on reduced viral transmission and better self-management?

Key Priorities

Here I outline key priorities based on my roles as a Respiratory Consultant directly involved in COVID-19 care, and on my academic research.

Need to address the following immediate challenges:

1. Covid, flu & RSV cases will all rise. Predicted higher rate of flu cases (lower immunity, less data for optimal flu vaccine) and a huge increase in RSV. There will be insufficient hospital beds for adequate segregation and infection control of these infections. Therefore, hospital acquired infection will rise.
2. Significant staff gaps (due to self-isolation) will jeopardise the delivery of safe care.
3. Care homes are shutting doors so hospital patients cannot be discharged to care homes.

Immediate Autumn/Winter Health & Social Care priorities

1. **Reduce respiratory hospitalisations** – prioritise flu vaccination and COVID booster programmes; see also Winter plan (in preparation, Respiratory Health Implementation Group, RHIG) re implementation of existing pathways (COPD exacerbations, intravenous antibiotics in community), widespread adoption of POCT for COVID/Flu and CRP in primary care to help determine care pathways and appropriate referrals.
2. Injection of resource to **prioritise adequate bed numbers and staffing.**
3. **Coherent social care strategy** to ensure flow of patients from hospital to care homes/supported care, following clear criteria on COVID negative status.
4. Use the current all Wales digital platform to introduce the new winter specific digital interventions which can be actively disseminated across all Health Boards.

Medium to longer term priorities

1. Harnessing any positive effects seen in lockdown, on reduced transmission of viruses and improved self-management
2. Public health messaging to **reduce viral transmission long-term** in vulnerable groups (targeted messaging, avoidance of high-risk environments, improved infection control measures, avoid patient mixing, masks)
3. **Improved self-management** – public messaging (role for Asthma UK BLF), **self-management apps** in asthma & COPD (already implemented) linked to national platform and develop personalised management via apps, care component delivered via app (e.g., annual review)
4. **Diagnostic hubs** – right patients on right treatment, stop unnecessary inhaler treatment (potentially saving up to £20 million), lung function testing unlikely to resume in primary care for foreseeable future
5. Long COVID – self-management apps, rehab programmes, future emerging treatments,
6. **Data gaps** – need disaggregated data by deprivation index in particular. The pandemic is likely to have far-reaching effect in widening existing disparities e.g., large inequalities in asthma care & outcomes (5). We need to address specific impacts on health and care of most **deprived groups**. Also, data gaps on outcomes in long COVID (particularly non-hospitalised).

References

1. Davies GA , Alsallakh MA , Sivakumaran S , et al . [Impact of COVID-19 lockdown](#) on emergency asthma admissions and deaths: national interrupted time series analyses for Scotland and Wales. *Thorax* 2021;76:865–71.doi:10.1136/thoraxjnl-2020-216380
2. Shah SA , Quint JK , Nwaru BI , et al . [Impact of COVID-19 national lockdown](#) on asthma exacerbations: interrupted time-series analysis of English primary care data. *Thorax* 2021;76:858–64.doi:10.1136/thoraxjnl-2020-216512
3. Alsallakh M, Sivakumaran S, Kennedy S, Vasileiou E, Lyons RA, Robertson C, Sheikh A, Davies GA. [Impact of COVID-19 lockdown on the incidence](#) and mortality of acute exacerbations of chronic obstructive pulmonary disease: national interrupted time series analyses for Scotland and Wales. (accepted *BMC Medicine*, May 2021)
4. Huh K , Kim Y-E , Ji W , et al . [Decrease in hospital admissions](#) for respiratory diseases during the COVID-19 pandemic: a nationwide claims study. *Thorax* 2021;76:939–41.doi:10.1136/thoraxjnl-2020-216526
5. Alsallakh MA, Rodgers SE, Lyons RA, Sheikh A, Davies GA. [Association of socioeconomic deprivation](#) with asthma care, outcomes, and deaths in Wales: A 5-year national linked primary and secondary care cohort study. *PLoS Med.* 2021 Feb 12;18(2):e1003497. doi: 10.1371/journal.pmed.1003497

Health and Social Care Committee Written Evidence Summary

Dr Matt Morgan, MBBCh BSc PhD FRCA FFICM

Consultant in intensive care medicine

Lead for critical care research in Wales

These are my personal and independent opinions and not representative of any formal body.

