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Agenda - Health and Social Care Committee

Meeting Venue:	For further information contact:
Hybrid - Committee room 5 Tŷ Hywel and video conference via Zoom	**Helen Finlayson**
Meeting date: 19 May 2022	Committee Clerk
Meeting time: 09.00	0300 200 6565
	SeneddHealth@senedd.wales

Private pre-meeting (09.00 - 09.30)

1 Introductions, apologies, substitutions and declarations of interest

(09.30)

2 Mental health inequalities: evidence session with Professor Carolyn Wallace, Wales School for Social Prescribing Research (WSSPR)

(09.30-10.30) (Pages 1 - 19)

Professor Carolyn Wallace, Director - Wales School for Social Prescribing Research (WSSPR)

Research brief

Break (10.30 - 10.45)

3 Mental health inequalities: evidence session with Public Health Wales

(10.45-11.45) (Pages 20 - 39)

Dr Tracey Cooper, Chief Executive - Public Health Wales

Julie Bishop, Director of Health Improvement - Public Health Wales

Senedd Cymru
Welsh Parliament

Joanne Hopkins – Programme Director for ACEs, Criminal Justice and Violence Prevention – Public Health Wales

Paper 1 – Public Health Wales

4 Motion under Standing Order 17.42 (ix) to resolve to exclude the public from items 5, 9 and 10 of today's meeting

(11.45)

5 Hospital discharge and its impact on patient flow through hospitals: consideration of draft report

(11.45-12.15) (Pages 40 - 105)

Paper 2 – draft report

Lunch (12.15 – 13.00)

6 Mental health inequalities: evidence session with Mind Cymru and Leonard Cheshire

(13.00-14.00) (Pages 106 - 131)

Sue O'Leary, Director – Mind Cymru

Ashra Khanom, Treasurer – Neath Port Talbot Black Minority Ethnic Community Association

Rhian Stangroom Teel, Public Engagement Manager – Leonard Cheshire

Nia Golding, Area Manager – Leonard Cheshire

Paper 3 – Mind Cymru

Paper 4 – Leonard Cheshire

Break (14.00 – 14.15)

7 Mental health inequalities: evidence session with Professor Sir Sam Everington

(14.15-15.00) (Pages 132 - 136)

Professor Sir Sam Everington

Paper 5 - Professor Sir Sam Everington

8 Paper(s) to note

(15.00)

8.1 Letter from the Chair to the Deputy Minister for Mental Health and Wellbeing regarding the provisional food compositional standards and labelling common framework

(Pages 137 - 140)

8.2 Response from the Deputy Minister for Mental Health and Wellbeing to the Chair regarding the provisional food compositional standards and labelling common framework

(Pages 141 - 148)

8.3 Letter from the Chair to the First Minister regarding the UK COVID-19 Inquiry draft terms of reference

(Page 149)

8.4 Response from the First Minister to the Chair regarding the UK COVID-19 Inquiry draft terms of reference

(Page 150)

8.5 Public attitudes to social care in Wales following the COVID-19 pandemic. Research commissioned by Senedd Cymru and produced in consultation with Senedd Research

(Pages 151 - 172)

8.6 Letter from the Chair to the Minister for Health and Social Services regarding the provisional common frameworks

(Pages 173 - 190)

8.7 Response from the Minister for Health and Social Services regarding the provisional common frameworks

(Page 191)

8.8 Letter from the Minister for Health and Social Services to the Chair regarding the Committee's report on the Supplementary Legislative Consent Memorandum (Memorandum No. 4) (the SLCM) on the Health and Care Bill (the Bill)

(Pages 192 - 193)

8.9 Letter from the Minister for Health and Social Services to Chair, Legislation, Justice and Constitution Committee regarding the Committee's report on the Supplementary Legislative Consent Memorandum (Memorandum No. 4) (the SLCM) on the Health and Care Bill (the Bill)

(Page 194)

8.10 Letter from the Chair to the Minister for Health and Social Services regarding women and girls' health quality statement and plan

(Pages 195 - 202)

8.11 Response from the Minister for Health and Social Services to the Chair regarding women and girls' health quality statement and plan

(Pages 203 - 204)

9 Mental health inequalities: consideration of evidence

(15.00-15.15)

10 Provisional food compositional standards and labelling common framework: consideration of draft letter

(15.15-15.30) (Pages 205 - 220)

Paper 6 - draft letter

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

Agenda Item 2

Document is Restricted

Iechyd Cyhoeddus Cymru
GIG CYMRU NHS WALES
Public Health Wales

Public Health Wales consultation response

Health and Social Care Committee inquiry into mental health inequalities

Summary

- The underlying causes of inequalities in mental health and well-being in Wales are shared with those of all health inequalities.
- Taking action on mental health inequalities will involve tackling the 'wider determinants' of health; i.e. the social, economic and environmental drivers of health, including having the resources for healthy living, education, fair work and a supportive home and wider physical and social environment.
- Some population groups in Wales are particularly vulnerable to poor mental health and well-being, as they are more likely to have adverse, rather than protective, experiences of these factors. They may also be at increased risk due to discrimination and stigma, or as a consequence of their physical health.
- Inequity in the causes of poor mental (and physical) health and well-being can be exacerbated by inequity in access to, and experience of, care and support services.
- People can experience compounding, negative impacts on their mental health and well-being at any one time and throughout their lives. For example, family stressors, including childhood trauma and financial strain, can affect the mental health of children. This, in turn, can lead to reduced educational attainment, affecting their future participation in the workforce/ ability to access services, which can then have further, negative impacts.
- Addressing inequalities in Wales requires a focus on the full spectrum of public health approaches, including: acting on the determinants of mental health inequalities, promoting mental well-being, preventing future mental health problems, and recovering from mental health problems.

Public health approaches

There are a number of public health approaches that can be taken to help address mental health inequalities, including:

- **Improving population-level data collection to support the design and evaluation of services and policies to ensure they are focused on prevention, meet need and deliver the intended outcomes;**
- **Embedding consideration of impacts on mental well-being as part of policy and investment decisions (Mental Health and Well-being in All Policies). This can be supported by implementation of the forthcoming health impact assessment regulations attached to the Public Health (Wales) Act 2017;**
- **Taking action on, and account of, the social, economic and environmental factors that influence mental health, well-being and inequalities (the wider determinants of health) and how they can interact with each other, and other factors such as discrimination, stigma and poor physical health, to have a cumulative, negative impact (intersectional inequalities).**

- **Taking a life-course approach, recognising the vital importance of the early years, children and young people, adults and older adults, with a focus on prevention, early intervention and resilience.**
- **Actively engaging and empowering communities in order to shift the power dynamic that drives inequalities, and re-orienting services to improve access, quality and equity.**

1. Introduction

Due to the breadth of topics felt to be captured by this consultation, Public Health Wales has chosen not to respond in the framework provided*.* However, connections to specific consultation questions have been drawn out where appropriate.

Throughout the response we have included examples of public health approaches for tackling specific aspects of mental health inequalities. In the final section, we identify what further action is needed to embed and build upon these approaches to reduce mental health inequalities in Wales.

2. Public health definitions of mental health inequalities

2.1 Mental health

"*Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community*" (WHO, 2004) 1

In its work, Public Health Wales seeks to recognise and consider the full spectrum of mental health and well-being. This includes mental well-being, medically defined and diagnosed conditions, such as anxiety, depression, psychosis and dementia; as well as symptoms and experiences of mental distress that are affecting someone's life and well-being.

2.2 Inequalities

Inequalities can be defined as measurable differences in mental health and well-being, or in the determinants of health and well-being, between groups and communities. Where these differences are systematic, avoidable and unfair, they are termed inequities. Mental health inequalities relating to socio-economic and structural factors are, by their nature, inequitable.

Specific groups in the population are at increased risk of poor mental health and well-being. This can be due to structural factors, such as the conditions in which they live and work; the impacts of factors such as discrimination and stigmatisation (see section 3); or other health issues, such as living with chronic pain. There can also be inequalities in physical health outcomes for people living with poor mental health i.e. their physical health needs can be overshadowed by their mental health presentations ("diagnostic over-shadowing"), and/or their medication can put them at increased risk of poor physical health.

While this response focuses on mental health and well-being, it is important to note that the underlying causes of inequalities in mental health and well-being are shared with those of all health inequalities. Work to address mental health inequalities needs to take account of this relationship. There is more detail on the factors underlying inequalities in mental health and well-being in section 3.

3. Factors contributing to poor mental health in Wales

Q1: What factors contribute to worse mental health within these groups?

We all have mental health and well-being, which is dynamic and affected – positively and negatively – by a range of factors such as social relationships, economic security, significant life events, community resources, the environment, our physical well-being, our ability to control key decisions that affect our life, our coping resources and more.

3.1 The wider determinants of health

The term 'wider determinants' refers to the social, economic and environmental factors that influence mental health, well-being and inequalities. The WHO has described these as the five 'essential conditions', or building blocks, for a healthy life[2]:

- good-quality and accessible health services;
- income security and an appropriate, fair level of social protection;
- decent living conditions (including housing, communities and the wider environment);
- good social and human capital (including education and skills, trust and relationships);
- decent work and employment conditions.

The wider determinants of mental health also include discrimination and stigmatisation. Experience of this, for example, racism, is associated with worse mental health outcomes[3].

Public health approach: mental health inequalities and work

Unemployed people have a greater risk of poor mental health than those in employment[4]. People experiencing long-term health conditions or disability, younger people and those from our most socioeconomically deprived communities, are more likely to be unemployed. These groups are also more likely to be exposed to other factors that contribute to poor mental health and well-being, increasing their risk.

For those in employment, the nature of their work can also affect their mental health and well-being. Participation in fair work provides people with a sense of purpose, a sense of control in their lives, and means that people have money and resources for a healthy life for them and their families. This reduces psychological stress, can create a stepping-stone out of poverty and helps children have the best start in life. Fair work can also contribute to an economy of well-being, improving mental and physical outcomes for the whole population, including those most disadvantaged.

Poor mental health is one of the main reasons or staff sickness absence across the UK[5] (see also section on 4.1 on the impact of the COVID-19 pandemic). A review of the data related to employment in Wales, suggests that more workers are being pushed towards part-time and/or insecure work where they have to work harder for fewer rewards and with less job security[6]. Lower paid, 'precarious work' is typically characterised by insecurity of employment, poor psychosocial working conditions and worse mental health.

There is evidence that working conditions contributing to workplace mental health and well-being can be improved in a number of ways[7,8,9]. PHW's Healthy Working Wales programme, works with employers to prioritise mental health and well-being in their workplaces, assisting them to develop and deliver a strategic and coordinated programme of delivery. The programme supports organisations to embed a range of evidence-based criteria to ensure that fair work design and organisational culture drives positive mental health and well-being outcomes; that mental health is monitored across the organisation; and that line managers are trained to understand risk factors. In addition, Healthy Working Wales works with partners to signpost to tailored interventions across the organisation, for teams and for individual employees, ranging across the mental health and well-being continuum.

More broadly, supporting participation in fair work can help improve mental well-being for those working and for their families. Employers have a key role in improving access to fair work, as do many public sector and other bodies, including through socially responsible

procurement. Ensuring that jobs have decent pay (fair reward), involve employees, are flexible to their needs and provide healthy environments, can reduce the stress on individuals and families, and improve well-being. PHW has established an expert panel to help influence how participation in fair work can be improved in a way that improves health, well-being and equity.

Public health approach: maximising the potential of the built and natural environments to improve mental health and well-being

Working across sectors to enhance the built and natural environment provides important opportunities for reducing inequalities in mental health. For example, greener environments have been shown to promote mental health and well-being and these benefits are greatest for socioeconomically disadvantaged groups, with inequality in mental well-being narrower in deprived groups that have good access to greenspace, compared to those with less access[10].

The Wales Health Impact Assessment Support Unit facilitates and supports engagement between public health, place making and planning in Wales.

The table below summarises some examples of the factors that influence mental health in Wales, such as low income, exposure to violence and abuse, loneliness, poor working conditions and social and gender inequalities. It also highlights the factors that can promote and protect mental health and well-being such as good parenting, equality, educational achievement and physical health[11].

Inequalities arise when some people or communities experience increased exposure to the adverse factors and/or have less access to protective factors, making them more likely than others to experience poor mental health and well-being. Multiple disadvantage and vulnerability factors can have a cumulative impact on someone's health and well-being, increasing their risk or worsening their experience.

Level	*Adverse factors*		*Protective factors*
Individual attributes	Low self-esteem	↔	Self-esteem, confidence
	Cognitive/emotional immaturity	↔	Ability to solve problems and manage stress or adversity
	Difficulties in communicating	↔	Communication skills
	Medical illness, substance use	↔	Physical health, fitness
Social circumstances	Loneliness, bereavement	↔	Social support of family & friends
	Neglect, family conflict	↔	Good parenting / family interaction
	Exposure to violence/abuse	↔	Physical security and safety
	Low income and poverty	↔	Economic security
	Difficulties or failure at school	↔	Scholastic achievement
	Work stress, unemployment	↔	Satisfaction and success at work
Environmental factors	Poor access to basic services	↔	Equality of access to basic services
	Injustice and discrimination	↔	Social justice, tolerance, integration
	Social and gender inequalities	↔	Social and gender equality
	Exposure to war or disaster	↔	Physical security and safety

Public health approach: recognising intersectional inequalities

People in more marginalised communities can experience less access to protective factors to overcome adversity, leading to a higher risk of a negative social health outcome due to adverse childhood experiences. Public Health Wales has undertaken specific research in this area looking at the experience of refugee and asylum-seeking children as well as the impact of violence on migrant, asylum-seeking refugee women and girls. COVID-19 has exacerbated the inequality of access to support in these communities, as they often rely on community led support based on trust established through face-to-face contact. Public Health Wales worked with the Wales Strategic Migration Partnership and Jahee to produce a leaflet in six languages to provide information about where to access support[12].

Poor physical health is a risk factor for poor mental health and well-being. In addition, there is a growing evidence that the "social and material conditions of daily life act through the mind to affect well-being and health"[13], i.e. that poor mental health and well-being can have consequences for physical health (see Figure 1 below).

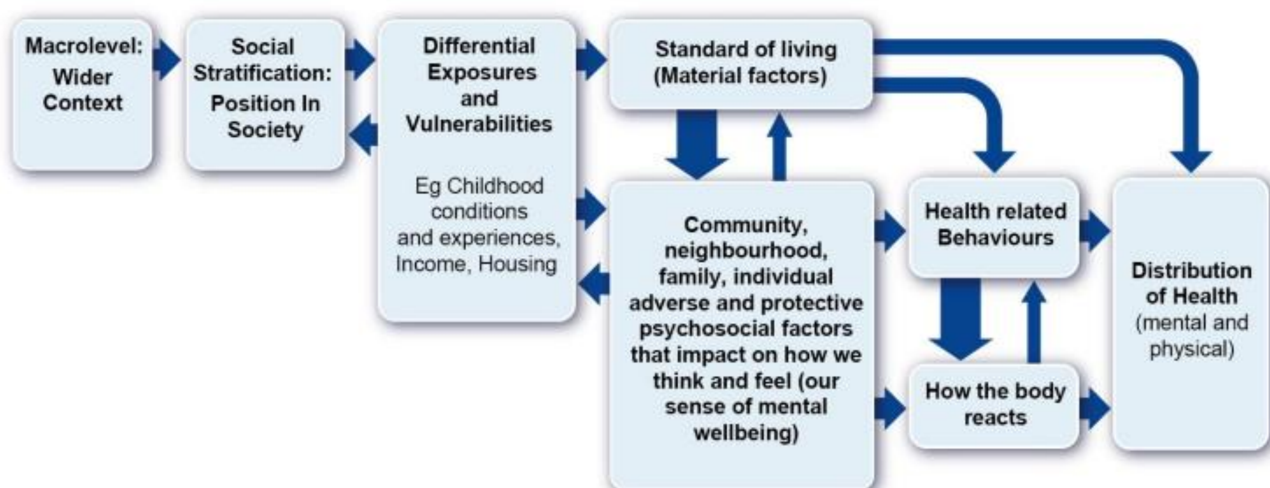

Figure 1: Psychosocial pathways to physical and mental health inequalities (from PHE, 2017)[14]

3.2 A life-course approach to understanding and addressing mental health inequalities

The interaction between mental health and well-being and the underlying factors that can contribute to it can have compounding affects across the life-course. For example, mental health inequalities can drive physical health inequalities and affect wider social outcomes, such as poorer educational attainment and a lack of participation in work, which can further, negatively impact on mental health and well-being.

A life course approach can provide a framework for understanding and addressing the root causes of inequalities, where there are opportunities at different stages in life to promote mental well-being and for interventions to support people and reduce adverse impacts on mental health (Faculty of Public health / Mental Health Foundation 2016).

About 50% of lifetime mental illness starts before the age of 14 and 75% of lifetime mental illness starts by the mid-twenties[15], making investment in childhood and adolescence fundamental to tackling mental health inequalities across the population for the long term[16].

Action is needed across the life-course, encompassing early years, children and young people, adults and older adults. Within this, there is a consensus that giving every child the best

possible start in life, including through support for parents, is fundamental to addressing inequalities in mental health[17].

Public health approach: focus on the First 1000 Days

Social and emotional development in the early years builds the foundation for future mental well-being across the life-course. There is strong international evidence indicating that the first 1000 days – during pregnancy and up to a child's second birthday - is a critical time. Positive influences can have a lasting impact and improve outcomes across the life-course, while susceptibility to negative influences means that the origins of many inequalities in health lie in early childhood and before birth[18][19].

Infant mental health describes the development of a child's ability to experience, express and regulate emotions during the first 1000 days. Focussing our efforts on improving infant mental health is an example of taking a life-course approach to reducing inequalities and provides an opportunity to improve the mental health of a generation. Central to achieving this is giving children the opportunity to live and grow up in supportive and nurturing environments that build secure parent-child attachment.

Poor parental mental health can have a significant impact on children's development, health and well-being[20]. It is estimated that perinatal mental illness affects up to 1 in 5 new mothers, and that women from deprived areas and some ethnic minority groups are more at risk[21]. Health Visitors and Midwives play an important role in supporting parents with poor mental health and the development of secure parent-child attachment. However, to optimally tackle inequalities in outcomes these universal services need to be enabled to work flexibly and provide early intervention through additional visits (enhanced universal provision) when families as experiencing increased need.

In addition to parental mental health, work by the First 1000 Days programme at PHW specifically highlighted the importance of adopting a public health approach to parenting support[22]. Social, economic and structural factors can impact on parents' capacity and capability to thrive in their parenting role and support their child to have the best start in life. Action on these factors represents the next key step for reducing inequalities and improving outcomes in the first 1000 days and, as a result, across the life-course.

Public health approach: trauma and ACE informed organisations

The Adverse Childhood Experiences (ACE) Support Hub is funded by Welsh Government and hosted by PHW[a]. It has established a centre of excellence for preventing ACEs, mitigating their impact and supporting those who have experienced ACEs and trauma. The Hub is looking to scale up this approach through collaboration with Traumatic Stress Wales to develop a Wales National Trauma Framework.

There is a need to understand the impact of ACEs and trauma across the life-course, for all ages, including the links to the wider determinants of health and opportunities to access protective factors at an individual, organisational and systems level. The Framework, and practical interventions such as the ACE Support Hub TrACE Toolkit, will help identify sources of resilience and to support peoples' access to them, based on need, and cognisant of historic, cultural and gendered experience.

One example of what has been shown to deliver positive change in this area is the research and development of trauma-informed approaches in Wales. This has included a literature review of trauma-informed terminology; the development of an animation to explain ACEs and trauma; and collaborative work with further and higher education and substance misuse services to develop Trauma and ACE informed organisations.

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[a] More information about ACE Aware Wales can be found through their website: https://aceawarewales.com

4. Inequalities in mental health and well-being in Wales

Q1: Which groups of people are disproportionately affected by poor mental health in Wales?

Evidence tells us that mental and substance use disorders are the second largest cause of "Years Lived with Disability" in Wales[23]. There is also evidence to show that some people, communities and population groups within Wales are more likely to experience poor mental health and well-being than others. Unfortunately, the data available only offers snapshots, rather than a comprehensive picture of the situation in Wales.

Whilst there is overlap in the risk factors for low mental well-being and mental health problems, there are some distinctions. The list below gives an overview of population groups that have been identified through a number of studies to experience inequalities in mental health problems specifically[24][25][26]. Here we use this as indicative of who may be at increased risk alongside selected examples of evidence of the mental health and well-being inequalities experienced by these groups in Wales.

- **Socio-economic status**: People living on a low income, including children living in low income families; people in debt, living in fuel poverty, or poor quality housing; people who are unemployed; people living in rented or social housing; and people who are homeless or at risk of homelessness.
    - In Wales, more than double the number of adults over 16 self-reported at least one mental health disorder in the most deprived fifth of the population compared to the least deprived in 2019/20[27].
    - Between 2014 and 2018, people living in the most deprived fifth of communities in Wales were almost twice as likely to die by suicide than in the least deprived (15.0 in 100,000 versus 8.5 in 100,000 people)[28].
    - About one in four children aged 11-16 with low family affluence in Wales rate their life satisfaction below 6, compared to only one in 10 of those with high family affluence[29]; and nearly 10% fewer children aged 11-16 with low family affluence felt they had the emotional support they needed from their family when compared with those with high family affluence[30].
    - Life satisfaction is much higher in adults over 16 in Wales if they are in employment[31].
- **Gender:** Women are more likely to experience common mental health problems and are specifically vulnerable in the perinatal period, with suicide being a leading cause of maternal mortality in a child's first year of life[32]. Men are more likely die from suicide, and have higher rates of substance misuse problems.
    - In Wales, the male suicide rate for 2020 in Wales was 16.7 per 100,000 compared to the female suicide rate of 4.3 per 100,000[33].
- **Ethnicity**: Ethnicity data is poorly collected in Wales. However, analysis has shown that Black, Asian and Minority Ethnic (BAME) groups living in the UK are:
    - more likely to be diagnosed with mental health problems
    - more likely to be diagnosed and admitted to hospital
    - more likely to experience a poor outcome from treatment
    - more likely to disengage from mainstream mental health services, leading to social exclusion and a deterioration in their mental health.
    - In Wales, BAME people are less likely to be referred by a GP for support despite this leading to higher percentages than average later being admitted to hospital with chronic mental health problems[34].
- **Sexuality**: Lesbian, gay, bisexual and transgender and questioning people (LGBTQ+).

    - In the 2019/20 Student Health and Wellbeing Survey in Wales, pupils who identified as neither a boy or a girl had lower well-being scores and higher loneliness scores than those identifying as either boys or girls[35].
    - A 2018 survey of 5,000 LGBTQ+ individuals across Wales, England and Scotland found that half (52%) had experienced depression in the previous 12 months and often faced discrimination in healthcare settings[36].
- **Physical health and disabilities**: People with long-term physical health conditions and disabilities. This includes people with autism, who are estimated to be 9 times more likely to die by suicide than the general population[37]. Adults in the UK with a disability report poorer average well-being than people without a disability across all four domains of well-being indicators[38].
    - 40% of Deaf people experience mental health problems, which is twice that of individuals in hearing populations. Wales is the only UK country that does not provide a clear pathway or service to meet the needs of Deaf people experiencing poor mental health[39].
- **Care settings**: Unpaid carers; older people in care homes; care experienced people (looked after children and care leavers)
    - Research undertaken by PHW shows poorer mental well-being of unpaid carers, which worsens with increasing intensity of care, and was affected by employment and education[40].
- **Abuse and violence:** People who have experienced Adverse Childhood Experiences; and people who have experienced violence, abuse or bullying.
    - Individuals in Wales with four or more ACEs are 6 times more likely to have ever received treatment for mental illness and 16 times more likely to have ever used illicit substances compared to individuals with no ACEs[41].
    - A Welsh Adverse Childhood Experiences Study showed that the prevalence of low mental well-being in adults increased with ACE count, rising from 14.2% of those reporting no ACEs to 41.1% of those with four or more ACEs. After adjustment for socio-demographics, the relationship between ACE count and low mental well-being remained with those experiencing four or more ACEs being nearly five times more likely (4.7) to have a low mental well-being than those with no ACEs[42].
- **Criminality**: Offenders and people in prison.

Another population group whose vulnerability to poor mental health and well-being in Wales are those in **farming**[43] **and fishing**[44] **communities**. Specific research by PHW describes how the recent uncertainty and change created by Brexit, in conjunction with challenges these communities were already facing, has increased feelings of anxiety, distress and a lack of control. This work highlights the need to help prevent and protect these communities from uncertainty as much as possible, and outlines approaches that work to promote improved mental health and well-being and build resilience. PHW has previously detailed the relationships between individual and community resilience; showing that strengthening resilience can have positive impacts on mental health and well-being, but the wider context plays a critical role[45].

4.1 Implications of the COVID-19 pandemic and future trends

During the COVID-19 pandemic, a number of the factors linked with increased vulnerability to poor mental health have been exacerbated or exposed, and this has been borne out by people's experiences. Qualitative evidence suggests that during the pandemic, vulnerability rapidly

arose, and was typically found to cluster together and be patterned along pre-existing lines of social inequality[46].

Analysis in Wales suggests that young people, women, those on lower incomes and people from Black, Asian and ethnic minority backgrounds experienced a disproportionate impact on their mental health during the pandemic up to March 2021[47]. In particular, residents in Wales from Black, Asian and ethnic minority groups were more likely to feel very anxious and isolated, worry a lot about their mental health and worry a lot about losing their job than White residents during lockdown.

Analysis in May 2021 of evidence gathered by PHW through it's 'How are we doing in Wales?' surveys during the pandemic revealed that[48]:

- More than 4 in 10 adults (42%) say their mental health is worse now than it was before the pandemic, equivalent to over 1 million people. Females and younger adults were more likely to report that their mental health had worsened.
- The proportion of adults worrying 'a lot' about their mental health and well-being rose from 13% in May 2020 to 31% in January 2021. Worry about mental health and well-being was greater in residents of more deprived communities, females and younger age groups.
- When asked in January 2021 whether, in general, the last 6 months of lockdown and other coronavirus restrictions had affected their quality of life, 22% of people said no, while 76% said it had made their quality of life worse and 3% said it had made it better[49].

The increased worry and anxiety experienced during the pandemic is likely to have impacted on sleep quality, another key influence on mental health and well-being[50].

Those who were asked to shield during the pandemic were more likely to have previous recorded history of mental health condition, and were more likely to seek treatment for mental health condition during the pandemic[51]. Further research is underway on the specific impact for children who were asked to shield, or live in shielding households.

Children and young people have also been disproportionately impacted by the COVID-19 pandemic, with poor mental health being identified as a significant risk factor in a recent report by the Violence Prevention Unit in Wales[52]. A Mental Well-being Impact Assessment of the impact of the pandemic on young people aged 10-24 is also due to be published shortly by PHW.

Healthy Working Wales commissioned research with employers across Wales in 2021 to discover the impact of the COVID-19 pandemic[53]. A key finding was that 'absences due to mental health issues and the long-term effect of COVID-19 on mental health was the largest concern for employers', 'despite individuals not often reporting issues'. The 2021 research found that employers felt the pandemic had exacerbated employee mental health issues in a number of ways, for example: anxiety, depression and low morale due to isolation, burnout and worries over job security.

The COVID-19 pandemic also demonstrated the unequal access to fair, work, compounding previous issues and raising new ones; some have been particularly affected, such as young people, older people, those from disadvantaged backgrounds, women, especially mothers, and ethnic minority groups.

Modelling analysis suggests that rising unemployment, without reparative interventions, could lead to the percentage of adults with mental health problems in Wales increasing gradually over 2020-2023 from 7.9% in 2019/20 to 10.9% in 2022/2[54].

The inequalities in engagement in childcare and education by children and young people, as well as the economic consequences of the pandemic, are likely to have long-term implications for mental health and well-being in Wales and across the UK[55].

A key issue on the horizon, that is already likely to be impacting on the mental health and well-being of people in Wales, is the 'cost of living crisis'. The impacts of increased energy prices, and the knock-on effects of this as well as inflation, is making it harder for people to keep their homes warm or purchase enough, healthy food for themselves and their families, among other impacts. These factors on their own would have negative impacts on mental health and well-being but will be further exacerbated by the stress and anxiety that comes with financial uncertainty[56]. Children living in poverty, people already on low incomes, and/or living in food and fuel poverty, will again be the worst hit after having also been exposed to some of the worst impacts of the COVID-19 pandemic, as set out above.

Other future trends and events that are likely to impact significantly on inequalities in mental health and well-being in Wales are climate change, population change and the changing nature of work. This is explored in more detail in a recent report jointly commissioned by PHW and the Future Generations Commissioner[57]. PHW is also due to publish a Health Impact Assessment on climate change that will highlight how people, particularly children and young people, are already experiencing negative impacts on their mental health and well-being due to anxiety and a perceived lack of agency.

5. Inequity in mental health services

Q2: For the groups identified, what are the barriers to accessing mental health services? How effectively can existing services meet their needs, and how could their experience of using mental health services be improved?

In addition to inequity in Wales in the underlying causes of poor mental health and well-being, there is also likely to be inequity in access, experience and outcomes of Welsh mental health services. In terms of access, for example, there is evidence that certain population groups may be less likely to seek out support because it does not meet their social, cultural, religious or linguistic needs. Alternatively, they may have inappropriate assumptions made about the care they need based, for example, on their race[58].

Once someone is receiving a service, it is not guaranteed that the way the service has been designed or delivered will ensure that they are as likely to benefit from it, or have as good an experience, as others. To address this it is vital to work with service users with lived experience and, in particular, those who are known to experience inequity, to co-design services and improve accessibility. The same co-design and community empowerment approaches should also be used to enable ongoing evaluation and improvement of mental health services. This reflects the aims of the Quality & Engagement Act, which will come into force in April 2023.

Research from PHW has highlighted variation in the use of mental health services among specific groups. For example, looking at mental health crisis events within acute healthcare services for children and young people, we have found a sharp linear social gradient, with those living in the most deprived areas being twice as likely to have a mental health crisis event in acute care than those living in the least deprived areas[59].

To place these findings on inequalities in access to mental health services in the wider context of mental health needs and outcomes, more detailed, person-level linked data across services, including community care, is needed. The fact that a mental health core data set for community services is being developed is welcome. But more action is needed to link data from across the healthcare system so that the impact of services and policies aimed at tackling mental health inequalities can be evaluated (see section 6).

Public health approach: community engagement & empowerment to improve service design and accessibility

Empowerment is more than the involvement, participation or engagement of communities[60]. Empowerment aims to enable people to take control of the actions and decisions that affect their lives[61]. Community empowerment that initiates greater individual and collective control is health promoting in its own right[62][63]. We know that empowerment also improves social relationships at the individual and population level[64], and improves service development and delivery[65].

Power is often referred to as the degree of control that individuals and communities have over their own lives. The amount of power that people feel they have is influenced by a wide range of factors, such as access to money, good education, good work, social status and availability of social support networks. Those experiencing poor mental health and well-being linked to these factors are therefore likely to also feel powerless. It is for this reason that to address inequalities in mental health and well-being it is necessary to work at altering the power imbalance that exists between an organisation, its professionals and its service users. PHW has developed 'Principles of Community Engagement for Empowerment' to support this approach[66].

A crucial element of empowerment is to enable people to communicate in the way that is most useful to them. PHW has championed this approach in a number of ways, including: PHW has also

- Ensuring publicly available information on COVID-19 was provided in a variety of formats including, for the first time, the widespread use of Easy Read formats[67].
- Promoting a British Sign Language version of ACTivate your life - a free online course to support mental well-being[68].
- Promoting an awareness of cultural competence and unconscious bias when proving mental health support[69].
- Ensuring that all specialist resources are available in Welsh, e.g. Improvement Cymru's Guided Self-help Booklet Series[70].

6. What further action is needed?

Q3: To what extent does Welsh Government policy recognize and address the mental health needs of these groups? Where are the policy gaps?
Q4: What further action is needed, by whom/where, to improve mental health and outcomes for the groups of people identified and reduce mental health inequalities in Wales?

Addressing inequalities in mental health and well-being requires a focus on the full spectrum of public health approaches including: acting on the determinants of mental health inequalities, promoting mental well-being, preventing future mental health problems and recovery from mental health problems[71][72].

It also needs to be considered in the context of overcoming an historic lack of focus on this topic within research, population health surveillance, health care policy, workforce development, and health services provision[73][74][75]. Achieving parity of esteem in Wales between physical health and well-being and mental health and well-being would be a significant step forward.

In this response, we have sought to identify specific examples of public health approaches to support tangible action on tackling inequalities in mental health and well-being. These include:

- Taking action on, and account of, the social, economic and environmental factors that influence mental health, well-being and inequalities (the wider determinants of health) and how they can interact with each other, and other factors such as discrimination, stigma and poor physical health, to have a cumulative, negative impact (intersectional inequalities).

- Taking a life-course approach, recognising the vital importance of the early years, children and young people, adults and older adults, with a focus on prevention, early intervention and resilience.
- Actively engaging and empowering communities in order to shift the power dynamic that drives inequalities, and re-orienting services to improve access, quality and equity.

Two additional, overarching public health approaches also require further action:

- Improving population-level data collection to support the design and evaluation of services and policies to ensure they are focused on prevention, meet need and deliver the intended outcomes;
- Embedding consideration of impacts on mental well-being as part of policy and investment decisions (Mental Health and Well-being in All Policies). This can be supported by implementation of the forthcoming health impact assessment regulations attached to the Public Health (Wales) Act 2017.

A broad range of current policy agendas in the Programme for Government provide opportunities to address inequalities in mental health and well-being, including the economic and education recovery programmes, climate change and nature recovery, socio-economic duty, investments in housing and tackling homelessness. Adopting a "Mental Health and Well-being in All Policies" approach across government would enable upstream action to ensure that policies across all sectors have maximum equitable positive impacts on mental health and well-being and avoid widening inequities.

We would hope and expect, given that they share many underlying causes and interactions, that significant progress on reducing mental health inequalities would also significantly reduce health inequalities in the round.

Public health approach: population-level data collection

Alongside input from service users, high quality data on population mental health and well-being is essential for directing investment, and designing and evaluating policies, interventions and services in an evidenced based way to ensure proportionate investment relative to need[76]. Currently, effective policy responses to improving mental health and reducing inequalities in Wales are impeded by significant gaps in high quality and timely population data including:

- Community epidemiological surveys to identify: up to date prevalence data on the full range of conditions that affect mental health (e.g. anxiety, depression, PTSD, bipolar disorder etc.) across the life course; factors associated with higher risk of mental health problems; and demographic inequalities in who is receiving treatment
- Data on utilisation, experience and outcomes of mental health services across primary and secondary care (across the life-course), that enables analysis of equity of access and outcomes for example, by gender, age and ethnicity.

We welcome the development of a mental health core data set for community services as well as ongoing work to improve demographic monitoring and outcome data collection in Mental health services[77]. But in order to have a data-informed, public health approach to service design and evaluation, more action is needed to collect data on mental health service use and outcomes and to link that data with other information from across the healthcare system.

Public health approach: mental health and well-being in all policies

Reducing inequalities in mental health requires action by the whole of government and across all sectors. It is important that all policies across all sectors ensure that their programmes do not widen inequities and consider how they can be reduced[78].

Mental Health in All Policies (MHiAP) is a systematic approach "to promote population mental health and well-being and reduce inequalities by initiating and facilitating action within different non-health public policy areas". It also "reinforces the accountability of (all) policy-makers for mental health impact"[79].

Mental Well-being Impact Assessment provides a comprehensive framework to support MHiAP by systematically assessing the impact of policies, programmes and projects on the protective factors for mental well-being (control, resilience and community assets, and participation and inclusion), social determinants, and population groups at risk of poor mental health[80]. This leads to recommendations and actions to maximise positive impacts, prevent or mitigate negative impacts and identify ways to measure and monitor the impact on population mental health and well-being.

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Agenda Item 5

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

Document is Restricted

Mind Cymru's response to the Health and Social Care Committee's Inquiry into Mental Health Inequalities

About Mind Cymru

We welcome the Health and Social Care Committee's inquiry into mental health inequalities as one of the most immediate and pressing issues within mental health currently.

In our strategy[1], launched in 2020, becoming a truly anti-racist organisation, supporting young people and fighting for people in poverty are three key priorities for us as an organisation. These are all groups who are subject inequalities in their experiences of poor mental health.

We have been developing our evidence base in these areas and our submission focuses on what we know or have specific expertise in. It is not an exhaustive exploration of all inequalities so it does not mean that we do not believe or feel inequalities experienced by other communities not mentioned in this response are not relevant, important or should not be addressed with urgency.

We believe it is also important to recognise in the context of this inquiry, experiencing poor mental health or receiving support for our mental health has an unequal impact on our lives. Those of us with a mental health problem are more likely to experience long term physical health conditions, have lower life expectancy, live in poverty, be excluded from education and/or employment and experience stigma. Whilst we will not be specifically addressing this point in our response it is important for the Committee to recognise that our starting point is already one of inequality,

[1] https://www.mind.org.uk/about-us/our-strategy/

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> "I begged a GP for help I told him I've been back and forth for 11 years I think it's more than depression. I begged him to send me to a psychiatrist he said no point he will tell you you're depressed like I did. I said please do it anyway he said he would. 2 months down the line I'm in dire need of some help so calls the Dr back to find out he did not refer me and I now have to wait again for the process of referral absolutely appalling."

Overview

Mental health inequalities, both in terms of access to support and experience, is one of the most urgent mental health issues in Wales. Our evidence clearly identifies that there are communities within Wales who have an unequal experience of poor mental health and have more barriers to accessing timely, effective support. Despite Welsh Government strategy clearly stating that tackling inequalities is central to its delivery, we have not seen this translate into widespread improvements.

If you are young, from a Black or ethnic minority background or live in poverty, you are more likely to experience challenges accessing support for your mental health. This is not acceptable, as access to support for your mental health is a universal human right, including for children and young people under the United Nations Convention on the Rights of the Child. There is a need for collective leadership at all levels to ensure those of us with a mental health problem are supported in all aspects of our lives that may impact on our condition with the joint goal of eliminating mental health inequality.

We would expect any future Welsh Government strategy to strongly focus on and ensure investment is available for tackling these deep seated inequalities in the coming years.

1. Which groups of people are disproportionately affected by poor mental health in Wales? What factors contribute to worse mental health within these groups?

As with our physical health, there are many determinants in our lives which influence our mental health, such as having a safe and secure place to live or growing up in poverty. Inequalities in

experiences of poor mental health must be considered within the context of the impact of these wider determinants.

The impact of Covid-19 pandemic

The coronavirus (Covid-19) pandemic has had a significant impact on the nation's mental health, whilst exacerbating and compounding pre-existing inequalities. It is important to note that in many cases the pandemic of the last two years did not cause these inequalities, they have been present in systems and our communities for some time.

Our evidence to the previous Health & Social Care Committee's inquiry into the impact of Covid-19, and its management on health and social care provides evidence on the overall impact of the pandemic, including its impact on existing inequalities. Additionally, Mind Cymru has published two research reports on the impact and consequences of the pandemic on mental health in Wales, which may provide further contextual evidence relevant to this inquiry.[2]

> "I suffered with anxiety and mild depression in 2017, but had received therapy and was coping well before March 2020. Since the pandemic began these symptoms have returned. I was put on furlough and the time spent alone with my thoughts with no distraction has been very damaging."

Evidencing mental health inequality

Understanding inequality of access within mental health services in Wales is severely impaired by limited availability of demographic data. This has long been a significant challenge and was raised in multiple inquiries by both the Health & Social Care Committee and Children and Young People Committee during the previous Senedd term.

Delays to the development of a Mental Health Core Dataset (MHCDS) and an outcome framework means it is not possible to fully assess access to and experiences of mental health services by

[2] https://www.mind.org.uk/media-a/6176/the-mental-health-emergency-wales-summary-report-english-1.pdf & https://www.mind.org.uk/media/8961/the-consequences-of-coronavirus-for-mental-health-in-wales-final-report.pdf

demographic groups. This issue has previously been highlighted by both the Equality & Human Rights Commission and the Socioeconomic Subgroup of the First Minister's BAME Covid-19 Advisory Group:

> "There are clear gaps in the data in Wales that make it difficult to understand the experiences of people sharing all protected characteristics. There is a particular lack of data broken down by the protected characteristics of sexual orientation, gender reassignment, religion or belief, and race. There is also a lack of disaggregated data on health outcomes.[3] – EHRC , 2018

Despite a lack of date what is available points to clear inequalities in experience of poor mental health in certain communities. For example, we know that:

- People from racialised communities are more likely than White people to be referred to mental health services via 'involuntary' routes including justice and social services, than they are through 'voluntary' routes such as their GP.[4]
- In June 2020, people from racialised communities in Wales reported on average more than 4.1 problems associated with mental distress on the GHQ-12 score[5], whilst White British individuals reported 2.7, a difference of 55% in relative terms.[6]
- Public Health Wales found racialised communities in Wales reported higher levels of anxiety, feeling isolated and worrying a lot about their mental health. They were also more likely to be worrying a lot about their job and finances[7]

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[3] Is Wales fairer? EHRC, 2018. https://www.equalityhumanrights.com/sites/default/files/is-britain-fairer-2018-is-wales-fairer.pdf
[4] https://pubmed.ncbi.nlm.nih.gov/30768415/
[5] The GHQ-12 score is a widely used measure to assess the severity of a mental health problem. The indicator reflects reported symptoms such as difficulties with sleep, concentration, problems with decision making, strain, and feeling depressed and overwhelmed. Scores range from 0 to 36, with higher scores indicating worse conditions.
[6] https://www.cardiff.ac.uk/__data/assets/pdf_file/0010/2533762/COVID-19-Mental-health-FINAL-08-07-2021.pdf
[7] https://phw.nhs.wales/topics/latest-information-on-novel-coronavirus-covid-19/how-are-you-doing/how-are-we-doing-in-wales-reports/how-are-we-doing-in-wales-a-focus-on-ethnicity/

- Analysis published by WalesOnline of the Mental Health Act s.135/136 dataset found that in 2020 Black people in Wales were almost three times more likely than White people to be detained by police under Section 135 and 136 of the Mental Health Act.[8]
- More than a quarter of young people in Wales do not feel like they have mental health support at school.[9]
- Young people experienced the largest deterioration in their mental health at the beginning of the pandemic. The average GHQ score among those aged 16-24 in November 2020 rose by 3 points, or 24%, relative to the pre=pandemic period.[10]
- Nearly one-third of 16–24-year-olds in the UK (31%) reported some evidence of depression or anxiety in 2017 to 2018; this is an increase from the previous year (26%) and the same period five years earlier (26%).[11]
- Waiting times within Local Primary Mental Health Support Services are significantly and consistently longer for children and young people than for adults.
- More than twice as many people in Wales (aged 16+) experience mental health problems in the most deprived quintile (16%) than the least deprived quintile (7%).[12]
- Young people in the lowest income bracket are 4.5 times more likely to experience severe mental health problems than those in the highest.[13]
- The mental health gap between the lowest and highest income quintiles has widened significantly during the pandemic. The average GHQ-12 score in November 2020 for the lowest income quintile increased by 39% compared top pre-COVID19 period. In contrast, the highest income earners only experienced a deterioration in their mental health of 0.6 point (or 6.5%) over the same period.[14]

[8] https://www.walesonline.co.uk/news/wales-news/black-people-continue-disproportionately-targeted-20749767
[9] https://phw.nhs.wales/news/new-profile-looks-at-mental-wellbeing-in-wales/
[10] https://www.cardiff.ac.uk/__data/assets/pdf_file/0010/2533762/COVID-19-Mental-health-FINAL-08-07-2021.pdf
[11] https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/youngpeopleswellbeingintheuk/2020
[12] https://statswales.gov.wales/Catalogue/National-Survey-for-Wales/Population-Health/Adult-general-health-and-illness/genhealthillness-by-wimddeprivation
[13] https://eur02.safelinks.protection.outlook.com/GetUrlReputation
[14] https://www.cardiff.ac.uk/__data/assets/pdf_file/0010/2533762/COVID-19-Mental-health-FINAL-08-07-2021.pdf

- On average, women in Wales exhibited worse levels of mental health after the onset of the pandemic, with the gap between reported wellbeing between men and women increasing from 9.9% to 14.1%.[15]

Finally, it is important to note that there is no routine, reliable and comparable measure of the prevalence (both treated and untreated) of mental health problems within the Welsh population. As a result, the true scale of mental health problems, inequalities between groups and changes overtime remains unclear. The absence of such a measure may also be masking inequalities and at risk-groups.

Racialised communities

Experiences of racism and discrimination can have a lasting and damaging impact on our mental health. This is supported by considerable research evidencing the links between experiencing discrimination and poor mental health: including depression,[16] anxiety and psychological stress,[17] and post-traumatic stress disorder (PTSD).[18] These issues were reflected in responses to the Welsh Government's Race Equality Action Plan[19].

Our research, carried out in 2020, showed that existing inequalities in housing, employment, finances and other issues have had a greater impact on the mental health of people from racialised communities than White people during the coronavirus pandemic.[20] The findings reflect data from participants in both Wales and England who were aged 25+ and identified as Black, Asian or minority ethnic (just under 5% of the 14,421 adults who completed our survey):

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15 Cardiff University (2021) Covid-19 in Wales: the mental health and wellbeing impact

16 The impact of gender discrimination on a Woman's Mental Health

17 Racism as a Determinant of Health: A Systematic Review and Meta-Analysis

18 The impact of discrimination on the mental health of trans*female youth and the protective effect of parental support

19 https://gov.wales/race-equality-action-plan-anti-racist-wales

20 https://www.mind.org.uk/media-a/6176/the-mental-health-emergency-wales-summary-report-english-1.pdf

- Problems with housing (30% of racialised people said this made their mental health worse vs 23% of White people), their job (61% vs 51%) their financial situation (52% vs 45%), difficulty getting physical health support (39% vs 29%) and caring for someone else in the house (30% vs 23%) disproportionately affected mental health for racialised communities.
- Racialised people are much more likely to want advice about money and benefits (40% vs 24%) and housing (19% vs 10%) to help manage their mental health.

This insight demonstrates the importance of considering the way in which experiences of multiple inequalities weave together to impact on our mental health. It is important that social issues are addressed alongside the particular mental health issue a person may be presenting with.

There is also the need to take into account specific stressors for some people within these communities, such as the experience of the immigration system. This includes having uncertainty over their status and experiences of seeking asylum or refugee status, including the journey to Wales from their home country. Those seeking asylum or refugee status often have a specific and complex experience of trauma that needs to be understood and tailored support needs to be provided in order to help begin to rebuild lives in Wales.

Children and young people

We know that adverse childhood experiences, particularly those in early childhood, significantly affect our mental health long into adulthood. However, unequal access to mental health services for children and young people has been an issue for many years. At all points in the system there are challenges for children and young people in accessing timely mental health support and broadly the picture in terms of access to support from mental health services has not improved quickly enough during the lifetime of the current Together for Mental Health strategy.

Many of the issues have been well established by the previous Senedd's Children, Young People and Education Committee's 'Mind Over Matter' report[21]. This was further built upon by the Wales Youth Parliament's own report entitled 'Let's Talk About Mental Health'[22]. Taken together these reports provide a clear story of inequality and a call to urgently improve the support provided to children and young people.