1. All Welsh healthcare should be evidence based or evidence generating

Wales played an essential role in developing the research basis for effective treatments of COVID. Recruitment of large numbers of Welsh patients into the RECOVERY study was recognised in a speech by [Boris Johnston](#). Showing the inexpensive steroid drug dexamethasone was safe and effective has saved countless lives globally.

This emphasis on evidenced based care should be extended to all interventions. Wales should support the structures, people and systems needed to deliver high quality healthcare evidence in both acute and chronic illness. Where high quality evidence is not available, data should be gathered on these interventions to lead to future improvements in care. I believe that all Welsh healthcare should be evidence based or evidence generating.

Barriers to this include the low numbers of clinical academics supported by institutions in Wales and underuse by some sectors of the already available pseudonymised data sources such as SAIL.

I call on this committee to endorse the statement that all Welsh healthcare should be evidence based or evidence generating, support clinical academics and allow easier access to pseudonymised data for research.

2. Online abuse: The standard you walk past is the standard you accept

Aneurin Bevan said that “the purpose of power is to give it away.” This pandemic has been fought not only by nurses, doctors and other health workers, but by the community pulling together to support each other through the tough times. Public understanding of the many complex and changing aspects of healthcare is therefore key.

Many health workers have chosen to spend their free time promoting public health messages and science by working with traditional and social media companies. There has been a small but significant amount of directed, targeted and coordinated online abuse against some of these [people](#). Not only does this undermine the public messaging around health promotion, but it can have a damaging effect on the individuals targeted.

I call on this committee to produce a clear statement, embedded in the NHS charter, making this targeted online abuse of healthcare workers unacceptable with no place to hide in the Welsh NHS.

3. Welsh care for Welsh patients: A severe respiratory failure service for Wales

Some Welsh patients with COVID and other respiratory illnesses need advanced treatments including extracorporeal membrane oxygenation (ECMO). This is currently only available in 5 UK centres, none of which are in Wales. Although Wales receives an excellent service from our English colleagues, there are advantages to treating Welsh patients needing ECMO in Wales.

This may allow more timely access to services, will help recruit and retain skilled staff, allow local shared decision making and be better for patients and their families. This is illustrated by the case of [Davide Compagnone](#), a fit and healthy young father working as a pharmacist, who survived severe COVID thanks to these advanced treatments.

Cardiff and Vale are progressing with a case to develop a severe respiratory failure service in Wales. Many aspects needed for a Welsh service are already in place with initial costings suggesting that compared with an English commissioned service, the costs may be neutral.

I call on this committee to support the concept of a Welsh severe respiratory failure service for patients in Wales.

Agenda Item 3

HSC(6)-3-21 Papur 6 / Paper 6

Briefing Paper to the Health and Social Care Committee of the Senedd

Professor Nicola Gray, Swansea University

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Key messages

- We are a team of academics and clinicians in Swansea University, Cardiff University, and the seven Health Boards in Wales.
- The research is in collaboration with the Divisional Directors of Mental Health and Learning Disability of all seven Health Boards in Wales, and the initiation of the research was at their request.
- The research explores the impact of the Covid-19 pandemic and emerging issues on the mental health and well-being of the population.
- We have completed two surveys to date and have just opened our third survey.
- The first survey spanned the time period of the first lock-down in Wales (9th June 2020 to 13th July 2020). 12,989 people participated in this survey from across all regions of Wales.
- We ensured that we had a minimum of 250 participants from each Local Authority in Wales in order to allow for a granular level of analysis. Our data is structured so that specific Health Boards, or specific Local Authorities, can access their data and ask questions about regional variation in well-being needs. We can drill down to specific communities, either geographically defined or defined on other criteria (such as age, or level of deprivation, or people who have experienced domestic abuse, etc).
- 37% of the sample reported moderate or severe levels of psychological distress, with 20% reporting severe levels of distress.
- There were key variations in levels of psychological distress across separate sectors of the community. For example:
 - The youngest age group (16-24 years) being 5.54 times more likely to be distressed compared to the oldest age group (75+).
 - Those with a previous mental health difficulty were 4.03 times more likely to be distressed compared to those without a previous mental health difficulty.