[21] https://senedd.wales/laid%20documents/cr-ld11522/cr-ld11522-e.pdf
[22] https://youthparliament.senedd.wales/our-work/emotional-and-mental-health-support/

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> "I have suffered with my mental health since I was 15, I wasn't taken seriously until I was 32, I was only offered tablets absolutely nothing else. I didn't even realise there was so many treatments available"

Experiences of poverty

The Money and Mental Health Policy Institute has published a range of reports highlighting how both experiencing financial hardship can lead to poor mental health but also that having poor mental health can make it harder to manage financial issues. This creates a vicious circle for many of us with a mental health problem.

Their report 'The State We're In' published in November 2021 highlighted how those of us with a mental health problem were at a higher risk of experiencing financial hardship during the pandemic when compared to the wider population. It found that people with a mental health problem were:

- Three times more likely to have fallen into problem debt than the wider population (15% compared to 4%).
- More than twice as likely to have relied on credit or borrowing to cover every day spending — for example, on food or heating (26% compared to 11%).
- More likely to have had zero savings to help them cope with emergencies. 1 in 4 people with mental health problems say they have no savings that they could use in emergencies (compared to 18% of the wider population), and nearly half (46%) say they can't afford to save money regularly.

The pressure, worry and stress of living on a low income, managing benefits, living in poor quality housing, being homeless or experiencing periods of unemployment can have a profound impact on our feelings of self-worth and wider mental health. The well-publicised concerns around the increasing cost of energy and other basic items will only further exacerbate this issue. Most mental health organisations have experienced an increase in people seeking support for managing their finances during the pandemic, some of whom are seeking help for the first time.

Women and girls

Women and girls face inequality and discrimination both in their daily interactions and through systems and institutions, which have often been designed around a male service-user by default, and can sometimes be male dominated.

Experiences of sexism and misogyny are often compounded by a woman or girls' intersecting experiences of discrimination on the grounds of their ability, age, class, ethnicity, gender identity, race, religion and sexual orientation - including racism, homophobia and transphobia.

The links between violence and abuse and poor mental health are unambiguous. UK wide research by Agenda shows that over half (54%) of women with extensive experience of physical and sexual violence meet the diagnostic criteria for at least one mental health condition and are also more likely to have multiple with about one in seven (15%) having three or more. Over a third (36%) of women in the extensive physical and sexual violence group have made a suicide attempt, and a fifth (22%) have self-harmed. One in ten (9%) have spent time on a mental health ward.[23]

Trauma can sometimes directly cause mental health problems or make someone more vulnerable to developing one. Some conditions are also known to develop as a direct result of trauma, including post-traumatic stress disorder (PTSD) and complex post-traumatic stress disorder (complex PTSD).

Whilst there have been developments in perinatal mental health support for prospective and new mothers, there remains some issues in providing support, namely the lack of progress on development a Mother and Baby Unit in north Wales despite ongoing discussions.

2. For the groups identified, what are the barriers to accessing mental health services? How effectively can existing services meet their needs, and how could their experience of using mental health services be improved?

Experiences of stigma

Whilst progress has been made in tackling stigma, many of us who experience mental health inequalities also experience higher levels of stigma from others as well as displaying self-stigmatising behaviours when considering our own mental health.

[23] Agenda (2016) Hidden Hurt

Time to Change Wales, the national anti-stigma campaign delivered by Mind Cymru and Adferiad Recovery and funded by the Welsh Government, has been at the forefront of tackling stigma for a number of years. In its most recent phase, the campaign sought to engage with Black and minority ethnic organisations, recruiting champions from these communities, in recognition that there was a need for more targeted, culturally informed support for communities in order to start a conversation about mental health that was both safe and informed. This has built upon work that Time to Change Wales has undertaken in more deprived communities, with many of the issues being similar.

Tackling stigma is important as it prevents people from seeking help at an early opportunity and can then lead to a deterioration where more intensive support is needed. Through tackling stigma we can help create a culture whereby all communities feel it is ok to talk about mental health and which actively encourages people to seek help and support.

Equally, during the pandemic Time to Change Wales reported an increase in people experiencing self-stigma[24]. This is where we seek to minimise our mental health as we believe there are bigger issues we or others are facing. This leads to neglecting the signs that we need support, even if it is just to talk to someone about our feelings and emotions.

> "Before March 2020, I had anxiety and depression. The past year has intensified those feelings. Perhaps I should contact my GP surgery, but I don't want to add to their already overburdened workload"

This reflects the experiences of several local Minds in Wales who work in and with communities that experience high levels of deprivation. Their reflections include the need to encourage a conversation about mental health and have safe spaces for people to speak about their experiences. This would help to tackle the level of exclusion that communities feel and experience, whether this is financial, social or digital.

Ystradgynlais Mind have been delivering Mental Health First Aid to rugby clubs in their area under the #ItTakesBallsToTalk campaign (which is delivered by a number of other local Minds as well). This utilises the environment of the rugby clubs, where there is a feeling of familiarity and safety, to start

[24] https://www.timetochangewales.org.uk/en/about/news/increase-self-stigma-amongst-those-suffering-mental-health-issues-covid-19-lockdown/

a conversation about mental health and how those participating can support each other. This has led to a range of conversations, which have gone beyond the formal training and have begun to create a culture where it is normal to talking about your mental health and peers are comfortable in listening and supporting.

Trust in services

We have heard from both racialised communities and those living in poverty that they do not feel mental health services are for them. This is a complex barrier that involves support being consistent, accessible and responding to the needs of people. For racialised communities it also means having a workforce that reflects them and their experiences. It has been highlighted that having to explain time and again experiences of discrimination, trauma, racism and specific cultural/community dynamics can be retraumatising and lead to feelings that the support available is unable to meet their needs.

"I have to explain to the therapist, my culture, and the nuance of my culture before I start speaking about what bothers me" Time to Change Wales participant[25]

Utilising the knowledge and trust that community organisations have built is an important way in which some of these issues can be addressed. They can act as a bridge to support people to identify support that may be appropriate as well as providing direct support themselves.

As an example, Neath Port Talbot Mind have been working with Neath Port Talbot BME Community Association to build connections and provide pathways to support for ethnic minority communities within the area. At the heart of this partnership has been the desire from both organisations to learn from each other, build trust, listen and be responsive to the needs of communities. Both organisations have recognised the strengths and knowledge they bring to the partnership, enabling workshops to take place to better understand experiences and what needs to be done to improve support.

More can be done to work with community organisations, the mental health voluntary sector and statutory partners to support community led initiatives to raise the profile of mental health and

[25] https://www.timetochangewales.org.uk/en/about/news/watch-our-stigma-symposium-2021-event/

provide trusted pathways to support. This could be ensuring community organisations are supported to engage with training and opportunities to become involved in programmes such as social prescribing, to providing more sustained investment in outreach teams from Local Health Boards, which have been focussed on Covid response, to build and maintain partnerships.

Access to early support

This is an issue for all groups with support offers being seen as not suitable (racialised communities), inaccessible (people living in poverty) or simply not able to meet demand (children and young people).

It is particularly stark for children and young people. For example, waiting to receive an assessment for primary mental health support can be considerably longer than the 28-day target, while the same target is regularly met for adults. There is a need to provide a greater range of non-medicalising support for young people in the early stages of developing worries about their mental health. This has to be based around their needs and supports them to understand what they are experiencing alongside different ways to manage their mental health.

There are a number of programmes delivered by local Minds which have provided these groups with support from Mums Matter (a perinatal support programme that includes establishment of peer support networks), social prescribing (a link worker with specific mental health knowledge supports people to find advice and activities that can improve their mental health) and Active Monitoring (a Welsh Government funded, nationwide service providing people with structured 121 sessions to help begin to manage their mental health). The strength of these programmes is that they have been operating as GP referral or as a self referral service, enabling people to find help themselves. Programmes such as these, commissioned by statutory services and delivered by the local voluntary sector, build on trusting bonds already formed with communities and it has been positive to see local commissioners looking to invest in these programmes.

Non-health service support

As identified above many of the root causes of poor mental health lie beyond the remit of the health service. Experiencing poverty, lack of or insecure employment, racism and discrimination, poor quality housing or homelessness, all have a significant impact on our mental health. Creating a better and more consistent link between mental health services and wider community support is

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critical in addressing some of these issues. If we receive support for our mental health, but do not feel secure in our wider lives then it is highly unlikely that we will be able to focus on improving our mental health.

Programmes undertaken by Llanelli Mind with partner organisations have sought to support people who are at risk of becoming homeless, providing them with support to remain in accommodation as well as opportunities to train, develop new skills, volunteer in their local community and have someone to talk to if they need it. This type of support was described as life changing and demonstrates how focussing on the social factors in people's lives can improve mental health outcomes.

Taking a trauma informed approach

In order to effectively meet the needs of these communities it is essential that a trauma-informed approach be delivered across services. Trauma-informed practices understand and respond to the high prevalence of trauma and its effects, as well as understanding that experiences of trauma can lead to development of coping strategies and behaviours that may appear to be harmful or dangerous. This has been identified as being particularly important when considering mental health support for women and girls, but equally can be effective for other groups.

Access to community mental health resilience

In October 2020 Mind, along with the Co-op, Scottish Association for Mental Health (SMAH) and Inspire (Northern Ireland), published a report entitled 'Together Through Tough Times'[26]. The report explored what created mentally resilient communities in four different communities in each nation. We identified several factors that created resilience including having community hubs, an active local voluntary sector, an open culture around talking about mental health, safe public spaces, strong community connections and a strong community narrative of support. These factors being present within a community meant that there was a structure or framework that created a resilience that people were able to utilise to support their own mental health and that of others.

The report also identified those groups within communities that may struggle to access these pillars of community resilience and many of these groups were the same that experience mental health

[26] https://www.mind.org.uk/media/9426/togther-through-tough-times-main-report_en.pdf

inequalities, including ethnic minority communities, young people, people experiencing poverty and people who are unable to leave their house due to caring responsibilities, a disability or an acute mental health condition. This creates a triple impact for some of being more at risk of experiencing poor mental health, being unable to access timely, appropriate mental health support and then also feeling excluded from some of the protection factors within communities that can help build mental health resilience.

The important role played by this community framework and infrastructure should not be downplayed. During the last two years we have seen how communities have come together to support those that need it and foster a narrative of community support. This narrative and the leadership needed on a community level to foster, grow and ensure it is inclusive needs to be recognised if we are to tackle mental health inequalities. The report makes a series of recommendations for building, safeguarding and improving community resilience as well as tackling the barriers so that everyone can benefit from what their community can provide.

3. To what extent does Welsh Government policy recognise and address the mental health needs of these groups? Where are the policy gaps?

The Welsh Government's 'Together for Mental Health'[27] Strategy has tackling inequalities as a prominent theme. The strategy makes clear the ambition that:

- People with protected characteristics and vulnerable groups, experience equitable access and services are more responsive to the needs of a diverse Welsh population

The strategy references taking a human rights approach as well as recognising the United Nations Convention on the Rights of the Child (UNCRC) as a framework for delivering the high-level outcomes for the strategy. Despite this, we do not believe that enough has been put in place to make the ambition of the strategy a reality for people.

Mind Cymru has previously called on the Welsh Government to re-join the Adult Psychiatric Morbidity Survey (APMS) which 'provides data on the prevalence of both treated and untreated

[27] https://gov.wales/together-mental-health-our-mental-health-strategy

psychiatric disorder in the English adult population (aged 16 and over)'.[28] Wales last participated in the study in 2000. Alongside measuring prevalence, the survey also provides insights on access to mental health services and unmet need which would ensure services have adequate resources and capacity to meet local need.

There is also an urgent need for the Welsh Government to explore and put in place a system for monitoring the mental health of young people at a population level. The Children and Young People's Well-Being Monitor, which was highlighted in Together for Mental Health as a way in which progress will be measured, has not reported since 2015.

In recent years Welsh Government has taken a number of steps to address some of the issues around mental health inequalities. We welcome the establishment by the Welsh Government of a Task and Finish Group to look specifically at the experiences of Black, Asian and minority ethnic communities, with a focus on actions that can be quickly taken to address the issues identified. The group, with a membership drawn from a range of mental health and Black and ethnic minority organisations, has identified a number of key areas in relation to access and experiences and will be looking to report in the coming months.

The development of statutory guidance for a whole school approach to mental health alongside the amendment made to the Curriculum and Assessment Act to place a greater prominence for mental health in the design of curricula could create a step change in the support provided to all pupils in Wales. It is very positive that Welsh Government took these steps to improve this provision and now this must be delivered to meet the needs of pupils. Young people have consistently fed back to us that they want more time during the school day to discuss issues relating to mental health, without being medicalised for the feelings that they are having.

Equally, the development of the NEST/NYTH framework for early and enhanced support[29] provides an excellent opportunity to transform the support provided for all children and young people in Wales. The framework will be used by Regional Partnership Boards to determine what support should be available to all children and young people who need it.

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[28] https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014#highlights

[29] https://collaborative.nhs.wales/networks/wales-mental-health-network/together-for-children-and-young-people-2/the-nest-framework/

The recent announcement by Welsh Government of a further three years of funding for Time to Change Wales is particularly welcome as the focus for the coming years will be working with organisations and employers to tackle stigma in racialised communities and in more deprived areas.

Overall, the policy and strategic framework is in place to tackle mental health inequalities, but there needs to be a greater focus on ensuring that the strategic direction and actions result in tangible improvements for people seeking support or experiencing poor mental health. There is also a need to diversify the voices around the table at all levels, in policy development, local delivery and service design, to ensure that community needs are being met.

4. What further action is needed, by whom/where, to improve mental health and outcomes for the groups of people identified and reduce mental health inequalities in Wales?

Mental health inequalities cannot be seen or tackled as solely an issue for our health services, it needs to be recognised across Welsh Government and public sector delivery in a range of activities. To this end there are a range of actions we would want to see developed:

- The successor strategy of Together for Mental Health to again make tackling mental health inequalities a priority, with urgency and time limited actions. This should be a regular discussion in all the partnerships and governance arrangements around any new strategy and there should be greater diversity of organisations around the table to inform these discussions.

- Welsh Government need to ensure there are no further delays in delivery of the Mental Health Core Dataset and that there are a full range of protected characteristics data is collected and published
- Welsh Government and Local Health Boards to ensure current data collected prioritises questions relating to protected characteristics, including providing extra training or guidance on approaching these questions if needed
- Welsh Government to publish data, with caveats around sample sizes, on protected characteristics and mental health services

- Welsh Government should re-join the Adult Psychiatric Morbidity Survey and explore options for measuring population level mental health prevalence for children and young people
- Funding should be made available on a local level to support community organisations to meet the mental health needs of the communities they represent
- Engagement and outreach support within every Local Health Board in Wales should be developed with long term investment to build trust and relationships with communities
- Recommendations from the 'Together Through Tough Times' report should be taken into account as Welsh Government develop their new mental health strategy, alongside being considered in work being undertaken around community development, planning and reviving town centres
- The Health Inspectorate Wales and Social Care Wales Mental Health Workforce Strategy should look to specifically tackle diversifying the mental health workforce, through providing information, financial support and mentoring
- Community organisations should be proactively engaged and supported to develop delivery of primary care programmes such as social prescribing, peer support and other community led initiatives
- Staff education and training across health services should take a trauma-informed approach, and should cover a gendered approach to trauma including violence and abuse, and wider inequalities. Clear and safe information recording and sharing about experiences of violence and abuse and related issues should be consistently implemented across health services to avoid the re-traumatisation of women having to repeatedly re-tell their stories.
- The mental health impact of violence against women and girls should be explicitly addressed, through a cross-department approach. This should be incorporated into a future mental health strategy for Wales following on from Together for Mental Health.
- Community based programmes such as Mums Matter, social prescribing, Active Monitoring and peer support should be part of a standard primary care, early support offer. These should support both self referral and GP referral.

We hope that this Committee inquiry will capture a range of voices and experiences directly from the communities experiencing mental health inequalities. Too often their voices are not heard

prominently enough in the discussions about their experiences. We believe the report of this committee should mark a watershed moment in moving the approach to mental health in Wales forward, becoming more inclusive of a wide range of experiences and meeting the needs of everyone in Wales.

We would be happy to discuss further any aspect of this response.

Simon Jones
Head of Policy & Campaigns
Mind Cymru

Mental health inequalities

About Leonard Cheshire

Leonard Cheshire is one of the UK's leading charities supporting disabled people. Led by people with experience of disability, we are at the heart of local life — opening doors to opportunity, choice and support in communities around the globe. At Leonard Cheshire, in Wales and throughout the UK, we support individuals to live, learn and work as independently as they choose, in order to play our part in creating a fair and inclusive society.

We are one of the UK's largest voluntary sector providers of services for disabled people. We have accommodation services, including supported living and registered care homes as well as social, education and leisure programmes, including day support, community outreach and respite support.

Which groups of people are disproportionately affected by poor mental health in Wales?

The Welsh Government's *Action on Disability: The Right to Independent Living: Framework and Action Plan* acknowledges that disabled people and people with learning disabilities are much more prone to mental health problems than the overall population,[1] and that the

[1] Welsh Government, *Action on Disability: The Right to Independent Living: Framework and Action Plan*, last updated 7th October 2019, p. 23. Accessed at: action-on-disability-the-right-to-independent-living-framework-and-action-plan.pdf (gov.wales) [Date accessed: 26/01/2022]; Foundation for People with Learning Disabilities, *Learning disability statistics: mental health problems*. Accessed at: Learning disability statistics: mental health problems | Foundation for People with Learning Disabilities [Date accessed: 26/01/2022]

COVID-19 pandemic has had a disproportionate impact on the mental health of disabled people.[2]

Prior to the pandemic, the average rating of anxiety for disabled people was 4.27 out of 10,[3] which already compared poorly to an average anxiety rate for non-disabled people of 2.66 out of 10.[4] We also know that some groups of disabled people suffer from a higher prevalence on mental health complications. Between 25% and 40% of those with a learning disability have complications regarding their mental health, compared to an average of 25% for the overall population.[5] Deaf people are 50% more likely to have mental health problems.[6]

However, during the pandemic the anxiety levels for disabled people increased to a high of 6 out of 10 during the initial pandemic in May 2020,[7] reflecting the wide range of impacts that the pandemic had for disabled people. Many disabled people were required to shield or isolate. Some living in care homes or supported living accommodation were forced to self-isolate for up to 28 days if they tested positive for COVID-19 (i.e. longer than the requirement in the public as a whole). In some instances, "Do Not Resuscitate" Orders were given during the initial wave of COVID-19, instructing medical teams that disabled people who had tested positive for coronavirus must not be resuscitated in the event that they suffered cardiac arrest.

As lockdown restrictions have eased, there has been an associated reduction in the proportion of disabled people who felt their well-being was being impacted by COVID-19,[8]

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[2] Welsh Government, *Locked out: liberating disabled people's lives and rights in Wales beyond COVID-19*, 2nd July 2021. Accessed at: [Locked out: liberating disabled people's lives and rights in Wales beyond COVID-19 [HTML] | GOV.WALES] [Date accessed: 25/01/2022]
[3] Office for National Statistics, *Disability, well-being and loneliness: UK, 2019*, 2nd December 2019. Accessed at: [Disability, well-being and loneliness, UK - Office for National Statistics (ons.gov.uk)] [Date accessed: 26/01/2022]
[4] *Ibid.*
[5] Foundation for People with Learning Disabilities, *Pass it Own*. Accessed at: [Pass it On | Foundation for People with Learning Disabilities] [Date accessed: 23/02/2022]
[6] All Wales Deaf Mental Health and Well-Being evidence to the Commission cited in Centre for Mental Health, *Mental health inequalities: factsheet*, 11th November 2020. Accessed at: [Mental health inequalities: factsheet | Centre for Mental Health] [Date accessed: 26/01/2022]
[7] Welsh Government, *Locked out: liberating disabled people's lives and rights in Wales beyond COVID-19*.
[8] *Ibid.*

and those who described feelings of loneliness.[9] Nevertheless, disabled people remain at least twice as likely to report feeling lonely as non-disabled people.[10]

What factors contribute to poor mental health within these groups?

A wide range of factors clearly contribute to poor mental health, and we welcome the July 2021 call of the Steering Group of disabled people established by the Welsh Government, for *"more research and better data… to understand the complex relationship between social factors, COVID-19 infections, mental well-being and disability in Wales."*[11]

One factor which we know about is access to digital technology and associated digital literacy, which became particularly important for the public as a whole during the pandemic as a means for reducing loneliness. However, access to digital technology is uneven, with the Welsh Government's Internet use and digital skills (National Survey for Wales) 2018-19 finding that only 79% of people with a long-standing limiting illness, disability or infirmity used the Internet, compared with 93% of those without such a condition. There is an urgent need for increased funding to enable the provision of training, ICT and Wi-Fi equipment to disabled people in Wales to improve digital inclusion and tackle loneliness and isolation.[12]

We also know that disabled people face a range of society-imposed barriers to employment, which itself serves as a means to combatting loneliness. Disabled people offer a wealth of talent, experience and perspective to the workforce, but 24% of employers admit that they would be less likely to employ someone with a disability and that 66% of employers admit that the costs of workplace adjustments were a barrier to employing a disabled person.[13]

We know that sports and social activities play a critical role in everyone's mental health and wellbeing, improving fitness and providing a vital sense of community. But all too often, disabled people have been excluded from accessing facilities. Historically, this has

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[9] *Ibid.*
[10] *Ibid.*
[11] *Ibid.*
[12] Leonard Cheshire Cymru, *Manifesto Asks: Annex 8: Improve digital literacy amongst disabled people*. 2020. Accessed at: Manifesto-Asks-Annex-8.pdf (leonardcheshire.org) [Date accessed: 23/02/2022]
[13] Leonard Cheshire, *Manifesto Asks Annex 5 Remove Barriers To Disabled People Gaining And Retaining Employment*, 2020. Accessed at: https://www.leonardcheshire.org/sites/default/files/2020-07/Manifesto-Asks-Annex-5.pdf [Date accessed: 23/02/2022]

sometimes been due to a lack of physical gym equipment, environmental factors (for example loud music can be challenging for some people with Autism Spectrum Disorder) or just a lack of understanding about the needs of disabled people, and the very fact that disabled people want to engage in sports and social activities. Going forward these issues need to be addressed.

Finally, the pandemic gave everyone an insight into a world where they could not get out and about. But inaccessible transport remains an ongoing reality for disabled people. For example, trains are often out of bounds for people with limited mobility and wheelchair users due to a lack of:

- accessible information when initially booking tickets or on-route;
- accessible routes to get to and from stations (with some dropped kerbs too steep or narrow to be safely negotiated in a wheelchair or mobility vehicle, some dropped kerbs compromised by parked vehicles in front of them and some not having a corresponding dropped kerb on the other side);
- step-free access to and from stations and trains;
- accessible toilets, which denies disabled people the basic dignity they are entitled to; and
- staff training (some disabled people have been repeatedly ignored by transport staff at rush hour, meaning that they get into work late, and then lose their job as a consequence).

Poor access to transport also has a negative impact on pursuing career and educational opportunities. Disabled people tell us this has resulted in them turning down job offers, missing interviews or not taking up an educational training course.[14]

For the groups identified, what are the barriers to accessing mental health services?

Research conducted in 2015 on behalf of the Welsh Government noted that there were *"significant geographical variations in access to healthcare services for disabled people across Wales, particularly regarding mental healthcare provision and access to rehabilitation services for people with chronic and long-term conditions."*[15] The report concluded that

[14] Findings from Leonard Cheshire's research conducted with ComRes in 2018. For more information: https://www.comresglobal. com/polls/leonard-cheshire-disability-uk-disabled-adults-survey-hate-crime-section/

[15] Smith, *Review of Evidence of Inequalities in Access to Healthcare Services for Disabled People in Wales*, p. 91, Para 8.1.

much of this inequality of access is attributable to a *“lack of provision or funding for appropriate services . . .”*[16]

Disabled people have previously complained about the Welsh Government’s suggestion that mental health support for disabled people be rationed primarily for crisis situations.[17] The Welsh Government has acknowledged in their Action Plan that there has to be greater emphasis on *“preventative support”* so that disabled people have the support which they need to obviate the requirement to access crisis mental health support in the first place.[18]

Going forward, we need clear evidence that preventative mental health services for disabled people are being prioritised and proactively used by disabled people. The Welsh Government should consider commissioning research into how disabled people engage with preventative mental health services in order to test the success of the relevant interventions.

How effectively can existing services meet their needs, and how could their experience of using mental health services be improved?

A key issue affecting disabled people and their ability to access mental health services is that they can only obtain appropriate treatment when they have reached a crisis.[19] We strongly recommend that the Welsh Government and NHS Boards implement measures to ensure that disabled people can obtain access to treatment and support when mental health problems start to develop rather than when they have reached a “crisis” situation. This in turn would relieve pressure on mental health staff whilst at the same time reducing many instances of severe mental illness amongst disabled people.

We strongly endorse the recommendation made in the Disability Steering Group’s ‘Locked Out’ report last year that the Welsh Government co-operate with Disabled People’s Organisations to improve the lives of disabled people who experience both isolation and loneliness.[20]

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[16] *Ibid.,* p. 91, Para 8.2
[17] Welsh Government, *Action on Disability: The Right to Independent Living: Framework and Action Plan,* p. 23
[18] *Ibid.*
[19] Welsh Government, *Action on Disability: The Right to Independent Living: Framework and Action Plan,* p. 23
[20] Welsh Government, *Locked out: liberating disabled people’s lives and rights in Wales beyond COVID-19*

We have noted that technology has been advocated as a means to reducing mental health inequalities.[21] A report by Public Health Wales in 2020 acknowledged that disabled people receive unequal health outcomes and championed greater digital inclusivity as a means of reducing such inequality.[22] Such measures will clearly be of benefit to some disabled people. However, as previously noted access to digital technology and digital literacy is lower amongst disabled people than non-disabled people,[23] so caution must be taken that the introduction of virtual counselling sessions (for example) does not inadvertently exclude and isolate.

To what extent does Welsh Government policy recognise and address the mental health needs of these groups?

What disabled people require is access to suitable and inclusive mental health services. Existing Welsh Government policy falls short of fulfilling this aim in several respects. While *The Together For Mental Health Delivery Plan 2019-2022 (TfMHDP)* commits the Welsh Government to ensuring that *"all people in Wales have access to appropriate mental health support"* and that mental health inequalities are reduced, more needs to be done to meet these targets.[24] Specifically, the Welsh Government needs to tackle the digital exclusion of disabled people and to guarantee accessible public transport across Wales.

Leonard Cheshire has long campaigned for accessible public transport methods in Wales.[25] Where specialised health care services are few and disparate, some people will be required to travel long distances for care and the difficultly of this task is by no means equal across Welsh society. Disabled people with limited mobility or without access to a car may struggle

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[21] Matthew Honeyman, David Maguire, Harry Evans and Alisha Davies, *Digital technology and health inequalities: a scoping review*, Public Health Wales NHS Trust, 2020. Accessed at: https://phw.nhs.wales/publications/publications1/digital-technology-and-health-inequalities-a-scoping-review/ [Date accessed: 26/01/2022]

[22] *Ibid.*

[23] Welsh Government, *Internet use and digital skills (National Survey for Wales), 2018-19*, 11th September 2019. Accessed at: https://gov.wales/sites/default/files/statistics-and-research/2019-09/internet-use-and-digital-skills-national-survey-wales-april-2018-march-2019-207.pdf [Date accessed: 26/01/2022]

[24] Welsh Government, *Together for Mental Health: delivery plan 2019 to 2022*, 24th January 2020. Accessed at: https://gov.wales/sites/default/files/publications/2020-10/review-of-the-together-for-mental-health-delivery-plan-20192022-in-response-to-covid-19_0.pdf [Date accessed: 26/01/2022].

[25] Leonard Cheshire, *Leonard Cheshire Cymru 2021 Senedd Election Manifesto Calls*, 24th July 2020. Accessed at: https://www.leonardcheshire.org/sites/default/files/2020-07/english-brochure.pdf [Date accessed: 26/01/2022].

to make such journeys without adequate provisions and could possibly incur higher transportation costs due to a lack of accessible public transport. The Royal College of Occupational Therapists has also noted that there is unequal access to occupational therapy, with people in more deprived areas often travelling further to receive services.[26] Without action on accessible means of public transport in Wales, these same issues are likely to impact on disabled people's experiences of accessing non-local mental health services.

NHS Wales have made significant steps over the pandemic in offering telehealth and digital health care services to the general public. For example, over 250,000 video consultations were delivered across Wales between March 2020 and October 2021[27], and online mental health resources such as ACTivate Your Life[28] and SilverCloud[29] enable people to access support at their own pace. Such innovations have the potential to break down the aforementioned transport barriers. However, a credible plan to improve the digital literacy and digital access of disabled people must accompany this, alongside a review of how effective such technologies are at improving mental health outcomes compared with in person treatment.

It is significant to note that actions to support the mental health of the neurodiverse throughout the pandemic, who are deeply affected by mental health problems in the UK[30]are absent from the *TfMHDP.*[31] Autistic people have thus been especially impacted by lockdowns, as this group tends to have fewer and weaker networks of support.[32] It is clear

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[26] Royal College of Occupational Therapists, *Health equity – what's next?*, 19th January 2022. Accessed at: https://www.rcot.co.uk/news/health-equity-whats-next [Date accessed: 26/01/2022].

[27] Digital Health Wales, *Over 250,000 video consultations delivered across Wales*, 6th October 2021. Accessed at: https://digitalhealth.wales/news/250k-vcs-across-wales [Date accessed: 26/01/2021].

[28] NHS Wales, *ACTivate Your Life*, n.d. Accessed at: https://phw.nhs.wales/services-and-teams/activate-your-life/ [Date accessed: 26/01/2021].

[29] Powys Teaching Health Board, *SilverCloud Wales Online Therapy*, n.d. Accessed at: https://pthb.nhs.wales/services/adult-and-older-peoples-mental-health-services/silvercloud-online-cbt/#:~:text=SilverCloud%20Wales%20is%20an%20Online,to%20deal%20with%20life's%20problems. [Date accessed: 26/01/2021].

[30] Autistica, *Autism and Mental Health: A Guide to Looking After Your Mind*, n.d. Accessed at https://www.autistica.org.uk/downloads/files/Mental-health-autism-E-LEAFLET.pdf [Date Accessed: 26/01/2021].

[31] Welsh Government, *Together for Mental Health: delivery plan 2019 to 2022*, 24th January 2020. Accessed at: https://gov.wales/sites/default/files/publications/2020-10/review-of-the-together-for-mental-health-delivery-plan-20192022-in-response-to-covid-19_0.pdf [Date accessed: 26/01/2022].

[32] National Autistic Society, *Left stranded: our new report into the impact of coronavirus*, 7th September 2020. Accessed at: https://s4.chorus-mk.thirdlight.com/file/1573224908/63117952292/width=-1/height=-

that more needs to be done to acknowledge and tackle the inequality which this group faces.

What further action is needed, by whom/where, to improve mental health and outcomes for the groups of people identified and reduce mental health inequalities in Wales?

- More work needs to be done to reduce the digital divide between disabled and non-disabled people. If digital health care services are to become an important part of the mental health infrastructure in Wales, it is crucial to ensure that marginalised groups do not miss out on such innovations. We call upon the Welsh Government to increase funding for the provision of training, ICT and Wi-Fi equipment to disabled people in Wales to improve digital inclusion and tackle loneliness and isolation.
- Where mental health services are not offered digitally, it is imperative that disabled people have accessible transport links to services. This can only be guaranteed if the Welsh Government adopt a credible, pan-Wales accessible transport initiative, composed of the following actions:
    - The establishment of a legally binding duty upon the Welsh Government to take all reasonable steps to ensure that all train journeys in Wales are fully accessible by 2030.
    - Ensure all active travel routes include dropped kerbs at least every 100 metres to prevent wheelchair users having to take lengthy detours to cross the road.
    - Reassess transport systems (buses, taxis, measurements used for wheelchair parking spaces) with the intention of removing restrictions for disabled people in Wales.

1/format=-1/fit=scale/t=444295/e=never/k=da5c189a/LeftStranded%20Report.pdf [Date accessed: 26/01/2021].

Professor Sir Sam Everington, Barrister, MBBS, MRCGP, OBE

5th May 2022

Dear Colleagues,

I look forward to meeting you all on the 19thMay. I enclose several articles and the manifesto for the college of Health (I am Vice-Chair) which give the background to some of the issues and some of the solutions.

There are several points I will draw out:

Mental, Physical and Social health are inextricably linked.

Prior to Covid, anti-depressant prescribing had doubled in the last 10 years. We need great biomedicine but not to medicalise every problem and ensure as clinicians in the NHS we recognise that our traditional medicine only tackles 20% of health care issues, the other 80% is social prescribing.

Mental health has also deteriorated significantly during covid and is causing enormous pressure on all parts of the NHS. At least 30% of GP consultations are pure mental health issues. One could argue that every consultation relates to mental health.

Social prescribing has a major positive impact on the health of the elderly and adults but there is little available for children.

We are piloting social prescribing in three schools across the country and believe it should be in every school.

The Bromley by Bow centre, where I work, is a pioneering charity and general practice with over 40 different services and activities and a community research project under its roof.

Social prescribing ensures holistic health care, with better outcomes and reduced pressure on the NHS.

Best wishes,

Sam

Professor Sir Sam Everington, MBBS, MRCGP, OBE
Chair Tower Hamlets CCG and Deputy Chair North-East London CCG
Vice Chair College of Medicine
GP, Bromley by Bow Partnership
NED East London Foundation Trust
Associate Director NHS Resolution

Obesity
Last autumn the chief exec of John Lewis said that 10years of digital sales growth had happened in one year. Well, is seems that the growth of digital sales wasn't the only long term trend to have accelerated under lock down. So too has the inexorable increase in prevalence in child obesity. This would usually rise at the rate of about 1% a year but in one year, between 2019/20 and 2020/21, it rose by approximately 5%. 5 years growth in the prevalence of child obesity in one year.

Given that the rise is greatest has been in the areas that already had highest levels of child obesity*, driven by factors of children a) growing up in poverty, b) of racially minoritised communities and c) those living in urban settings, and that 5% is the average across England, the increase in prevalence of obesity in Tower Hamlet's children is likely to be considerably higher than 5%.

*Tower Hamlets has the 6th highest levels of child obesity in England.

This represents a considerable challenge to the future health of the population of Network 6, and to its health and care providers.

•Those who were obese as children or adolescents are 5x more likely to be obese as adults.
•There is a strong correlation between childhood obesity and diabetes, hypertension and certain types of cancer. Network 6 already has high rates of diabetes, which are set to increase by 33% in the next eight years.
•The current cohort of children are likely to have a higher prevalence of diabetes, and to develop it earlier in life, than the current adult population.

Life expectancy: Parts of England and Wales see “shocking” fall

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Data showing greater falls in life expectancy in the poorest areas of England than in the wealthiest have led to questions over whether the government's levelling-up agenda is achievable without a fundamental shift in approach.

The latest data from the Office for National Statistics show that men born in the poorest areas of the country are now expected to live almost 10 years less (73.5 years in the period 2018 to 2020) than those in the richest areas (83.2 years), and women eight years less (78.3 versus 86.3).

There were "statistically significant" decreases in male and female life expectancy in the most deprived areas when compared with the period 2015 to 2017, said the ONS.

The figures also show that in the most deprived areas people are living more of their life in ill health. Girls born in the poorest areas of England live 19 years less in good health than those born in the wealthiest areas.[1]

In 2018 to 2020 healthy life expectancy at birth for girls and women was 51.9 years in the most deprived areas and 70.7 years in the least deprived areas. The figures for boys and men were 52.3 and 70.5 years, respectively.

David Finch, assistant director of healthy lives at the Health Foundation, said the data showed the uneven effects of the covid pandemic and a "staggering difference in life chances."

Michael Marmot, director of the Institute of Health Equity at University College London, described the figures as shocking, saying that they showed a continuing trend of worsening health inequalities. "They are telling us a great deal about how well society is functioning. If health is getting worse, then society's needs are not being met," he told The BMJ.

In February the government published its white paper on levelling up, which reiterated the ambition to improve healthy life expectancy by five years by 2035, while narrowing the gap between the experience of the richest and poorest people.[2] However, a recent analysis by the Health Foundation showed that on current trends it would take 192 years to reach this target.[3]

Finch said, "Reducing these stark inequalities requires a fundamental shift towards a whole-government approach that actively improves the conditions needed to create good health, such as adequate incomes to cope with the rising cost of living, secure jobs, and decent housing.

"The upcoming disparities white paper presents a clear opportunity to move beyond the rhetoric and into action."

The new figures on life expectancy include the first year of the pandemic, when the country's most deprived areas experienced the highest rates of death involving covid-19. The data included covid deaths in 2020, but the ONS noted that these cannot show the full impact of covid deaths on inequalities.

Women living in the most deprived areas were expected to live two thirds (66.3%) of their lives in good general health, while those in the least deprived areas would live more than four fifths (82%), the data show.

Separate figures published by the ONS for Wales showed similar trends in life expectancy.4 Female life expectancy at birth in the most deprived areas of Wales fell "significantly" from 79.1 in 2015-17 to 78.4 in 2018-20. However, the equivalent drop for boys and men, from 74.3 to 74.1, was not statistically significant.

In Wales, boys and men in the most deprived areas were expected to spend 54.2 years on average in good general health, which compared with 67.6 in the least deprived areas. For girls and women the respective figures were 53.3 and 70.2 years. Deprivation is measured differently in Wales, with local areas assigned one of five levels, while in England there are 10 levels.

Alison Garnham, chief executive of the Child Poverty Action Group, commented, "This is really worrying data and the message is stark: poverty kills. The picture on child poverty is likely to worsen in the year ahead as costs soar and families face a real terms cut in universal credit. The sticking plaster responses we've seen so far from government are hopelessly inadequate. Ministers must respond to the scale of the problem by bringing benefits in line with inflation. That's the minimum protection needed for children in low income families."

The picture is likely to get worse in the coming year. A separate analysis released by the ONS shows that in March 2022 around nine in 10 adults reported an increase in the cost of living over the previous month, whereas in November 2021 the proportion was six in 10 adults.5 Nearly a quarter of adults reported that it was very difficult or difficult to pay their usual household bills in the previous month, up from 17% in November.

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Y Pwyllgor Iechyd a Gofal Cymdeithasol

—

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Lynne Neagle MS
Deputy Minister for Mental Health and Wellbeing
Welsh Government

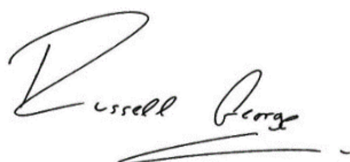
18 March 2021

Dear Lynne

Provisional food compositional standards and labelling common framework

To inform our consideration of the food compositional standards and labelling provisional common framework, we would welcome the views of the Welsh Government on the matters set out in the annex to this letter by Friday 22 April.

Yours sincerely



Russell George MS
Chair, Health and Social Care Committee

cc Huw Irranca-Davies, Chair, Legislation, Justice and Constitution Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

Annex: Common frameworks: request for further information

To assist our deliberations on the food compositional standards and labelling provisional common framework, we would welcome further information on the matters listed below. We would be grateful to receive your response by Friday 22 April.

Reasons

1. Why is a framework needed for this policy area?

2. The framework sets out that governments will be able to diverge under this framework "where evidence is clear that divergence is both necessary and proportionate to meet local needs". How will you determine if divergence is "necessary and proportionate"?

3. This framework is closely linked to frameworks for food and feed safety and hygiene and nutritional labelling, composition and standards. How will the connections between these common frameworks be managed?

Managing divergence

4. The framework requires the Welsh Government not to take forward a policy proposal in scope until it has gone through a joint decision-making process. What impact could this have on the competence of the Senedd and Welsh Government?

5. The framework requires that Welsh Government not launch a public consultation, or progress in any other material way, with a policy proposal in scope, until it has been considered by the FCSL officials' group. How will this affect the role of Welsh stakeholders in developing Welsh law and policy?

6. Why will changes to the law be in scope of the framework's decision-making processes where EU law allows scope for national measures to achieve common outcomes?

7. Why will changes to the law be in scope of the framework's decision-making processes that would only apply to businesses established or products circulated in Wales?

8. The UK Government intends to bring forward new proposals on food labelling as part of its upcoming National Food Strategy. What consideration have you given to these proposals and whether any changes should apply in Wales?

9. Are you content that the list of legislation in scope of the framework in Annex C is complete? For example, why are regulations on spreadable fats listed, but regulations on olive oil absent?

Role of the Foods Standards Agency (FDA)

10. How will the Welsh Government ensure the FSA has the expertise and capacity to make decisions and recommendations on future food labelling and compositional standards for Wales?

11. Will Welsh Government officials play any role in the work of the FCSL officials' group?

12. What progress has been made in the review of FSA Wales announced in June 2021?

13. When will the Welsh Government and Food Standards Agency publish an updated Concordat?

UK Internal Market Act 2020

14. What impact could the UK Internal Market Act 2020 have on Welsh law on food compositional standards and labelling?

15. Do you intend to request any exclusions from the Act in this common framework area?

EU and Northern Ireland

16. How will the Welsh Government continue to monitor changes to EU law on food compositional standards and labelling and assess the implications of divergence from the EU and Northern Ireland?

17. How will you assess the risks and benefits of keeping pace with changes to EU law on food compositional standards and labelling?

International law and international agreements

18. What international obligations are there in this policy area?

19. Will the governments work together to agree positions for international policy on food standards, and (if so) how?

20. Why does the framework make no reference to the UK-EU Trade and Cooperation Agreement?

21. The framework provides that it will enable the governments to "consider any implications stemming from international trade which have a direct bearing on the operation of a Common Framework." Do you consider that this gives the Welsh Government adequate involvement in UK positions on food compositional standards and labelling during international trade negotiations?

Governance and dispute resolution

22. Do you consider the dispute resolution mechanism robust enough for its intended purpose?

23. If another government objects to a Welsh Government policy proposal through the dispute resolution mechanism, could that cause delays to Welsh legislation?

24. Why are no time limits for dispute resolution set?

How the framework was developed

25. How did the Welsh Government engage with stakeholders on the development of the framework?

26. How does the framework reflect the responses of stakeholders in Wales?

Review and revision

27. How will the Senedd be able to contribute to the review and amendment process for the framework?

28. How will stakeholders be able to contribute to the review and amendment process for the framework?

Lynne Neagle AS/MS
Y Dirprwy Weinidog Iechyd Meddwl a Llesiant
Deputy Minister for Mental Health and Wellbeing

Llywodraeth Cymru
Welsh Government

Eich cyf/Your ref
Ein cyf/Our ref

April 2022

Dear Russell,

Re: Provisional food compositional standards and labelling common framework.

Many thanks for requesting the views of the Welsh Government in relation to the food compositional standards and labelling common framework. The Welsh Government responses to the questions are attached.

During the development of Common Frameworks (across the programme as a whole) a number of cross-cutting issues became apparent which would affect all Common Frameworks.

These included how frameworks would refer to their interaction with:

- international relations and trade
- the Northern Ireland Protocol
- the UK Internal Market Act exclusions process
- the Intergovernmental Relations Review and
- the EU-UK Trade and Cooperation Agreement

In order to support with the resolution of these issues, the senior official level UKG-DA Common Frameworks Project Board agreed standardised language on the four cross-cutting issues for inclusion in Common Frameworks.

The agreed approaches were discussed by UKG and DA constitutional minsters at a Quadrilateral meeting in September 2021, and the standard wording was agreed at a ministerial Quadrilateral in November 2021.

Yours sincerely,

Lynne Neagle AS/MS
Y Dirprwy Weinidog Iechyd Meddwl a Llesiant
Deputy Minister for Mental Health and Wellbeing

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Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

Annex: Common frameworks: request for further information

1. **Why is a framework needed for this policy area?**

   Currently, agri-food goods can be marketed and sold throughout the UK so long as they are compliant with relevant legislative requirements, largely contained within retained EU Regulations. Now and going forward, all parties to the framework agree that a level of commonality across food compositional standards and labelling (FCSL) policy is beneficial, particularly for those businesses who operate across UK borders. The agreements as set out within the framework therefore provide for close collaboration with consistency of approach across all four nations always being sought in the first instance, whilst recognising that the opportunity for divergence should remain where it is agreed that it is necessary and appropriate.

2. **The framework sets out that governments will be able to diverge under this framework "where evidence is clear that divergence is both necessary and proportionate to meet local needs". How will you determine if divergence is "necessary and proportionate"?**

   The parties to the framework have the ability to diverge within their territories (having followed the processes set out in this Concordat for managing divergence or dispute resolution) where Ministers have evidence to demonstrate that divergence is both necessary and proportionate for providing consumer protection within the area or territory in question.

   What is necessary and/or proportionate will necessarily be determined on a case-by-case basis in the context of the evidence that identifies the potential need for divergence.

3. **This framework is closely linked to frameworks for food and feed safety and hygiene and nutritional labelling, composition and standards. How will the connections between these common frameworks be managed?**

   Officials working in these areas will continue to follow existing four-nation processes. The common frameworks are made up of the same organisations that already have established mechanisms in place for close collaborative working.

   A good example of work already underway is the four-nation review of the Bread and Flour Regulations 1998. This is being undertaken by officials in the Food Standards Agency, the Welsh Government, Defra, Food Standards Scotland, The Department of Health and Social Care in the UK Government and The Department of Health in Northern Ireland.

   The review includes the fortification of folic acid in flour which sits within the remit of the nutritional labelling, composition and standards (NLCS) framework. Using the structures set up within this framework, officials have set up a joint policy working group to review the regulations and proposals for consultation across government. Subject to Ministerial agreement there will be a UK-wide consultation to encompass all the proposed changes to the Bread and Flour regulations including those outside the scope of this framework such as the fortification of folic acid.

Managing divergence

4. **The framework requires the Welsh Government not to take forward a policy proposal in scope until it has gone through a joint decision-making process. What impact could this have on the competence of the Senedd and Welsh Government?**

   Ministers will retain the right to make individual decisions for their governments, such as whether to make legislation. The competence of the Senedd and Welsh Government will therefore remain unchanged.

The framework does not impinge upon the ability of the Welsh Government to make separate policy or legislation for Wales. Divergence in policy or legislation in devolved areas will continue to be possible, and the framework will provide a more formal route for early discussion of either joint or separate policy making. However, the dispute resolution mechanism can be utilised should an administration consider another administration's policy to be damaging, for example being not compliant with international standards or having significant deleterious impacts in other countries.

5. **The framework requires that Welsh Government not launch a public consultation, or progress in any other material way, with a policy proposal in scope, until it has been considered by the FCSL officials' group. How will this affect the role of Welsh stakeholders in developing Welsh law and policy?**

The role of Welsh stakeholders in developing Welsh law and policy will remain unchanged. The process for requiring proposals to be discussed by the FCSL officials group before consultation will be beneficial to Welsh stakeholders as it will ensure there is co-ordinated parliamentary and stakeholder engagement and communication across the UK. It will also provide a co-ordinated UK position on FCSL policy, resulting in clear and consistent messaging for consumers and industry.

6. **Why will changes to the law be in scope of the framework's decision-making processes where EU law allows scope for national measures to achieve common outcomes?**

National measures will be in scope of the framework but not within the scope of dispute resolution processes. This serves to ensure that all parties to the framework are aware of any proposed changes being made across the UK in this policy area and have a chance to engage at the earliest stage. This will not stop Welsh Ministers' ability to make national measures for Wales but will provide an opportunity to have harmonised rules across the UK if that is desirable to Ministers.