- Those with the highest levels of deprivation were 1.76 times more likely to experience psychological distress compared to those with lower levels of deprivation.
- The second survey followed approximately 6 months after the first. It adopted the same methodology as the first survey and spanned the period of 18th January 2021 to 7th March 2021. 10,428 people participated in this survey from across all regions in Wales.
- Levels of distress in the population had deteriorated further, with 40.4% of the sample reporting moderate or severe levels of psychological distress, and 23% reporting severe levels of distress.
- The pattern of variation across different sectors of the community was similar to the first survey, but became more pronounced for some groups. For example:
 - The youngest age group were now 10 times more likely to be distressed compared to the oldest age group.
 - Those with a previous mental health difficulty were 3.2 times more likely to be distressed compared to those without a previous mental health difficulty
 - Those with the highest levels of deprivation were 2.18 times more likely to experience psychological distress compared to those with lower levels of deprivation.
- The research also highlighted the broader psychosocial determinants that we already know are associated with decreased mental health and well-being. These include experiencing food insecurity, domestic abuse, social isolation, and financial problems. We need ongoing prevention strategies to support people who experience these stressors and issues.
- Within the second survey we now investigated **protective factors** associated with reduced levels of psychological distress and enhanced well-being. Here we found:
 - People with high levels of hope for the future were 7.8 times less likely to experience moderate or severe levels of psychological distress.
 - People with high social connectedness were 5.7 times less likely to experience moderate or severe levels of psychological distress.
 - People with high levels of psychological resilience were 4.8 times less likely to experience moderate or severe levels of psychological distress.

Conclusions

- We conclude that our research exploring the impact of the Covid-19 pandemic in Wales is showing a **significant and continuing impact** on the mental health and wellbeing of the population.
- We need to continue monitoring these effects within our communities over the longer term.
- Our results are commensurate with other research projects across the world indicating a deterioration in mental health that has been sustained since the start of the pandemic. Hence, this is not a brief reaction to a natural disaster causing a ‘blip’ in poor mental health, as some have argued, and strategic planning for the future mental health and well-being of the population is required.
- Importantly, there are specific groups that have been particularly impacted by the Covid pandemic. These groups need special attention in terms of continued monitoring and intervention. A key group of concern are adolescents and young adults.

Recommendations

- We need a strategy that encompasses a whole population approach to the management and intervention of wellbeing issues in our communities. This needs to focus on how we can bolster and promote protective factors (such as hope, resilience, and social connectedness) and address psychosocial stressors associated with poor mental health.
- The well-being needs of the population needs to be at the forefront of our thinking right from the beginning and early intervention is key to recovery.
- Research following other natural disasters and public health emergencies has also indicated that early intervention at a population level is critical to prevent further deterioration in mental health over time. This is needed to reduce the number of people presenting to specialist mental health services in the future, with the risk that these services become overwhelmed.
- A focus on the mental health and well-being needs of the population needs to be at the heart of our Covid recovery programme, and should not be viewed as an ‘add on’ or optional extra.
- We require a whole system approach, with a focus on early intervention, to address these issues, involving both statutory agencies and third sector organisations, working

together with their communities. Specialist mental health services will not be able to cope with this dramatic and sustained decrease in mental health and wellbeing across the board and only a whole system approach of collaborative working, led by policy, will be effective.

- We need to work collaboratively with our communities, enabling local ownership, and co-producing solutions. There is a role for local multi-agency strategic planning forums, such as Public Service Boards, who understand the needs of their local communities and can engender and facilitate local ownership of strategic priorities.
- The protective factors identified by our research (hope, resilience, and social connectedness) are important pointers to future recovery strategies. For example, we need to consider how we communicate hope to our population via central messaging from our political leaders and communication strategies from Health Boards and Local Authorities. How can we act to promote hope and resilience?
- Whole population interventions on engendering resilience and promoting social connectedness are also possible intervention strategies for the future.

Further information

- A summary of the findings of our two mental health and well-being surveys, and the two NHS reports of these, can be accessed via our web-site:
- <http://www.wales-wellbeing.co.uk>, under the tab 'Our Findings'.

INFORMING THE COMMITTEE'S STRATEGIC PLANNING AND PRIORITISATION FOR THE SIXTH SENEDD

Briefing Paper for the Health and Social Care Committee, Senedd Cymru

Thursday 7th October 2021

Much has been discussed over recent weeks and months about all of the challenges facing the health and social care system in Wales. The pandemic has clearly acted as a huge stress test on an already stretched system, and we are now beginning to understand some of the impacts of this.