7. **Why will changes to the law be in scope of the framework's decision-making processes that would only apply to businesses established or products circulated in Wales?**

The FCSL policy area is covered by a variety of retained EU laws (listed in Appendix C of the Framework Outline Agreement (FOA)) and associated domestic legislation which implements this in the UK. Changes in those areas, including proposals to change retained EU law and proposals to create new legislation in the FCSL policy area are in scope of the framework and its decision-making processes. Welsh Ministers will take decisions on changes to all areas of retained EU FCSL law, following recommendations from officials. The framework means that Ministers will be informed of the approaches recommended in other nations, and that consensus should be sought on the approaches to take, whether consistent across nations or different.

8. **The UK Government intends to bring forward new proposals on food labelling as part of its upcoming National Food Strategy. What consideration have you given to these proposals and whether any changes should apply in Wales?**

Any changes to legislation within scope of the FCSL Framework proposed as a result of the National Food Strategy will be subject to the framework process, including dispute resolution.

9. **Are you content that the list of legislation in scope of the framework in Annex C is complete? For example, why are regulations on spreadable fats listed, but regulations on olive oil absent?**

I am content that legislation within the policy remit of the four parties to the framework are listed in Annex C of the framework. Olive oil falls within the marketing standard policy area, which is a

Welsh Government-led area in Wales. The FSA in Wales has no policy responsibility for marketing standards, and therefore olive oil is outside of the scope of the FCSL Framework.

Role of the Food Standards Agency (FSA)

10. **How will the Welsh Government ensure that the FSA has the expertise and capacity to make decisions and recommendations on future food labelling and compositional standards for Wales?**

The FSA in Wales is funded directly from the Welsh Government's Health and Social Services budget in accordance with Section 39 of the Food Standards Act 1999 and produces full resource accounts annually, which are audited by the National Audit Office.

Welsh Ministers agreed an uplift in FSA in Wales funding in order to resource some of those functions which were conferred on Welsh Ministers as a result of EU Exit and are delivered by the FSA in Wales.

This increase in staffing capacity allows the FSA in Wales to contribute to developing policy in relation to food labelling and compositional decisions for Wales. This will be kept under review to ensure that the FSA in Wales continues to have the resources, expertise and capacity to make decisions and recommendations on the future of food labelling and compositional standards for Wales.

11. **Will Welsh Government officials play any role in the work of the FCSL officials' group?**

The FCSL officials group is a forum for all UK nations to examine proposed amendments to, or entirely new legislation in, food compositional standards and food labelling and is made up of representatives from the FSA in Wales and Northern Ireland, Defra and Food Standards Scotland. The role of the FSA in Wales is to represent the interests of the Welsh Ministers. Where appropriate, officials from the Welsh Government, Scottish Government, UK Government Departments and Department of Health in Northern Ireland may be invited to meetings of this group or policy groups set up under the Officials group to discuss specific policy issues. The Welsh Ministers are kept sighted on this work. Officials from the FSA in Wales also seek a steer from the statutory Welsh Food Advisory Committee on key policy issues.

12. **What progress has been made in the review of FSA Wales announced in June 2021?**

The Welsh Government has twice been out to tender to procure the necessary contractor to undertake the review but has been unsuccessful in appointing anyone. I intend to re-commission for a review to be undertaken later this year.

13. **When will the Welsh Government and Food Standards Agency publish an updated Concordat?**

Updating the Concordat is reliant on the completion of the proposed review of the FSA in Wales.

UK Internal Market Act 2020

14. **What impact could the UK Internal Market Act 2020 have on Welsh law on food compositional standards and labelling?**

The FCSL Framework will operate in the context of the UK Internal Market Act 2020 (UKIMA), where the effect will be determined on a case-by-case basis.

15. **Do you intend to request any exclusions from the Act in this common framework area?**

    There are no intentions to request an exclusion.

EU and Northern Ireland

16. **How will the Welsh Government continue to monitor changes to EU law on food compositional standards and labelling and assess the implications of divergence from the EU and Northern Ireland?**

    EU food compositional standards and labelling law continues to be applicable in Northern Ireland. The FCSL Officials group will continue to consider implications of new EU legislation for Northern Ireland.

    Horizon-scanning processes are in place to monitor upcoming EU changes that will need to be implemented in Northern Ireland. The FCSL Framework ensures that any proposals for divergence among the GB nations are subject to four-nation consideration and that Ministers in all four nations have the opportunity to raise a dispute with their counterparts.

17. **How will you assess the risks and benefits of keeping pace with changes to EU law on food compositional standards and labelling?**

    While the framework will promote the delivery of consistent policy approaches through collaborative working in areas where the UK has the ability to set its own approaches, under the Northern Ireland Protocol EU food law will continue to apply in Northern Ireland, therefore divergence will emerge over time.

    The potential EU driven change, especially legislative changes, will be fed into the four-nation FCSL Officials group to consider what it means for the UK as a whole. The FCSL Officials group will consider the risks and benefits. This will be done through a variety of means, i.e. stakeholder engagement, the development of impact assessments, consumer research where appropriate to ensure the interests of consumers, industry and enforcement authorities are considered across the UK.

International law and international agreements.

18. **What international obligations are there in this policy area?**

    The FCSL Framework will facilitate co-operation across the UK to ensure the UK can negotiate, enter into, and implement trade agreements. The framework is also designed to ensure the UK can continue to fulfil international obligations such as Codex and World Trade Organisation membership.

19. **Will the governments work together to agree positions for international policy on food standards, and (if so) how?**

    International policy formulation will be developed in line with the appropriate intergovernmental structures. International obligations will be implemented in line with these agreements. In this respect, the parties will automatically use any updated International Relations Concordat, and the wider outcomes of the Joint Intergovernmental Relations Review, as the basis for such international considerations

20. **Why does the framework make no reference to the UK-EU Trade and Cooperation Agreement?**

    The FCSL Framework was not intended to provide enhanced engagement on matters relating to the UK-EU Trade and Co-operation Agreement. The FCSL Framework is a mechanism for UK-wide co-operation in relation to the devolved matters of food compositional standards and labelling policy.

21. **The framework provides that it will enable the governments to "consider any implications stemming from international trade which have a direct bearing on the operation of a Common Framework." Do you consider that this gives the Welsh Government adequate involvement in UK positions on food compositional standards and labelling during international trade negotiations?**

    The framework will provide opportunity for discussions of UK positions on FCSL policy issues, including where they may be relevant to the negotiation or implementation of a trade agreement.

Governance and dispute resolution

22. **Do you consider the dispute resolution mechanism robust enough for its intended purpose?**

    Yes, the dispute resolution mechanism includes participants from each government, with attempts being made in the first instance to provide a resolution at the lowest possible level, with escalation to more senior officials if required.

    Equally, with the decision-making process and the creation of sub-groups on particular matters, officials from each nation will participate in the process, with a representative from any of the four governments being permitted to establish a sub-group where required.

    It will be imperative, however, that consumers, industry bodies and business are consulted in a timely manner to influence decision making on any proposed changes to food compositional standards and labelling policy, due to the significant impact changes could have on business.

23. **If another government objects to a Welsh Government policy proposal through the dispute resolution mechanism, could that cause delays to Welsh legislation?**

    The dispute resolution processes exist to manage disputes at an official and Ministerial level. In the event that disputes arise, the FCSL Framework includes dispute avoidance principles and processes. It is expected that only a very small number of cases will need dispute resolution approaches.

    Every effort would be made at working level to resolve any disagreements over difference of approach. Official level disputes will first be referred to bodies of senior officials. In the rare event that a dispute cannot be resolved by officials, it may be escalated to be managed by Ministers. If Ministers cannot agree a way forward, the dispute may be referred to the appropriate intergovernmental structures (the Inter-Ministerial Standing Committee - IMSC[1]) for resolution.

24. Why are no time limits for dispute resolution set?

It is recognised that disputes may vary in nature, complexity and operational context and therefore a set time limit would not be conducive to reaching the best outcomes for all governments.

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[1] The IMSC has been established as a result of the Inter-governmental Relations Review (IGRR). It will meet every other month to consider issues which cannot be agreed at portfolio level or to bring together strategic considerations affecting many different portfolios.

How the framework was developed

25. How did the Welsh Government engage with stakeholders on the development of the framework?

Industry stakeholder engagement on the FCSL Framework proposals was undertaken in two parts in October 2020 and June 2021.

In October 2020, engagement involved key food and feed industry stakeholders from across the four countries being approached for initial feedback and questions about the framework proposals. No responses were received in Wales.

An online stakeholder engagement event took place on the revised proposals (including addition of Lot Marking) on 17 June 2021. Alongside FSS and Defra, colleagues in the FSA presented the proposals for the framework to more than 30 stakeholders from across the UK, many of whom represent industry across the four nations. The revisions were minor, clarifying the scope of the framework and adding clarification on items not in scope.

There were three attendees from Wales, the British Veterinary Association, Hybu Cig Cymru and the Farmers Union of Wales

26. How does the framework reflect the responses of stakeholders in Wales?

While there were no specific responses to the consultation in Wales, the UK stakeholder event was very well attended. No significant concerns regarding the FCSL Framework were raised, but stakeholders did express interest in the scope of the framework, and interactions with other connected frameworks like the NCLS and the Food and Feed Hygiene and Safety Frameworks. There was also an interest in cross-cutting issues such as the UK Internal Market Act and The Northern Ireland Protocol.

Industry were keen for their views and opinions to be included in early policy development of any potential labelling or composition change.

Review and revision

27. How will the Senedd be able to contribute to the review and amendment process for the framework?

The FCSL Framework will be regularly reviewed and updated to ensure it remains fit for purpose. This will be achieved through following the Review and Amendment process.

The review and amendment process will be led by the FCSL Officials Group, with engagement from Senior Officials and Ministers.

The Senedd will be informed of upcoming review periods in order to feed into the process.

28. How will stakeholders be able to contribute to the review and amendment process for the framework?

If changes are proposed to the scope or functioning of the FCSL Framework, stakeholders will be consulted in advance of Ministerial agreement.

Y Pwyllgor Iechyd a Gofal Cymdeithasol

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Health and Social Care Committee

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Rt Hon Mark Drakeford MS
First Minister
Welsh Government

01 April 2022

Dear Mark

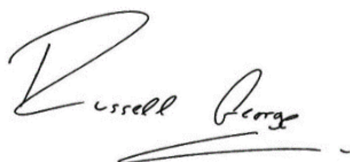
UK COVID-19 Inquiry draft terms of reference

Further to my letter of 19 January 2022, I confirm that the Health and Social Care Committee considered the draft terms of reference for the UK COVID-19 Inquiry at our meeting on 24 March 2022, and agreed to write to Baroness Hallet. I enclose a copy of that letter for your information.

While there are different views within the Committee about whether or not a specific Welsh public inquiry into the handling of the pandemic should also be established, we are nevertheless agreed in our clear expectation that the Welsh Government will engage fully and openly with the UK Inquiry. We would welcome your assurance on this point.

We are also agreed on the importance of transparency, both in respect of the inquiry itself, and in terms of the Welsh Government's engagement with it. To this end, we would be grateful if you could confirm whether you anticipate that the Inquiry will have the power to publish its own report and interim reports, or whether publication will be a matter for the UK Government.

Yours sincerely,



Russell George MS

Chair, Health and Social Care Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

Y Gwir Anrh/Rt Hon Mark Drakeford AS/MS
Prif Weinidog Cymru/First Minister of Wales

Llywodraeth Cymru
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3rd April 2022

Dear Russell,

Thank you for your letter of 1 April regarding the independent UK Covid-19 Inquiry draft terms of reference, and for sight of your response to its chair Baroness Hallett.

I remain committed to the independent UK Covid-19 Inquiry. In November, in a letter to the Prime Minister, I said the Welsh Government would take an approach of candour – we will engage fully and openly with the inquiry.

You asked whether the inquiry would be able to publish its own reports. I understand the chair will be responsible for publishing the inquiry's reports, including any interim reports.

MARK DRAKEFORD

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Public attitudes to social care in Wales following the COVID-19 pandemic

Research commissioned by Senedd Cymru and produced in consultation with Senedd Research

Dr Simon Williams[1 2]

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TOP-LINE SUMMARY

Study design

- An online survey was completed by 2569 respondents between February 11th and March 11th, 2022. Additionally, online focus groups were conducted with a sample of 14 participants. The inclusion criteria were adults aged 18 years and over living in Wales

- A limitation of the study is the lack of Black and Asian Minority Ethnic respondents. Also, although respondent age range was 21-95 years, there was, relative to general adult population a disproportionately high number of older adults (average age = 64) (This likely reflects this age group's greater interest in the topic).

Key findings

- *Four-in-ten of those who felt that they or someone in their household/close family needed social care during the past two years did not receive or make use of it.* The main reasons people gave for not receiving/making use of social care were: a lack of availability or staff shortages; the coronavirus pandemic; being deemed ineligible or otherwise not being offered care; not wanting to ask for help/being "too proud"; and the application or access processes being too complex.

- *Satisfaction with social care was variable,* with approximately one-third either very or quite dissatisfied and a little over half either very or quite satisfied with social care services for themselves or a household or close family member.

- *The vast majority of respondents felt that the social care system in Wales was in need of reform* (86%), and that reforming the social care system should be a priority for the UK and Welsh Governments (94%).

- *A significant majority of respondents felt that reducing the costs of social care for those that need it should be a priority for the UK and Welsh Governments* (85%).

- *Nearly all respondents agreed that social care should be valued in the same way as health care* (95%), and that social care workers should be seen as equal to health care workers (91%). Most participants agreed that social care staff should have comparable pay (78%), working conditions (83%) and career progression opportunities (82%) relative to equivalent career stage NHS staff.

- *Respondents felt the pandemic has had a big strain on social care* (mean=9.00) as well as on health care (m=9.24) (on a 1-10 scale, with 10 being 'major strain')

- *Respondents felt that a career in social care was not very attractive* – both to them personally (m=3.42) or to others in general (m=4.08), and less attractive than a career in health care, to them personally (m=5.0) and in general (m=6.06) (perceived attractiveness rated on a 1-10 scale, with 10 being extremely attractive).

- Unsatisfactory pay, unsatisfactory working terms and conditions, unsatisfactory career security and progression pathways, better opportunities in other sectors, burn out/excessive work, lack of recognition or value given to the profession and the added strain of the COVID-19 pandemic on the social care workforce were all rated as playing an important role in the shortage of social care staff (M=7.16-8.29) (Factors rated on a 1-10 scale, with 10 being 'it has played an extremely important role')

- The need for more *consistency, personalisation, integration*, *recognition* and *investment* in social care were all themes that emerged in the focus groups. Specifically, participants argued that there was a need for more consistency in the social care received, a need for more personalised care, a need for better integration between health and social care; and a need for more investment in social care. Some felt that reform should see the integration of social care into the NHS, while others argued for the establishment of a separate 'National Care Service'.

Implications for policy and practice:

- It is concerning that approximately 4-in-10 of those feeling in need of social care did not receive or make use of social care services. Social care policymakers and providers should seek to understand and address what people feel are the main barriers to accessing or using social care, including: increasing provision for those who need it; encouraging and enabling those who feel they need social care to apply (and working to de-stigmatise social care); consider broadening the eligibility criteria where appropriate; simplifying and providing more support for applying to/accessing social care.

- Amongst participants in this study, there was considerable support for social care reform, for making social care reform a priority for government, and for reducing the costs of social care in Wales. As such, any proposals and discussions for social care reform in Wales would likely be welcomed by many within the Welsh public. In particular, there was considerable support for the idea of a more integrated and 'joined up' health and social care system, and one that was less reliant on private funding (e.g. via the incorporation of social care into the NHS or via the establishment of a 'National Care Service' for Wales).

- Social care work was widely felt to be under-valued. There was considerable support for improving the pay, working conditions, career and professional development opportunities, and ultimately recognition, of social care workers in Wales. Doing so could help the staff shortage problem and could help improve the overall satisfaction with services received. Government and stakeholders should consider substantial reform in the training, accreditation, professional development and working conditions of social care workers.

- The COVID-19 pandemic was widely felt to have caused considerable strain on social care. It was also cited as one of the most common reasons as to why those who felt they needed care, didn't or couldn't access it during the past two years. Major challenges for social care going forward include (1) Ensuring, and communicating to those in need, that adequate COVID-19 safety precautions and measures remain in place, as appropriate, in order to provide as safe as possible care, and (2) Addressing the added backlog that the pandemic will have contributed to, including those related to staff shortages due to illness and isolation and those related to COVID-19 policy measures.

BACKGROUND

The COVID-19 pandemic has shone further light on some of the challenges facing social care in Wales and looks to have exacerbated a crisis that was already extant.[1] [2] This has led to the intensification of longer-standing arguments that social reform is necessary and that the pandemic presents an added impetus and opportunity for reform.[3] [4]

In addition to an added demand, due to an ageing population and health inequalities, compounded by the pandemic, there are two main challenges facing social care in Wales: systemic challenges and workforce challenges.[5]

A major systemic challenge is the fact that social care in Wales is currently provided by a number of different public, private and voluntary providers. In particular, it is argued there is

[1] https://www.theguardian.com/society/2020/feb/12/wales-social-care-home-crisis-councils-bankruptcy
[2] https://research.senedd.wales/research-articles/social-care-a-system-at-breaking-point/
[3] https://www.nuffieldtrust.org.uk/news-item/social-care-reform-what-is-the-vision
[4] Dowling, E. The Care Crisis: What Caused It and How Can We End It? London: Verso 2021.
[5] https://www.wcpp.org.uk/wp-content/uploads/2021/12/Challenges-and-Priorities-for-Health-and-Social-Care-Wales-Briefing-Note-.pdf

a need to ensure that social care provision is seamless, and that those using the services feel as though they are having a "single package", tailored (personalised) to their needs - even where it is made up of multiple different providers, which can make governance, access and ultimately access complex.[6] [7] [8]

The major workforce challenges are the recruitment and retention of care workers. For example, it has been suggested that social care is perceived as being a relatively low status job (e.g. compared to health care work).[9] It has been suggested that social care policy in Wales is dominated by a narrative of individual dependency and reliance, rather than discussed in terms of its social value and its connection to human rights, dignity and respect.[10] Additionally, the COVID-19 pandemic has had a significant negative impact on the mental wellbeing of many social care workers, for example, anxiety related to perceived increased risk to themselves as a result of a lack of pandemic preparedness and infection-reducing measures and personal protective equipment (PPE).[11] [12] [13]

Stakeholders, including Care Forum Wales and the Wales Trade Union Congress (TUC) have called for additional funding for social care to enable social care workers to earn as much as comparable staff in the NHS combined with wider improvements to working conditions.[14] [15] In its plan, *A Healthier Wales,* the Welsh Government has set out its vision of a 'whole system approach to health and social care', which is focussed on health and wellbeing, and on preventing illness.[16] This includes developing "new models of care" which "strengthen the support, training, development and services available to the workforce with a focus on building skills across a whole career and supporting their health and wellbeing".[17] The Welsh Government has recently announced further funding to enable a national recruitment campaign in order to increase pay and meet the real living wage in Wales, fund a national recruitment campaign and professionalise social care including improving career progression opportunities.[18] The Welsh Government is also exploring the possibility of establishing a "National Care Service" for Wales.[19]

With these developments, debates and challenges in mind, and two years into the pandemic, there is a need for more evidence about people's recent experience and perceptions of social care in Wales, including whether they have accessed services when needed, whether they

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[6] https://gov.wales/sites/default/files/publications/2021-09/a-healthier-wales-our-plan-for-health-and-social-care.pdf
[7] https://gov.wales/sites/default/files/publications/2018-01/Review-health-social-care-report-final.pdf
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[16] https://gov.wales/sites/default/files/publications/2021-09/a-healthier-wales-our-plan-for-health-and-social-care.pdf
[17] https://gov.wales/sites/default/files/publications/2021-09/a-healthier-wales-our-plan-for-health-and-social-care.pdf
[18] https://gov.wales/96m-investment-give-tens-thousands-social-care-staff-1000-extra-payment
[19] https://gov.wales/first-step-national-care-service-expert-panel-announced

were satisfied with care received, and whether they feel social care should be reformed, valued more, and how much they feel it has been impacted by the pandemic.

This research explores the following questions:

1. What are participants' experiences of social care in Wales? Specifically:
   a. For those that feel they, or someone in their household or close family, have needed social care over the past two years, did they receive or make use of those services. If not, why not?

2. What are participants' views on whether social care should be considered equal to health care in Wales? Specifically:
   a. Should social care services be valued equally to health care services?
   b. Should social care workers be valued equally to health care workers?

3. What are participants' views on the social care workforce in Wales? Specifically:
   a. How attractive do participants feel a job in social care is to them personally, and to others in general?
   b. How attractive do participants feel a job in social care is relative to a job in healthcare (to them personally and to others in general)?

4. To what extent do participants feel as though the COVID-19 pandemic has affected:
   a. The social care system and the social care workforce?
   b. The extent to which social care is valued?

METHODS

Participants

Eligibility criteria for this study were (1) Living in Wales; (2) Aged 18 or older. Sampling for the study was non-probability, combining convenience and snowball sampling approaches. Recruitment for the study was facilitated by HealthWise Wales (targeted research participant pool of 38,000 adults in Wales who have signed up to have research projects advertised to them). Additionally, recruitment was supplemented via social media (e.g. Facebook and Twitter posts) snowball sampling, as well as through advertising via Swansea University press office (e.g. via study press release). Focus group participants were compensated for their time with a £10 gift card. Survey respondents were entered into a prize draw for an iPad. Informed consent for focus groups and surveys was provided. The study was granted ethical approval by Swansea University Department of Psychology's Ethical review Committee. As of 17th March 2022, 14 participants took part in the focus groups and the survey had received 2569 responses. Participants' demographic characteristics are reported in Table 1.

Survey (n=2569*)		**Focus groups (n=14)**	
Characteristic	**N (%)**	**Characteristic**	**N**
Gender	2501	*Gender*	14
Male	896 (35.8)	Male	7 (50)

Female	1596 (63.8)	Female	7 (50)
Other	9 (0.4)	Other	0 (0)
Ethnicity	2513	*Ethnicity*	14
White	2473 (98.4)	White	14 (100)
Mixed/multiple ethnic groups	16 (0.6)	Mixed/multiple ethnic groups	0 (0)
Asian/Asian British	9 (0.4)	Asian/Asian British	0 (0)
Black/African/Caribbean/Black British	2 (0.1)	Black/African/Caribbean/Black British	0 (0)
Other ethnic group	13 (0.5)	Other ethnic group	0 (0)
Education (highest level)	2494	*Age* M=63.9(SD=12.7) (Range=30-82)	
Postgraduate degree (e.g. MSc, PhD)	464 (18.6)		
First degree (e.g. BA, BSc, B.Ed.) or equivalent	776 (31.1)		
HNC / HND / BTEC Higher, or equivalent	405 (16.2)		
A / AS levels or equivalent	182 (7.3)		
Apprenticeship	68 (2.7)		
O Level / GCSE grades A-C or equivalent	268 (10.8)		
O Level / GCSE grades D-G or equivalent	38 (1.5)		
Foreign qualifications	12 (0.5)		
Other qualifications	213 (8.5)		
No qualifications	68 (2.7)		
Age M=62.9(SD=12.5) (Range=21-95)			

* The total number of respondents was 2569, but participants were not required to complete all survey questions and so specific numbers of respondents for each question are given.