In order to help Members in their deliberations about priorities to consider as they set their work programme, I thought it might be helpful to bring to you an excerpt from some of the latest evidence on the experiences and views of people from within Wales and across the UK, with a particular focus on the care system.¹

Key findings on care experiences

- One in six adults (18%) have experienced problems with getting the right care for an elderly relative
- One in six people (17%) feel they've had to fight to get social care support for a loved one or for themselves
- One in two (52%) unpaid carers feel they've had to fight to get care or treatment for a loved one or for themselves, which is nearly double the rate (29%) for those who are not unpaid carers
- One in five (22%) people from ethnic minority backgrounds regularly care for another adult, compared to one in eight (13%) people who identify as white.

Key findings on funding

- Half of the people living in Britain (54%) don't know if social care is free and one in five (20%) believe it's free for all which it isn't
- The country is divided on whether people should pay for the cost of care in old age if they can afford it
- Most people (71%) see health and care services as underfunded

So, what are the implications of this? What should you be thinking about as you set your work programme for the sixth Senedd? In my view there are three areas that you might want to think about, which mirrors a number of the questions that were raised in the Committee's Meeting of 23rd September:

¹ The data reported here comes from a survey which was commissioned by [Engage Britain](#) and conducted by Yonder to investigate themes coming out of 101 community conversations to further explore views on health and care. I am an unpaid Steering Group member for Engage Britain and was approached by them to provide my independent views on the health and social care system in Wales. [Engage Britain](#) is a registered charity, fully independent of government, using participatory methods to bring solutions to policy makers across the UK. This was [a nationally representative survey](#) of 4,010 UK adults. Online fieldwork was undertaken between 5-8 July 2021 and the data presented are weighted to the UK population profile by age, gender, region, socioeconomic grade and ethnicity.

1. Ongoing challenges for unpaid carers across Wales require further attention

The burden of responsibility for unpaid carers has been exacerbated over the last 18 months during COVID. Unpaid carers provide a minimum of 96% of all the care that is provided across Wales (a figure that is likely to have grown under the pandemic), and whilst the previous Health and Social Care Committee's [report](#) shone a light on those experiences, emerging evidence from the [national evaluation of the Social Services and Wellbeing Act](#) that I am leading would suggest that the 'fight' to get support from social services as found in the survey is a daily reality in Wales. The Welsh Government has done much to respond to the recommendations made, and continues to do work hard in this regard, but further attention on this is warranted.

2. Concerns over the sustainability of the workforce persist, and have been exacerbated

[Research](#) that we undertook last summer pointed to the disparities in pay and conditions across the social care workforce in Wales that persist. The study demonstrated that there is evidence of variation in pay and conditions within and between each of the social care sectors and between them and the NHS. Findings showed that, while pay and conditions were consistent factors influencing recruitment and retention in the social care workforce, other important factors include the values and motivations of staff; the importance of being a 'good employer' with staff feeling valued, appreciated, supported and included; and staff feeling part of a team and having open communication with supervisors and managers. Things have now reached crisis point for many organisations, and this issue needs to be consistently monitored and reviewed.

3. Understanding why health and social care integration does (or doesn't) work could help

There is a clear context for the integration of health and social care in Wales, with the most recent iteration of this aspiration in the Welsh Government's [A Healthier Wales](#). At the frontline, high-level strategic statements policy statements need to be implemented and operationalised. This is not often an easy task. One of the ways to more effectively integrate work across health and social care practice is for practitioners within those teams to become more informed and reflexive about what works for them and why. There is an important precedent for this in Wales as part of the education reforms under the umbrella term of [Curriculum for Wales](#) which has sought to build a growing network of schools who have developed a range of enquiry skills to explore professional learning requirements for the new curriculum. Might it be possible to develop an approach to professional enquiry within health and social care that could be used across the whole of Wales to build integrated health and social care teams that are more aware of how to optimise their working relationships?

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<https://wihsc.southwales.ac.uk> · <https://wihsc.southwales.ac.uk/cymraeg>



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Agenda Item 5

By virtue of paragraph(s) vi of Standing Order 17.42

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