Table 1: Demographic characteristics of participants in this report

Data collection and analysis

Surveys were conducted online via the survey platform Qualtrics. The questionnaire included: background demographics; questions on whether they or anyone in their household/close family had needed care and made us of it, and whether they were satisfied with it; questions focused on participants' views on the social care system in Wales (including their views on whether and how reform of the social care system is needed); participants' views on the social care workforce, participants' views on whether the COVID-19 pandemic has affected social care and people's perceptions of social care. A full list of interview and survey questions are available on request as supplementary materials. Relevant survey questions are reported with data in the results section along with response category frequencies and descriptive statistics. All data were kept securely and confidentially in line with ethics committee requirements in order to protect participants' identities.

Focus groups were conducted online (via Zoom) and lasted approximately one hour each. Focus groups were audio recorded and transcribed. Focus groups discussed participants' views on social care in Wales, including their views on: social care reform in Wales; parity of esteem between social care and health care; the problems facing recruitment and retention in social care work; and whether and how the COVID-19 pandemic had changed their views on

social care and how the pandemic may have affected social care work. Following transcription, focus group data was analysed using a framework approach.[20] This entailed inductively coding open-text survey data transcripts in order to generate themes as they emerged, informed both by the research questions and the initial survey results. Focus group themes are presented below. All participants were assigned pseudonyms to protect their identity.

RESULTS

Experience of and satisfaction with social care

Respondents were asked whether they felt they needed social care services over the past two years (since April 2020), and whether they had accessed or made use of them. Overall, 261 (10.2%) respondents said they felt they had needed social care, and 560 (21.8%) respondents felt someone in their household or close family needed social care during this period.

	Did receive/make use N (%)	*Did not receive make use N (%)*	*Total N (%)*
Needed care for themselves	159 (60.9)	102 (39.1)	261 (100)
Needed care for someone in household/close family	321 (57.3)	239 (42.7)	560 (100)

Table 2: Proportion of respondents who felt that they or someone in their household/close family needed social care since April 2020, and whether or not they received/made use of it.

Of those needing social care for themselves, 102 (39.1%) did not receive or make use of social care services, and of those who had someone in their household or close family who they felt had needed social care, 239 (42.7%) did not receive or make use of them (Table 2).

Respondents were also asked why they, or others in their household or family hadn't received or made use of social care services, despite feeling they needed them. The main reasons given included: no availability/staff shortages (e.g. "no carers available to look after my mother", "was referred but LA [Local Authority] said too busy to do assessment"); being deemed ineligible/refused/not provided (e.g. "I was not offered the help I needed"; "there has been no emotional support for myself. Even though I am disabled with my condition worsening, the court didn't deem that I am. I never really received any support"); the impact of the COVID-19 pandemic on social care (e.g. "it was due to Covid they stopped coming to see me", "I was afraid of catching Covid, I'm high risk"). For those with family or household members who needed care but didn't receive or make use of it, another common reason was not wanting to ask, due to a sense or pride or shame or stigma (e.g. "Pride, not

[20] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1117368/

wanting to be a burden"; "my Elderly mother fell I haven't felt like bothering Social Services as media says how overwhelmed they are".) (Table 3).

Reason for not receiving/making use of social care	*For themselves N (% of 69 text responses)*	*For family member (N) (% of 135 text responses)*	*Total N (% of 204 text responses)*
No availability/staff shortage	19 (27.5)	26 (19.3)	45 (22.1)
Deemed ineligible/refused/not provided	13 (18.8)	21 (15.6)	34 (16.7)
Didn't want to ask (e.g. others need it more/pride/stigma)	2 (3.0)	28 (20.7)	30 (14.7)
Covid-19 pandemic	14 (20.2)	15 (11.1)	29 (14.2)
Application process too complex/didn't know how	9 (13.0)	11 (8.1)	20 (9.8)
Miscellaneous/other	5 (7.2)	15 (11.1)	20 (9.8)
Waiting time	2 (3.0)	14 (10.4)	16 (7.8)
Family providing unpaid care	3 (4.3)	4 (3.0)	7 (3.4)
Cost	2 (3.0)	1 (0.7)	3 (1.5)

Table 3: Most common reasons why respondents who felt they, or someone in their household or close family, needed social care, didn't receive or make use of it

Those respondents who had accessed social care, or who had someone in their household or close family who had, were asked to rate their satisfaction with the care received. Overall, experiences were inconsistent, with approximately one-third either very or quite dissatisfied and a little over half either very or quite satisfied with social care services for themselves or a household or close family member (Figures 1a and 1b).

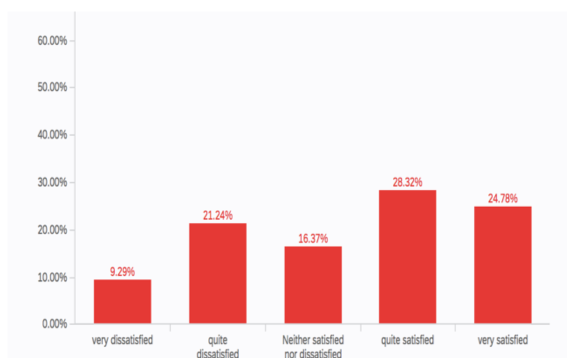

Figure 1a: Satisfaction with social care services amongst those who used them for themselves

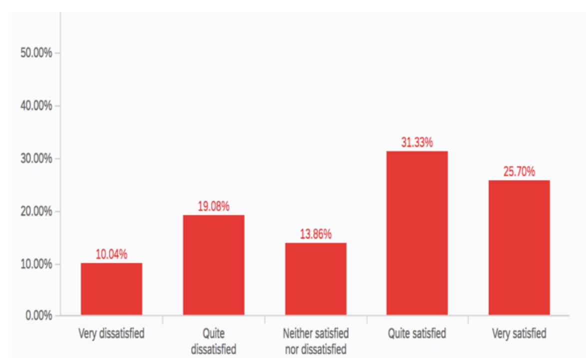

Figure 1b: Satisfaction with social care services amongst those who had someone in their household/ family use them

Social care reform

The vast majority (86%) of respondents felt that the social care system in Wales was in need of reform, most of whom strongly agreed with this (60% of total respondents) (Figure 2a). Similarly, the vast majority (94%) of respondents felt that reforming the social care system should be a priority for the UK and Welsh Governments, most of whom strongly agreed with this (72% of total respondents) (Figure 2b).

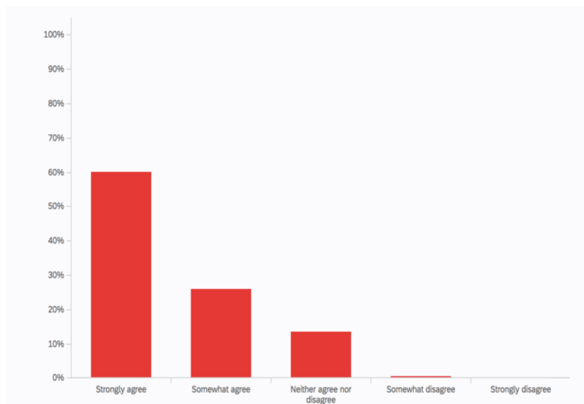

Figure 2a: The social care system in Wales needs to undergo reform

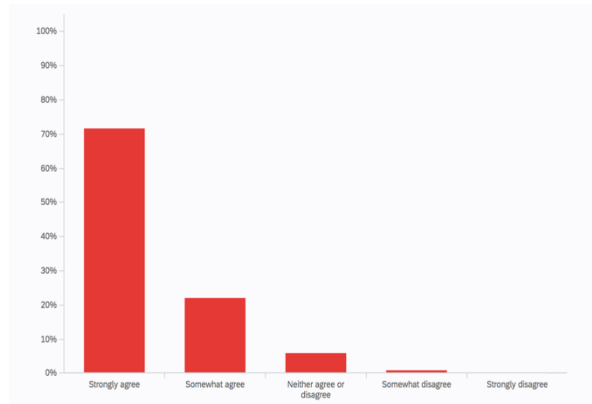

Figure 2b: Reforming the social care system should be a priority for the UK and Welsh Governments

In terms of paying for social care, a significant majority (85%) of respondents felt that reducing the costs of social care for those that need it should be a priority for the UK and Welsh Governments, just over half (56%) of those responding strongly agreeing (Figure 3).

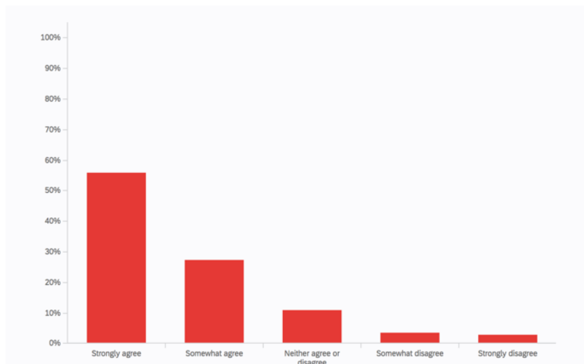

Figure 3: Reducing the costs of social care for those who need it should be a priority for the UK and Welsh Governments

Parity of esteem

Survey respondents also answered questions on the issue of 'parity of esteem'. Nearly all respondents (95%) agreed that social care should be valued in the same way as health care, with three-quarters of all respondents (75%) strongly agreeing with this (Figure 4a). Additionally, nine-out-of-ten (91%) respondents felt that social care workers should be seen

as equal to health care workers, with two-thirds (66%) strongly agreeing with this (Figure 4b).

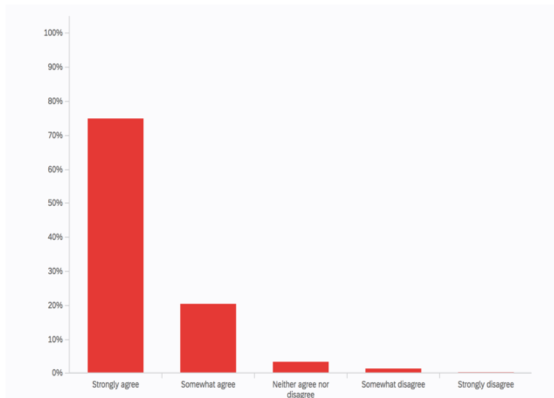

Figure 4a: Social care should be valued in the same way as health care

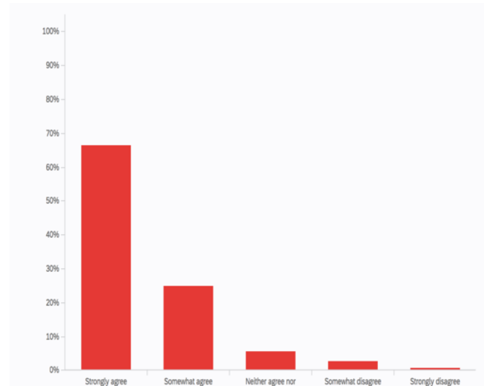

Figure 4b: Social care workers should be seen as equal to health care workers

Respondents were asked whether they felt they now valued social care work more, compared to before the pandemic. Just under half (46%) felt that they agreed (either strongly or somewhat) that they now valued social care work more, compared to before the pandemic (Figure 6). Respondents were also asked about their views as to whether, compared to similar career-level NHS staff, social care staff should have comparable pay, working conditions and career progression opportunities. Overall, most participants agreed that they should have comparable pay (78%), working conditions (83%) and career progression opportunities (82%) (Figure 5).

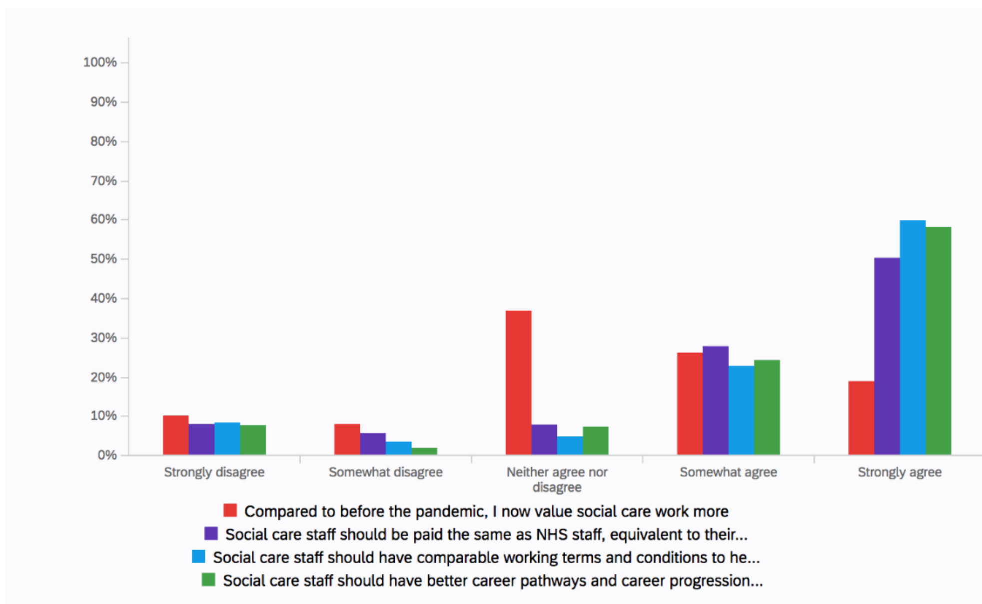

Figure 5: Participants' views on whether they value social care work more now compared to the pandemic, and on whether social care workers should be comparable to equivalent career-stage NHS workers in terms of their pay, working conditions and career progression opportunities.

To follow up participants' views on the perceived impact of the COVID-19 pandemic on social care, respondents were asked a question directly on how much (on a scale from 1-10,

with 1 being no strain and 10 being a major strain) the pandemic had put a strain on both social care services and NHS services in Wales. Overall, they felt the pandemic has had a major strain on both social care (M=9.00(SD=1.35) and NHS services (M=9.24(SD=1.24) in Wales.

The social care workforce

Respondents were also asked questions on the issue of recruitment and retention related to the social care workforce. Specifically, respondents were asked (on a scale from 1-10) how attractive they felt a career in social care was to them personally and to others in general. For comparison, they were also asked how attractive they felt a career in the NHS was to them personally and to others in general (Table 4). Overall, respondents felt that a career in social care was not very attractive to them personally (M=3.42(SD=2.48)) and to others in general (M=4.08(SD=1.70)), and less attractive than a career in health care, both to them personally (M=5.01(SD=3.06)), and to others in general (M=6.06(SD=1.91)).

Question	**N**	**M**	**SD**
How attractive is a career in social care to you personally?	1729	3.42	2.48
How attractive do you think a career in social care is to others/in general?	2058	4.08	1.70
How attractive is a career in the National Health Service to you personally?	1780	5.01	3.06
How attractive do you think a career in the National Health Service is to others/in general?	2090	6.06	1.91

Table 4: Participants ratings on the attractiveness of social care work and NHS work to them personally and others in general

Respondents were also asked what they felt the biggest reasons why people were possibly leaving or not applying to social care jobs. They were asked to rate, on a scale of 1-10 how much of a role they felt each factor is playing in the shortage of social care staff (with 1 being 'it hasn't played a role at all' and 10 being 'it has played an extremely important role') (Table 5). Unsatisfactory pay, unsatisfactory working terms and conditions, unsatisfactory career security and progression pathways, better opportunities in other sectors, burn out/excessive work, lack of recognition or value given to the profession and the added strain of the COVID-19 pandemic on the social care workforce were all rated as playing an important role in the shortage of social care staff (M=7.16-8.29). In particular, the added strain of the pandemic (M=8.29 (SD=2.01) and the lack of recognition given to social care work (M=8.21(SD=2.01) were the two highest rated factors.

Factor	**N**	**M**	**SD**
Unsatisfactory pay	2137	8.03	2.04
Unsatisfactory working terms and conditions	2127	7.89	2.02
Unsatisfactory career security and progression pathways	2123	7.16	2.19
Better opportunities in other sectors	2137	7.88	2.00
Burn out/ excessive work	2118	8.08	2.11
Lack of recognition or value given to the profession	2122	8.21	2.01
The added strain of the COVID-19 pandemic on the social care workforce	2123	8.29	2.01

Table 5: Participants ratings on the factors playing a role in the shortage of social care staff.

Qualitative findings

Focus groups also discussed the question of whether social care was in need of reform, what type of reforms they would like to see happen, whether social care should be valued in the same way as health care (parity of esteem) and why social care work was seeing problems in recruiting and retaining staff.

Five prominent, related, themes emerged: *consistency, personalisation, integration, recognition* and *investment*. Specifically, participants argued that there was a need for more consistency in the social care received, a need for more personalised care, a need for better integration between health and social care; the need for more recognition for social care workers, and a need for more investment in social care.

Consistency

Participants drew on their experience of using social care, for example for a spouse or parent, to argue that, as they saw it, social care was not consistent enough. Specifically, they argued that either the quality of care received was inconsistent (e.g. some care providers providing better quality care than others) or that there was a lack of "continuity" of care (e.g. a lack of communication or co-ordination between different care staff or care providers). For example, one participant discussed how, as someone in full-time work, struggled to care for her mother, who required regular care that she felt was not met due to the lack of time allocated or because certain care staff were not permitted to undertake certain activities (e.g. helping with medical eye drops):

> "What I found really sad was that my mom had dementia and there was no continuity … three times in a day she had the visit and you could have three different people, and that's someone with memory issues. It was difficult to get a pattern. … As a family we were struggling to manage her condition because she needed these eye drops four times a day, and I work full time. And so, the in-house provider was providing the care …… then the after so many weeks when our local manager was off, somebody else came in and said there was a note in the book saying 'drops not given, we're not allowed to do it. … Sometimes they didn't turn up at all, saying they'd forgotten. … But you're afraid to complain you're afraid to complain in case you lose the service." (Eira, Female, 60s)

As the above quote suggests, some participants felt as though it was difficult to make a complaint about the inconsistent social care they were receiving because they were "afraid" of losing the service. Others felt that it was difficult to complain about services, which they felt were not consistent or "joined up" because there was no clear or single person they could complain to:

> "You certainly couldn't describe it [social care service] as in any way joined up … When my wife got to the point where she needed care at home, I was dealing with social services, but I didn't actually know where to start. it's not easy to navigate your way through, and you find yourself talking to different people at different times, but about the same thing. … and if you wanted to understand something more or make a complaint about how the way it worked, … you'd ring the local authority and you get to be a different person each different time. (Wynford, Male, 70s)

Personalisation

Participants tended to argue that although the care staff[21] themselves were often "good", "sensitive" or compassionate", the social care system and the way in which care services were managed or organized was felt to be "impersonal", or even, as one participant argued, "callous":

> "A couple of years ago my wife was diagnosed with motor neurone disease. The carers we had, without exception were very, very good, very sensitive … but once you get into what you might call the management layer or the bureaucracy, you are simply a number and a case and they want you on one list or on another list. It's terribly impersonal – callous in a way. You're in a situation where someone needs care, you only need care because the situation is critical to that person and their immediate family, and you immediately find you're a commodity. (Wynford, Male, 70s)

Participants tended to argue that one of the reasons why it felt impersonal and not "joined up" (above) was because the system was "commercially driven" as a result of "privatisation" of social care which some felt "uneasy" about. One participant discussed how there was more of a need to personalise and tailor social care to the needs of the family of the person receiving care, as well as the person themselves:

> "They're caring for an individual, but they're caring for that family as well, because if the family is trying to support people to be at home, that package and the needs to be tailored around what helps everybody, you know. And I just found that the timing wasn't helping me at all" (Eira, Female, 60s)

Integration

Participants argued that, in their experience co-ordination between health and social care services was lacking and should be better "integrated":

> "Healthcare social care should really be one service in a similar way. They should be knitted together (Denys, Male, 70s)

Participants argued that, from the perspective of those needing them, social care and health care were connected, because adequate social care could enable people to live at home longer and either avoid hospital for longer or leave hospital sooner (i.e. "bed blocking"):

> "I think it is about integration, it's about bringing these things together … I think what the last two years has shown, it's an unfortunate term, but bed blocking - it's shown the issues between health and social care and what can happen when it goes wrong, and if there's not enough capacity in both or how you move people through." (Bryn, Male, 50s)

Some argued that they should be more "joined up" or "one":

[21] NB: Participants references to 'carers' usually refer to professional care staff (as opposed to unpaid carers) unless otherwise noted.

“There is no joined up process ….I think part of the bed blocking program that we're seeing is the result of the lack of joined up thinking and the lack of proper processes as to who's responsible for what part of the process of getting somebody out from a hospital environment.” (Diane, Female, 70s)

“I think that they, the NHS and social care, are regarded as two complete entities, and I believe that they should be one” (Enid, Female, 60s)

Others argued that social care should be fully integrated within the National Health Service:

“You can't describe it as part of the National Health Service, which I would have thought it was and ought to be.” (Wynford, Male, 70s)

Recognition

Focus group participants also discussed some of the perceived reasons why social care was experiencing difficulties in recruiting and retaining staff. One of the main themes that emerged from the focus groups was that of recognition for the profession and its staff.

A common argument was that social care was seen as a “secondary”, “fallback” or “Cinderella” service to the NHS, and social care workers were seen as “second-class citizens” compared to NHS workers. Participants tended to feel that this was a perception that was unlikely to change fully, due to the fact that NHS staff were involved in “saving your life”, but that for them, social care staff played an important role in enabling people to lead independent lives:

“The general perception I've got of social care is that it's a fallback service …the NHS doctor or nurse is physically involved in the business of actually saving your life, the social worker is secondary, and I’m not sure that is a perception you are ever going to be able to change. … But on the other hand there are a number of things that the social care services do which enable people like myself and Enid and people of our generation lead independent lives, and we want to lead independent lives, but if the unavailability of social care means we are being forced into a care home or whatever, that is not the preferred option.” (Thomas, Male, 70s)

Relatedly, some participants argued that, unlike healthcare, which was perceived to be relevant to people of all ages, social care was primarily associated with “the elderly” meaning that many people didn’t see it as a priority, until they, or someone in their family, needed it:

“It [social care] most definitely does need to have more recognition. If you ask people ‘do you want more buses, or do you want better social care?’ [they will say] ‘well I’m not really at that stage at the moment, so I'll have more buses. … But if you ask do you want a GP practice in the area or do you want X, people will always choose a GP surgery … but they are intertwined. [Social care] It’s a second thought. … you only need it when you need it. It shouldn’t be health *or* social care - it should be health *and* social care.” (Alys, Female, 30s)

Some participants also pointed to the fact that social care was, they felt, often portrayed in a negative light in the media, something that might be influencing their perceptions of it:

> "Social work generally only really gets in the news when there's bad news … when its failing default you don't tend to hear much about the successes. Whereas the NHS is pretty much the reverse … certainly during the pandemic. … A lot of my views on the status of social care present time is largely based on this negative perception it's got." (Denys, Male, 70s)

Participants also discussed how social care workers were, they felt, "undervalued":

> "I think they're treated like second class citizens, basically in the workplace, that needs to change." (Gareth, Male, 60s)

> "They're totally undervalued. I think it's exploitation." (Diane, Female, 70s)

Participants argued that social care workers should get better recognition. A common argument was that social care staff had increasingly been given less responsibilities and more restrictions on what they could do in the role. Some argued this had contributed to an image of social care work as "menial" and a perception that the role had been de-skilled (or "dumbed down"):

> "People seem to view it as something that you do if you can't be a nurse, a very basic, menial job. Mum's been talking to her carers, and they have been doing it a while, the job's been dumbed down, they have been given less responsibility and I think that is a problem, and if you want to encourage people into doing what is a very important job, you need to give them more responsibility, you need to put them on a parity with NHS staff, and just stress what an incredibly important job it is (Angharad, Female, 50s).

Many felt that the lack of recognition was associated with a lack of pay, and a lack of job security and a career pathway ("they need a professional route"):

> "As I understand it, these folks are on minimum wage, on zero-hour contracts, … probably half the carers that we saw over the 18 months were doing the job because it was the only job they could get… And so, it struck me it's almost the employer of last resort. Social care … they are the Cinderellas in a way." (Wynford, Male, 70s)

Some participants suggested that one way to improve the career development opportunities of social care staff was to provide a more integrated or permeable career path, such that social care workers could more formally and readily occupy similar or equivalent roles in the NHS, and vice versa. One participant explained how this might help enhance the professional opportunities and abilities of both NHS and social care staff:

> "Perhaps also a route between health and social care is a very similar roles, so that people can move between the two sectors … and lots of opportunities for that next level up. …. It would improve your personal and professional abilities to be able to see the world from the health, as well as the social care, point of view." (Bryn, Male, 50s).

Some argued that the lack of remuneration had a negative impact on care staff motivation, and even ability, to undertake their role:

> "Most carers I come across are fantastic. They are on very little money. You know I wouldn't do that job for the money they they're being paid. So, most of them I take my hat off to but it's really sad when you see somebody who is has become cynical and poor at the job because you see the impact it's having on the person they are caring for. I think the whole thing has to be seriously looked at." (Daffydd, Male, 60s)

Others argued that, despite their commitment to the role, people were leaving care roles because of the low pay and long hours, for work that was emotionally demanding and, during the pandemic, risky:

> "You get paid more work at Lidl's [supermarket]. I have family members who are carers [i.e. paid care staff] and they are 100% committed to those roles, but you know, you're struggling to pay your electricity bill. My dad's partner, she had to give it in because she would do a 15-hour day [and] she might see 20 people, providing personal care and up and down the M4 [motorway] caring for somebody that had no family and there was that emotional guilt … Going into the pandemic, they were asking them to put their own lives at risks with inadequate PPE [personal protective equipment], not enough money and no respite, and fear that they were going to bring it [the virus] home. (Alys, Female, 30s)

Investment

A fifth theme in the focus groups concerned the costs of social care, including how it should be paid for, and whether social care should be better funded. Participants generally felt that social care needed more funding:

> "It's not getting a big enough by to the cherry, but will it ever change?" (Gareth, Male, 60s)

Most participants also tended to express the sentiment that people should not have to bear too great a cost for social care, including recipients having to sell their home to pay for care. They argued that, as with health care, paying tax and national insurance during their adult life meant that social care, or at least a greater proportion of it, meant they were, or should have been, already paying for it:

> "Should someone's house be sold to pay for social care? I would think definitely not because people have normally worked hard all their lives. If they've got a house, then they would like hopefully to leave it to their children or something like that, rather than the government stealing it to pay for social care. … Even as a pensioner I'm still paying tax and most all of my working life, I paid National Insurance so I should not be paying for any care I need in the future." (Gareth, Male, 60s)

Some participants argued that the decision of whether, where and how to apply for social care should be shaped by what the recipient and their family needed, rather than by "financial pressures":

> "There's financial pressures around the system in all ways, and it would be nice to be able to remove those financial things away from the decision making and what's best for the individual what's best for the family." (Bryn, Male, 50s)

As discussed above (see: Integration) some participants felt that social care should be integrated into the NHS, or that they should be considered one inter-woven service, while others specifically argued that a National Care Service working in a joined-up way with the NHS could ameliorate some of the current challenges that applicants or recipients experienced in trying to access, and pay for, care. This they argued would reduce the stress that many families experience in trying to set up care:

> "I think there should be a National Care Service., whether or not, this is integrated into the NHS, I think the financials will come after - a more centralized structure, to get people out of the hospitals and into homes … as as opposed to desperately running around all the different care homes to see who's got a bed and to see what they've got. … It's a stressful situation … it would be nice to have one central information point." (Bryn, Male, 50s)

Study limitations

Although there was a very wide age range of survey respondents – from 21 to 95 years of age – the average age of the sample was 64 years old (and a standard deviation of 12.5 years). As such, it is important to note that, overall, the survey's average age is older than the general adult population. The recruitment and sampling strategy for the survey did not seek to be representative of the Welsh population, or to provide a random stratified sample. The survey was advertised to all adults on a large participant pool via HealthWise Wales, with all eligible individuals (all adults over 18) invited to take part. It is likely that, with all non-random samples, a degree of response bias will be incurred. In this instance, the larger number of respondents aged >50 years, and smaller number of participants aged <50 years likely reflects the fact that older adults will have more experience of social care, either directly as users themselves, or indirectly through a spouse, partner or parent who has received or needed care. Also, it may reflect the common perception (as was discussed in focus groups) of social care as something that is associated with an older (or "elderly") population, and as something that is only thought about "when you need it". As such, a challenge going forward is to promote greater and broader interest in, and appreciation of the value of, social care to the public, including younger adults. As discussed above, and in more detail below, this could entail emphasizing how interconnected health and social care.

Also, there was an underrepresentation of Black and Asian Minority Ethnic (BAME) respondents in the survey. This partly reflects the demographics of Wales - with 98% of participants in this described their ethnicity as White compared to 95% of people living in Wales overall.[22] This is particularly important going forward, since there are a number of racial and ethnic inequalities related to health and social care in Wales, and BAME individuals may face additional barriers to accessing social care.[23] [24] Future research, including our own, should endeavor to use additional recruitment methods and outlets, and include messaging that suggests individuals from BAME communities are particularly encouraged to take part.

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[22] https://gov.wales/equality-and-diversity-statistics-2017-2019#:~:text=Main%20points-,Ethnicity,or%20'Other%20ethnic%20group'.

[23] https://www.wcpp.org.uk/wp-content/uploads/2021/03/Improving-Race-Equality-in-Health-and-Social-Care-Policy-Briefing-.pdf

[24] https://onlinelibrary.wiley.com/doi/full/10.1111/hsc.12116

IMPLICATIONS FOR POLICY AND PRACTICE

From the perspective of the Welsh public, the COVID-19 pandemic has exacerbated the already significant strain on social care services in Wales. Overall, this study has found there is a considerable appetite for social care reform in Wales. Taking into consideration the scope of the research and the aforementioned limitations, a few main policy and practice implications can be drawn. These will be discussed and summarized below.

Removing barriers to accessing or making use of social care

It is very concerning that approximately 4-in-10 of those who felt that either they or someone in their household or close family that needed help from social care, did not receive or make use of social care services. This study provides further, Wales-specific, evidence of the 'unmet needs' that exist, where people who need care are not receiving or making use of it.[25] Previous research on social care suggests that these unmet needs are related to a number of related supply and demand factors, including people in potential need of care not applying when they needed it and being denied access to services due to being deemed ineligible by social services'. For example, research suggests that services may not be able to meet the needs of those who do apply or who are already in the system.[26] [27] [28] Additionally, people may not be applying for support where it is needed, due to factors such as a lack of information about services available, a reliance on family or other unpaid care, and perceptions around the stigma attached to using local-authority-assessed social care.[29] [30]

This study found that there were a number of barriers from the perception of the public. Many people who had not received social care when they or someone in their household/family needed it because there was not enough provision or availability. As such, extending provision through additional funding and social care workers could help improve access by those in need. Secondly, some participants reported not accessing care because of the perception that there was not enough care services "to go around". In addition to ensuring adequate provision and availability of social care services for those who need it, government and social care service providers may also need to combat the belief that there is insufficient provision or that care should be "rationed" such that only those in greater need should be able to access it.

Unpaid carers play an enormously important role in providing care and improving the quality of life of those in receipt of their care. However, this can come at significant cost to the carers themselves, including in relation to their own wellbeing.[31] Many unpaid carers, and

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[25] https://www.kingsfund.org.uk/publications/whats-your-problem-social-care#unmetneed
[26] https://www.health.org.uk/sites/default/files/NHS-70-What-Can-We-Do-About-Social-Care.pdf
[27] https://www.ageuk.org.uk/latest-news/articles/2018/july/1.4-million-older-people-arent-getting-the-care-and-support-they-need--a-staggering-increase-of-almost-20-in-just-two-years/
[28] https://www.cqc.org.uk/sites/default/files/20191015b_stateofcare1819_fullreport.pdf
[29] https://www.sciencedirect.com/science/article/pii/S0378512215300207
[30] https://socialcare.wales/cms_assets/file-uploads/Preventative-support-for-adult-carers-in-Wales.pdf
[31] http://eprints.lse.ac.uk/87978/

those who are receiving their care will understandably choose and prefer have care needs met at home, for example by a family member or close other. However, the challenge for social care services is to ensure that this is indeed a preference, and not out of necessity (real or perceived) as a result of a lack of social care provision. Also, many respondents reported that those in their household or close family who they felt needed care, but didn't make use of it, didn't do so because of a sense of pride – that is, of a negative association of local authority-provided social care or of going into a care home. The best way to change negative perceptions of social care is to provide social care that feels both more personal and professional. However, simultaneously, efforts can be made by all social care stakeholders, and society in general, to work towards shaping a more positive image of social care, and de-stigmatising the need for social care, such that those who are in genuine need of it do not feel "too proud" or ashamed of receiving it.

Another common barrier to access was the perceived complexity of the application process. For some this was a deterrent to applying where they felt a genuine need for social care existed. Streaming the application and administrative process and providing additional support for those who would like to apply for, or who receive, social care, but are unsure of various processes involved, would likely reduce the numbers of those who need care, but who are not receiving it.

Responding to the appetite for social care reform

This study suggests there is a considerable appetite for reform. Overall most respondents in this study felt that reform of social care should be a priority for the UK and Welsh Governments. There has been much dialogue in and outside of health and social care policy circles in Wales, and the UK generally, about the need for social care reform for some time.[32] However, it has also been noted that many key reforms are yet to materialize.[33] This perception, that reform has long been talked about but not yet enacted, was reflected by some participants in this study ("will it ever change?"). As such, irrespective of what it specifically entails, social care reform would be welcomed by a large proportion of the Welsh public – and perhaps particularly by older adults (50+) who either are in receipt of care for themselves or others, or who are perhaps more cognizant of social care due to being of an age they consider more likely to need it in the near future. Future research should seek to include a larger proportion of younger adults (<40 years), including via focus groups, to explore more deeply their views on social care. A broader challenge for social care reform, may be to address the perception that social care is "for the elderly". Although focus group participants argued that health and social care were, or should be, inexorably linked, they also suggested that many people don't really start thinking about it, or don't see it as important "until you need it".

Arguments have been made that health and social care in the UK has been too disjointed and insufficiently integrated.[34] Amongst participants in this study, there was a commonly held view that (because health and social wellbeing are inexorably linked) health and social care services should be better integrated and joined up. As such, the present study suggests that a

[32] https://www.ijhpm.com/article_3790_fce0ce70c68441db088b5dda686927f8.pdf
[33] https://www.kingsfund.org.uk/publications/whats-your-problem-social-care#unmetneed
[34] https://www.kingsfund.org.uk/publications/whats-your-problem-social-care#unmetneed

critical mass of the Welsh public, and certainly amongst older adults, may support genuine and significant attempts to more fully integrate health and social care in Wales. This would add weight to arguments in favour of achieving the "seamless care" that is yet to be experienced by many in Wales.[35] In terms of the nature of reform, this was explored in the qualitative data, with some arguing for better integration of social care into the existing National Health Service, and others arguing in favour of establishing a National Social Care Service, the care equivalent of the NHS.[36] There was significant support for reducing costs of social care, with many arguing that care should be indirectly funded (through tax, national insurance etc.) and thus free at the point of need. As such, this would add evidence of public support for the impetus or rationale behind a National Care Service in Wales.[37]

Improving the pay, working conditions, career pathways and recognition of social care work

There was considerable support for moves to improve the recognition of social care workers in Wales, including considerable support amongst survey respondents for the idea of them being valued in the same way as NHS employees. Focus groups brought out a more nuanced view, with participants suggesting that although social care work was unlikely to achieve the social status of front-line healthcare workers (who were "in the business of saving lives") there was still a common feeling that social care work played an invaluable role in both freeing up hospital and health care capacity and, crucially, in helping people to attain a better quality of life, lead a more independent life, and reducing or sharing the caring responsibilities of families and unpaid carers.

Social care work in Wales is experiencing a number of challenges related to the recruitment and retention of care staff, including a high turnover of staff.[38] A major cause of the shortage of social care work is its relatively low pay. Average earnings in the social care sector in Wales are approximately £16,900, compared to the national average earnings of £29,200 (per full-time equivalent).[39] Another issue has been the lack of integration of health and social care work and the lack of professional career development opportunities for social care workers (relative to health care workers).[40] [41]

Overall, participants felt that social care careers should be transformed – with better pay, better working terms and conditions (including secure, permanent contracts for care staff) and better career development opportunities. Many felt that the best way to raise the status of social care work was to "professionalise" it, for example by adding educational and professional qualifications, coupled with clear career progression opportunities, akin to the ones they argued were available to health care workers.

[35] https://gov.wales/sites/default/files/publications/2018-01/Review-health-social-care-report-final.pdf
[36] https://www.bmj.com/content/365/bmj.l4349.full
[37] https://gov.wales/first-step-national-care-service-expert-panel-announced
[38] https://gov.wales/sites/default/files/publications/2020-06/welsh-government-response-to-shortage-occupation-list.pdf
[39] https://socialcare.wales/cms_assets/file-uploads/The-Economic-Value-of-the-Adult-Social-Care-Sector_Wales.pdf
[40] https://gov.wales/sites/default/files/publications/2018-01/Review-health-social-care-report-final.pdf
[41] https://socialcare.wales/cms_assets/file-uploads/Workforce-strategy-ENG-March-2021.pdf

Mitigating the impact of the pandemic on social care

The COVID 19 pandemic has contributed to or worsened backlogs in health and social care in Wales.[42] Participants in this study felt that the COVID-19 pandemic had placed a major strain on social care services. This has had impacts on people's willingness to access care, people's ability to receive care, and the perceived quality of care received. Unfortunately, those who have been most in need of social care are also include many of those who are also at highest risk of severe COVID-19 outcomes, including hospitalisation and death for example older adults aged 70+ and/or clinically vulnerable adults including those with certain disabilities. As such, the pandemic may have created a new dilemma for some of those needing social care for themselves or their family: access social care and potentially increase risk of infection or not access social care and potentially experience worsening health or quality of life, and potentially place additional demands on unpaid carers as a substitute. Additionally, some people have not felt they received the social care they needed during the pandemic, for example due to care staff or some services being unavailable in their area at the time or unable to attend due to COVID-19-related restrictions.

As with health care services, a challenge going forward for social care services may be a potential backlog of those needing care who were either unable to access care or receive sufficient care because of Covid-related staff absences and shortages or restrictions, as well as those who did not want to apply or re-apply because they were concerned about infection risk or because they did not want to "bother" services (or felt others were in greater need). As such, services will need to look for ways of engaging, accommodating and supporting those whose care needs may have been postponed or disrupted due to the pandemic.

Summary

Drawing on the experiences and perceptions of participants in this research, the following implications can be drawn to inform policy and practice around the issue of social care reform:

(1) *Social care policymakers and providers need to understand and address the reasons behind why people who might need social care are either not able or willing to access it* (roughly 4-in-10 in this study). Particular attention can be paid to:
   a. Widening and clarifying eligibility criteria for social care. Increasing provision such that all those in need of social care are able to receive it.
   b. Working to reduce the time delay between application and receipt of social care services.
   c. Simplifying the application and administrative processes for those in need of social care.

(2) *Making social care reform a priority in Wales*. Particular attention can be paid to:
   a. Reducing, or where possible removing, costs of social care services for people.
   b. Ensuring a more integrated, "joined-up" health and social care system.

[42] https://www.bevancommission.org/publications/doing-things-differently-tackling-the-backlog-in-the-aftermath-of-covid-19/

c. Consideration of integrating social care within the National Health Service or the establishment of a dedicated National Social Care Service in Wales.

(3) *Enhancing the recognition and attractiveness of social care work.* Including:

a. Further improvements to the pay and job stability of social care workers.
b. Improved working conditions and career development opportunities for social care workers (analogous to those in the NHS).

(4) *Mitigating the impacts of the COVID-19 pandemic on social care in Wales.* Including:

a. Ensuring, and communicating to those in need, that adequate COVID-19 safety precautions and measures are in place, as appropriate, in order to reduce infection risk during care visits.
b. Addressing the added backlog that the pandemic will have contributed to, including those whose care had been delayed due to COVID-19 policies/staff absences and due to people delaying their application.

HSC(6)-16-22 PTN 06

Agenda Item 8.6

Y Pwyllgor Iechyd a Gofal Cymdeithasol

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Health and Social Care Committee

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Eluned Morgan MS
Minister for Health and Social Services
Welsh Government

21 March 2022

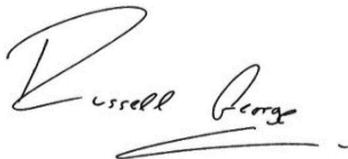
Dear Eluned

Provisional common frameworks

Thank you for your letters of 17 January 2022 regarding the Public Health Protection and Health Security; Blood Safety and Quality; and Organs, Tissues and Cells (apart from embryos and gametes) provisional common frameworks.

Our views on these provisional common frameworks are set out in the annex. I look forward to receiving your response by Monday 9 May.

Yours sincerely



Russell George MS
Chair, Health and Social Care Committee

cc Tracey Cooper, Chief Executive, Public Health Wales
Huw Irranca-Davies MS, Chair, Legislation, Justice and Constitution Committee, Welsh Parliament
Baroness Andrews, Chair, Common Frameworks Scrutiny Committee, House of Lords
Colm Gildernew MLA, Committee for Health, Northern Ireland Assembly
Gillian Martin MSP, Health, Social Care and Sport Committee, Scottish Parliament
William Wragg MP, Chair, Public Administration and Constitutional Affairs Committee, House of Commons

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

Annex: Public Health Protection and Health Security; Blood Safety and Quality; and Organs, Tissues and Cells (apart from embryos and gametes) provisional common frameworks

Risks and benefits of the common framework approach

1. The purpose of common frameworks is to establish common approaches in some areas that were previously governed by EU law, but that are within areas of competence of the devolved governments or legislatures.[1] They are a key tool for intergovernmental working and discussion on approaches to law and policy now that the UK is no longer a member of the EU.

2. The Public Health Protection and Health Security (PHPHS), Blood Safety and Quality (BSQ) and Organs, Tissues and Cells (apart from embryos and gametes) (OTC) common frameworks set out how the Governments will work together and make decisions on regulatory alignment and divergence in the post-Brexit context.

3. The structures provided by these common frameworks could enhance joint working and promote a shared approach to tackling common challenges. They could offer opportunities for the Welsh Government to influence and inform decisions taken by other Governments, as well as providing defined routes for engagement at an international level.

4. However, the common frameworks also present potential risks, such as relinquishing regulatory freedom in favour of a common approach, making it harder for Welsh stakeholders to influence decisions, and risking blurring accountability to individual Parliaments.

5. Such benefits and risks are not unique to the common frameworks that we have considered, but cut across the whole common frameworks programme. In February 2022, the Scottish Parliament Constitution, Europe, External Affairs and Culture Committee concluded that:

> *"[…] Common Frameworks […] have the potential to resolve the tensions within the devolved settlement through managing regulatory divergence on a consensual basis while facilitating open trade within the UK internal market.*
>
> *261. But the Committee believes there is a risk that the emphasis on managing regulatory divergence at an inter-governmental level may lead to less transparency*

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[1] Joint Ministerial Committee (EU Negotiations), Communique, 16 October 2017

and Ministerial accountability and tension in the balance of regulations between the Executive and the Legislature".[2]

6. The correspondence we have received from the Welsh Government in respect of common frameworks has not always clearly articulated the risks and benefits of working through those frameworks, or how they might be managed.

Recommendation 1: The Welsh Government should explain how it will identify and manage risks associated with and arising from the PHPHS, BSQ and OTC common frameworks on an ongoing basis, including how information about such risks will be shared with Senedd committees.

Implications for making Welsh law and policy

7. The PHPHS, BSQ and OTC common frameworks require Governments to discuss and agree approaches to law and policy, and set out processes for resolving any disputes or disagreements that arise. As such, the frameworks could, in practice, limit the exercise of devolved competence.

8. This will not only affect the Welsh Government as it makes policy or prepares legislation, but will also affect the development of Senedd Bills. For example, Members who wish to table amendments to Bills passing through the Senedd, or committees that plan to introduce committee Bills, may need to consider the implications of relevant common frameworks, and potentially how to engage with these intergovernmental arrangements.

9. It could also make it more difficult for stakeholders in Wales to influence the development of Welsh law and policy.

10. When the Governments agreed principles for common frameworks, they agreed that they should "maintain, as a minimum, equivalent flexibility for tailoring policies to the specific needs of each territory as is afforded by current EU rules."[3] We regard this as an important principle.

11. In its report in February, the Scottish Parliament Constitution, Europe, External Affairs and Culture Committee recommended that:

> *"…there should be a similar agreement between the Scottish Government and Scottish Parliament that, as a minimum, there should be no dilution of public consultation or of parliamentary scrutiny."*[4]

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[2] Scottish Parliament Constitution, Europe, External Affairs and Culture Committee, *UK Internal Market inquiry*, 22 February 2022, p.42

[3] Joint Ministerial Committee (EU Negotiations), Communique, 16 October 2017

[4] Scottish Parliament Constitution, Europe, External Affairs and Culture Committee, *UK Internal Market inquiry*, 22 February 2022, p.36

12. Thought should be given to whether such an agreement between the Senedd and the Welsh Government would be helpful.

Recommendation 2: The Welsh Government should set out how it will ensure that the PHPHS, BSQ and OTC frameworks will maintain, as a minimum, equivalent flexibility for tailoring policies to the specific needs of each territory as was afforded by current EU rules.

Recommendation 3: The Welsh Government should seek intergovernmental agreement that the PHPHS, BSQ and OTC common frameworks will lead to no dilution of public consultation or of parliamentary scrutiny in policymaking or the legislative process.

Recommendation 4: The Welsh Government should explain how it will ensure that these common frameworks will not limit the role of the Welsh Government, the Senedd, or stakeholders in Wales when making law and policy for Wales. This should include how the Welsh Government will facilitate the engagement of committees or Members of the Senedd with the common frameworks if required, to ensure that frameworks do not represent a barrier to the operation of the Senedd's legislative procedures.

Transparency

13. We recognise that the process of reaching four-Government agreement on common frameworks is necessarily iterative and can be complex. It was helpful that initial draft versions of the BSQ and OTC provisional common frameworks were published in early 2021. However, it is far from ideal that the final provisional frameworks were not published for scrutiny until the end of 2021, especially as they have already been in operation since the end of the transition period on 31 December 2020.

14. The frameworks will, rightly, remain under review. This is especially important in the context of learning from the response to the COVID-19 pandemic.

15. However, the frameworks themselves include limited information about ongoing reporting to Parliaments and stakeholders, engagement with stakeholders, or scrutiny of changes proposed during review and amendment processes. We explore each of these issues below.

Reporting on the operation of frameworks

16. In November 2021, the House of Lords Common Framework Scrutiny Committee noted its disappointment that the PHPHS framework did not include a commitment to ongoing engagement with Parliament. It stated that:

> *"Transparency in this area should include regular statements to legislatures on the functioning of this framework. We recognise that there are a number of initial*

reviews of the framework scheduled and instead would suggest coinciding the planned three-yearly reviews with such engagement.

We recommend that the framework should be updated to include a commitment to update each of the 4 UK legislatures on the ongoing functioning of this framework after the conclusion of the three-yearly reviews."[5]

17. It made similar comments in December 2021 in respect of the BSQ and OTC frameworks.[6]

18. In a letter to the Fifth Senedd's External Affairs and Additional Legislation Committee in January 2020, the then Counsel General and Brexit Minister committed to "lay a report before the Senedd at least annually, which provides an assessment of the functioning of each Common Framework".[7] We welcome this commitment from the Welsh Government.

19. In November 2021, the Counsel General told the Senedd's Legislation, Justice and Constitution Committee that the four Governments had "committed to future reporting on the frameworks as part of the process for the oversight of the frameworks within the Intergovernmental Relations Review", and that this would assist Senedd committees in monitoring frameworks in the longer term.[8]

20. In January 2021, in response to questions about how the Senedd and stakeholders would be updated on the continuing operation of the frameworks, including any changes, the Minister for Health and Social Services told us that:

"The **expectation** *is that reports on frameworks will be public documents once they are signed off by portfolio Ministers and will be made available to the relevant committees in the four nations as well as relevant stakeholders."*[9] *[emphasis added]*

21. The Counsel General repeated this 'expectation' in oral evidence to the Legislation, Justice and Constitution Committee on 31 January 2022.[10] In a letter to that Committee in March 2022, he stated

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[5] Letter from the Chair of the House of Lords Common Framework Scrutiny Committee to the Minister of State for Health, 23 November 2021

[6] Letter from the Chair of the House of Lords Common Framework Scrutiny Committee to the Minister of State for Health, 14 December 2021

[7] Letter from the Counsel General and Brexit Minister to the External Affairs and Additional Legislation Committee, 23 January 2020

[8] Letter from the Counsel General and Minister for the Constitution to the Legislation, Justice and Constitution Committee, 19 November 2021

[9] Letter from the Minister for Health and Social Services (BSQ and OTC common frameworks), 17 January 2022

[10] Legislation, Justice and Constitution Committee, RoP [paragraph 54], 31 January 2022

that the "exact format of the annual reporting mechanism is currently being worked through at an official level".[11]

22. We appreciate that the frameworks and associated reporting are intergovernmental arrangements, and that the Welsh Government may not be able unilaterally to guarantee that these joint reports will be published. Nevertheless, we are concerned that full agreement has not yet been reached on this important point of transparency, and that a commitment to publishing reports is not included in the frameworks.

Recommendation 5: In line with the recommendations made by the House of Lords Common Framework Scrutiny Committee, the Welsh Government should secure intergovernmental agreement to update the PHPHS, BSQ and OTC common frameworks to include a commitment to update legislatures on the ongoing functioning of the frameworks after the conclusion of each review.

If this commitment is not included in the frameworks, the Welsh Government should confirm that joint reports on the frameworks will nevertheless be published in line with its stated expectation.

If intergovernmental agreement on this point cannot be secured, the Welsh Government should explain the reasons why intergovernmental reports will not be published, and confirm that it will nevertheless publish unilateral annual reports in line with its previous commitment.

Stakeholder engagement

23. The PHPHS, BSQ and OTC frameworks offer limited commitments on stakeholder engagement. All three frameworks provide that the parties may use third parties to provide advice in certain circumstances. The BSQ and OTC frameworks also include commitments to communicate changes to the frameworks to stakeholders.

24. We note that following scrutiny of the BSQ and OTC frameworks, the House of Lords Common Framework Scrutiny Committee stated:

> *"While we note the commitment to communicate changes in the frameworks to stakeholders, we regret the absence of a commitment to more meaningful ongoing stakeholder engagement. In our Committee's March 2021 report, we concluded that frameworks were weakened by the lack of stakeholder consultation and recommended that future reviews of frameworks should include an open and well-publicised stakeholder consultation process that reaches beyond the small number*

[11] Letter from the Counsel General and Minister for the Constitution to the Legislation, Justice and Constitution Committee, 2 March 2022

of stakeholders previously consulted. We believe that this is necessary in these frameworks as it is with other frameworks."[12]

25. The House of Lords Committee recommended that the frameworks should be updated to "include an ongoing commitment to stakeholder engagement" including an open consultation process as part of the first two-year review.[13] In respect of the PHPHS framework, it similarly recommended that the first three-year review should include an open consultation process with stakeholders.[14]

26. In this context, we welcome the Welsh Government's commitment to engage with "relevant stakeholders during the review or amendment process as appropriate".[15]

27. We agree with our colleagues in the House of Lords that there must be ongoing, open and meaningful engagement with stakeholders on the operation of these frameworks. We believe that this should be provided for within the frameworks themselves.

Recommendation 6: In line with the recommendations made by the House of Lords Common Framework Scrutiny Committee, the Welsh Government should secure intergovernmental agreement to update the PHPHS, BSQ and OTC common frameworks to include:

Provision that the first review of each framework should include an open consultation process with stakeholders.

Commitment to ongoing stakeholder engagement.

Should either of these outcomes not be secured, the Welsh Government should explain the reasons why not, and outline what will be done instead to ensure that there is ongoing, open and meaningful engagement with stakeholders across the UK.

Scrutiny of changes during review and amendment

28. The PHPHS, BSQ and OTC frameworks do not offer a role for parliamentary scrutiny of changes proposed during review and amendment processes.

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[12] Letter from the Chair of the House of Lords Common Framework Scrutiny Committee to the Minister of State for Health, 14 December 2021

[13] Letter from the Chair of the House of Lords Common Framework Scrutiny Committee to the Minister of State for Health, 14 December 2021

[14] Letter from the Chair of the House of Lords Common Framework Scrutiny Committee to the Minister of State for Health, 23 November 2021

[15] Letter from the Minister for Health and Social Services (BSQ and OTC common frameworks), 17 January 2022; Letter from the Minister for Health and Social Services (PHPHS common frameworks), 17 January 2022

29. In the Minister for Health and Social Services' letter to us on 17 January 2022 she suggested that Senedd committees will be notified if changes are made:

> *"If changes are made to the frameworks then these will be notified to Senedd committees in order for them to carry out the level of scrutiny they deem appropriate and necessary."*[16]

30. The Counsel General told the Senedd's Legislation, Justice and Constitution Committee on 31 January 2022 that the Welsh Government was open to considering recommendations made by the Senedd or stakeholders as part of the process of reviewing the frameworks.[17] In a letter to that Committee on 2 March 2022, he confirmed that the Welsh Government would notify the Senedd and stakeholders when a common framework is reviewed, and consider their recommendations before the review process concludes.[18]

31. We welcome this commitment. While scrutiny of any changes that have been made is clearly important, it would doubtless be more effective to ensure that the Senedd and other Parliaments are able to scrutinise any proposed changes before they are made. It would also be helpful for us to be notified in sufficient time in advance of any planned review to enable us to take an informed decision about whether any detailed work is required to help inform the development of any proposed changes.

32. To avoid duplication, it would also be helpful for such notification to include information about how and when stakeholders will be engaged in any particular review, and how and when any consultation responses will be made public.

Recommendation 7: The Welsh Government should confirm that it will notify Senedd committees in advance of reviews of the PHPHS, BSQ and OTC common frameworks and ensure that committees have an opportunity to scrutinise any proposed changes. Notifications should include information about the proposed approach to consultation with stakeholders.

Dispute resolution

33. We welcome the Minister for Health and Social Services' commitment to notify the relevant Senedd committee(s) of any disputes raised under the three common frameworks. We recognise that the dispute resolution process set out in the frameworks comprises a number of stages, with only those disputes that cannot be resolved at official level to be escalated to Ministers.

[16] Letter from the Minister for Health and Social Services (BSQ and OTC common frameworks), 17 January 2022

[17] Legislation, Justice and Constitution Committee, RoP [paragraph 52], 31 January 2022

[18] Letter from the Counsel General and Minister for the Constitution to the Legislation, Justice and Constitution Committee, 2 March 2022

Recommendation 8: To ensure proportionality, the Welsh Government need only notify Senedd committees of disputes arising under the common frameworks that are escalated to Ministerial level.

34. We note that the frameworks do not specify any timelines or time limits for dispute resolution. The BSQ and OTC frameworks state that when disputes arise, the making of legislation may be postponed until all four Governments are in agreement on how to proceed.

35. It is possible, therefore, that the resolution of disputes could result in delay to Welsh Government legislation or policy decisions, with knock on implications for the time available for scrutiny, implementation or spending.

Recommendation 9: The Welsh Government should set out its views on whether any time limits should be specified within the dispute resolution process.

36. The common frameworks were published before the Intergovernmental Relations Review was completed, but note that they would be updated to reflect the Review's outcomes.

37. We note that the Review has now been completed, and that it includes a revised inter-ministerial dispute resolution process through which disputes over common frameworks can be escalated.[19]

Recommendation 10: The Welsh Government should confirm that, before they are finalised, the PHPHS, BSQ and OTC common frameworks will be updated to reflect the new inter-ministerial dispute resolution process set out in the review of intergovernmental relations published in January 2022.

Provisional PHPHS common framework

Background

38. The provisional PHPHS common framework sets out how the UK Government, devolved governments and public health agencies will work together on public health protection and health security outside the EU.

UK Health Protection Committee: transparency of operation

39. The PHPHS framework states that the UK Health Protection Committee (UK HPC) has agreed a shared work programme. It also explains that the UK HPC is replacing the EU Health Security Committee (EU HSC) in the domestic context. We note that the EU HSC publishes information about

[19] UK Government, *Policy paper: review of intergovernmental relations*, 13 January 2022

its work, including its rules of procedure, membership, background documents, and reports on its activity.[20]

40. We believe that there should be similar transparency about the work and operation of the UK HPC.

Recommendation 11: The Welsh Government should seek intergovernmental agreement that the UK Health Protection Committee should publish and provide regular updates on its shared work programme. This should include the publication of reports of its meetings.

Resources and capacity

41. The PHPHS framework states that the parties have agreed that the implementation of the shared work programme will be delivered within their existing resources, and will not be contingent on allocation of new resources by any party.

42. Public Health Scotland gave evidence to the Scottish Parliament's Health, Social Care and Sport Committee on 21 December 2021, during which it raised concerns about its ability to deliver its responsibilities under the work programme within its existing resources, particularly within the context of the ongoing response to the COVID-19 pandemic:

> *"In the programme that has been set by the Health Protection Committee, Scotland has been identified as the lead in three areas—review of disease notifications, analysis of the four-nations working groups and a look at the evolving science of genomics with regard to collaborations, co-operation and sharing of data sets and information. Those are big pieces of work.*
>
> *I can speak only for Public Health Scotland, but I have to say that we would be extremely hard-pressed to contribute meaningfully to those pieces of work and reviews."*[21]

43. In the Minister for Health and Social Services' letter to us of 17 January 2022, she acknowledged that the UK HPC and Four Nation Health Protection Oversight Group (HPOG) work programme, which underpins the PHPHS common framework, would "require resources to ensure that Wales can make a full and ongoing contribution and an assessment of the resources required is currently

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[20] See European Commission, Health Security Committee and Health Security Committee reports on COVID-19 outbreak [accessed February 2022]

[21] Scottish Parliament Health, Social Care and Sport Committee, Official Report, 21 December 2021

underway".[22] On 12 January 2022, Public Health Wales told us that resourcing for Wales' representation on the UK HPC and the HPOG would be met from existing budgets.[23]

Recommendation 12: The Welsh Government and Public Health Wales should confirm whether they have any concerns about the potential resource or capacity implications associated with the work programmes of the UK Health Protection Committee or the Health Protection Oversight Group. This should include setting out the outcome of the assessment of resources referred to by the Minister for Health and Social Services in her letter of 17 January 2022, and, if the work programme is to be resourced from within existing budgets, details of where the funding and staff resource allocated to the work programme has been transferred from.

Recommendation 13: The Welsh Government and Public Health Wales should ensure that the work programmes published by the UK Health Protection Committee and the Health Protection Oversight Group include details of which bodies will be responsible for carrying out which activities, and how such activities will be resourced.

Representation and secretariat

44. The framework provides that the rotating chair of the UK HPC will be supported by a secretariat provided by the UK Department of Health and Social Care, whereas the rotating chair of the HPOG will be supported by a secretariat from the UK Health Security Agency (UKHSA). In each case, the framework provides that each nation may also designate a secretariat to support the group's progress alongside the permanent representative.

45. Therefore, while the chairs of the UK HPC and the HPOG will rotate between the four nations, the secretariats will be provided primarily by UK bodies.

Recommendation 14: The Welsh Government and Public Health Wales should explain why there will not be a joint secretariat established for the UK Health Protection Committee or the Four Nation Health Protection Oversight Group. They should also indicate whether they intend to designate any supporting secretariat for either group.

International obligations

46. The framework recognises that public health protection policy aims to protect populations living across geographical regions and international boundaries. It states that it takes an "all hazards" approach to cross-border health protection and health security. As such, it takes into account

[22] Letter from the Minister for Health and Social Services (PHPHS common framework), 17 January 2022

[23] Letter from Public Health Wales, 12 January 2022

international obligations in these areas, such as the WHO's International Health Regulations (IHR) and UK-EU requirements agreed in the Trade and Cooperation Agreement (TCA).

47. In her letter of 17 January 2022, the Minister for Health and Social Services advised that the framework would enable the four Governments to formulate common stances and approaches where appropriate, and to strengthen coordination in other areas. This could include developing UK-wide approaches to public health issues that could be communicated to international partners, including the WHO, the European Centre for Disease Control (ECDC) and EU Member states.

Recommendation 15: The Welsh Government should ensure that information about international activity within the scope of the PHPHS common framework is included in its regular reports to the Senedd on the operation of the common frameworks. This should include:

Recent activity carried out by the Welsh Government or Public Health Wales.

Details of common stances agreed with other parties to the framework for the purpose of international engagement.

Information about upcoming international developments or obligations that would be within the scope of the framework.

Relations between UK and EU agencies

48. In December 2021, the UKHSA signed a Memorandum of Understanding (MoU) with the ECDC.[24]

49. However, we note that Public Health Scotland told the Scottish Parliament's Health, Social Care and Sport Committee that it had some concerns about the extent of devolved engagement in the process of agreeing the MoU:

> *"We are not quite there yet, because the current technical committee has 15 representatives from the UK Health Security Agency but only one from Wales, two from Northern Ireland and three from Scotland. Some work is therefore needed to make sure that we are adequately represented in those technical discussions."*[25]

50. The TCA provides that UK access to the EU's Early Warning and Response System (EWRS) for communicable diseases can be granted on request. However, it is not clear from the framework documents and MoU whether this has been secured.

[24] UK Government, Press release: UKHSA signs memorandum of understanding with ECDC, 2 December 2021

[25] Scottish Parliament Health, Social Care and Sport Committee, Official Report, 21 December 2021

Recommendation 16: The Welsh Government and Public Health Wales should explain how they engaged in the process of developing and agreeing the Memorandum of Understanding with the European Centre for Disease Control, and how Wales will engage with the ECDC through the PHPHS common framework.

Recommendation 17: The Welsh Government should confirm whether UK access to the EU's Early Warning and Response System (EWRS) has been secured, and, if not, whether access will be requested through the PHPHS common framework.

Provisional BSQ and OTC common frameworks

Background

51. The provisional BSQ and OTC common frameworks set out how the UK Government and devolved governments will work together and manage divergence in these policy areas outside the EU.

Review of retained EU law

52. The UK Government has set out its intention to legislate to enable retained EU law to be amended more easily.[26]

53. In her letter of 17 January 2022, the Minister for Health and Social Services stated that any proposed amendment or repeal of retained EU law would be undertaken through a "separate process" to the frameworks.[27]

54. However, the UK Government has subsequently said that it is:

> *"…committed to the proper use of Common Frameworks and will not seek to make changes to retained EU law within Common Frameworks without following the ministerially-agreed processes in each framework".*[28]

55. Managing divergence between different parts of the UK in areas covered by retained EU law is a core purpose of the common frameworks programme. It is therefore important that any amendment or repeal of retained EU law in common framework areas be taken through the relevant common frameworks, not a "separate process".

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[26] UK Government, *The benefits of Brexit: how the UK is taking advantage of leaving the EU*, January 2022

[27] Letter from the Minister for Health and Social Services (BSQ and OTC common frameworks), 17 January 2022

[28] UK Government, *The benefits of Brexit: how the UK is taking advantage of leaving the EU*, January 2022, p.33

Recommendation 18: The Welsh Government should confirm that any proposed amendments or repeals of retained EU law within the scope of the BSQ or OTC common frameworks will be undertaken through the common frameworks and not by a separate process.

Recommendation 19: The Welsh Government should commit to notifying the Senedd, including the relevant committee(s), of any proposals to amend or repeal retained EU law within the scope of the BSQ or OTC frameworks that would affect Wales or Welsh patients.

UK Internal Market Act 2020

56. Part of the purpose of the BSQ and OTC frameworks is to ensure the smooth functioning of the UK internal market.

57. The UK Internal Market Act 2020 (the 2020 Act) sets out new market access principles in law. In essence, the principles aim to allow goods permitted or imported into any one part of the UK to be sold or supplied in any other part, with some exceptions. The UK and devolved Governments have agreed a process for considering UK Internal Market Act exclusions in common framework areas.[29]

58. The Welsh Government's view is that the 2020 Act implicitly diminishes the powers of the Senedd and the Welsh Government.[30]

59. In her letter of 17 January 2022, the Minister for Health and Social Services confirmed that these common frameworks do intersect with the 2020 Act, and referred to the agreed process for agreeing exclusions.[31] However, neither of the common frameworks includes any reference to the 2020 Act or to the exclusion process.

60. In December 2021, the House of Lords Common Frameworks Scrutiny Committee highlighted that the UK Government had previously acknowledged the interaction between the 2020 Act and the frameworks. That Committee felt that even though it was "unlikely for there to be conflicts between these frameworks and the Act, we believe an approach that is prepared for that eventuality should be preferred". It recommended, therefore, that the "frameworks should be updated to reference its interaction with the UK Internal Market Act 2020 and acknowledge the process for agreeing exemptions from that Act".[32] We agree with our colleagues in the House of Lords.

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[29] UK Government, Guidance: process for considering UK Internal Market Act exclusions in common framework areas, 10 December 2021

[30] Welsh Government, Written Statement: legal challenge to the UK Internal Market Act 2020, 18 January 2021

[31] Letter from the Minister for Health and Social Services (BSQ and OTC common frameworks), 17 January 2022

[32] Letter from the Chair of the House of Lords Common Framework Scrutiny Committee to the Minister of State for Health, 14 December 2021

Recommendation 20: The Welsh Government should explain the impact of the UK Internal Market Act 2020 on the movement of blood, organs, tissues and cells, including any risks to the practical effect of Welsh legislation and policy, and whether it is considering requesting any exclusions from the Act.

Recommendation 21: In line with the recommendation made by the House of Lords Common Framework Scrutiny Committee, the Welsh Government should secure intergovernmental agreement to update the BSQ and OTC common frameworks to refer to their interaction with the UK Internal Market Act 2020 and acknowledge the process for agreeing exemptions from that Act.

Northern Ireland Protocol and divergence from the EU

61. Under the Northern Ireland Protocol, any changes to EU law on the safety and quality of blood, organs, tissues and cells must be applied in Northern Ireland.

62. The frameworks provide information about how Governments will consider the implications of changes to law and policy in Northern Ireland and Great Britain for divergence, but offers limited detail about how this will work in practice.

63. In December 2021, the House of Lords Common Framework Scrutiny Committee welcomed the updated language in the frameworks relating to the Northern Ireland Protocol, describing it as "a great improvement". But that Committee felt that there was still a need for the frameworks to include additional detail to tailor the commitment to the specific processes of these frameworks, as:

> *"The current language does not make clear at what point in the EU legislative process measures that will be implemented in Northern Ireland through the Protocol will be submitted for the risk assessment process".*[33]

Recommendation 22: In line with the recommendation made by the House of Lords Common Framework Scrutiny Committee, the Welsh Government should secure intergovernmental agreement to update the BSQ and OTC common frameworks to include additional detail on when changes introduced in Northern Ireland through the Protocol on Ireland/Northern Ireland will be considered in these frameworks.

64. The Minister for Health and Social Services told us in January 2022 that she was aware that the European Commission planned to revise the EU Directives on the safety of blood, tissues and cells early in 2022.[34] She stated that the Welsh Government would, with the other Governments in the UK, consider what implications such changes might have. She added:

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[33] Letter from the Chair of the House of Lords Common Framework Scrutiny Committee to the Minister of State for Health, 14 December 2021

[34] European Commission, Revision of the EU legislation on blood, tissues and cells [accessed February 2022]

"We would not propose to make any unilateral changes in Wales, preferring to take a joint approach with the rest of the UK in respond to any changes in the EU, providing that the detail of any such joint approach is appropriate for Wales".[35]

Recommendation 23: The Welsh Government should explain how it will assess the risks and benefits for Wales of keeping pace with changes in Northern Ireland and the EU, as opposed to maintaining the status quo in Great Britain, and what position it will take in intergovernmental discussions on these matters.

International obligations

65. Part of the purpose of common frameworks is to ensure compliance with international obligations.

66. In respect of blood, organs, tissues and cells, Wales must comply with WHO standards and with new UK-EU obligations contained in the Withdrawal Agreement and TCA.

67. The frameworks mention that Governments will share information on UK, EU and international issues, but do not go into detail. However, in her letter to us on 17 January 2022, the Minister for Health and Social Services told us that:

"These frameworks do not specifically cover international obligations – and so do not alter current obligations with which organisations are already familiar".[36]

Recommendation 24: The Welsh Government should secure intergovernmental agreement to update the BSQ and OTC common frameworks to include detail of how Governments in the UK will work together on international and UK-EU obligations relating to blood, organs, tissues and cells. This should include how Wales will be represented in relevant discussions at the WHO and at UK-EU forums.

[35] Letter from the Minister for Health and Social Services (BSQ and OTC common frameworks), 17 January 2022

[36] Letter from the Minister for Health and Social Services (BSQ and OTC common frameworks), 17 January 2022

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Russell George AS/MS
Chair
Health and Social Care Committee
Senedd Cymru
Cardiff
CF99 1SN

9 May 2022

Dear Russell,

Thank you for your letter of 21 March in relation to the provisional common frameworks for Public Health Protection and Health Security; Blood Safety and Quality; and Organs, Tissues and Cells (apart from embryos and gametes). I note the Committee's recommendations in relation to these frameworks.

Until all legislatures in the UK have had the opportunity to complete scrutiny, we will be unable to address these recommendations formally.

Please accept this letter as a holding reply and be assured, we will consider these recommendations as soon as possible. I commit to providing a full response as soon as practicable.

Yours sincerely,

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

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We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Russell George MS
Chair, Health and Social Care Committee
Senedd Cymru
Cardiff Bay, Cardiff, CF99 1SN

By email: SeneddHealth@senedd.wales

09 May 2022

Dear Russell,

Thank you for the Health and Social Care Committee's report laid on 25 April in relation to the Supplementary Legislative Consent Memorandum (Memorandum No. 4) (the SLCM) on the Health and Care Bill (the Bill).

I appreciate that the lateness of the tabling of the amendment by the UK Government, in relation to commercial dealing in organs for transplantation abroad, did not provide the Senedd with the scrutiny period it would normally be afforded. I fully acknowledge the importance of full and effective scrutiny by the Senedd, where it is being asked to agree to the UK Parliament legislating on its behalf in areas which impact on Wales. As you will appreciate, the UK Parliamentary timetable is outside of our control, however, I took steps to lay the SLCM as soon as I possibly could to give as much time as possible to its consideration.

In your report you express concern at the apparent 'overuse' of Legislative Consent Motions and that this could be undermining devolution. This was also discussed in the Legislative Consent Motion debate on 26 April. I understand the concerns and indeed the First Minister's principles for legislating in UK Bills make it clear we follow the principle that primary legislation in devolved areas should be enacted by the Senedd. However, the principles also acknowledge there are, and will continue to be, circumstances in which it is sensible and advantageous if provision, which would be within the Senedd's legislative competence, is sought for Wales in UK Parliament Bills, with the consent of the Senedd. Our approach to the Health and Care Bill aligns with the principles.

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We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

I am copying this letter to Huw Irranca-Davies MS, Chair of the Legislation, Justice and Constitution Committee.

Yours sincerely,

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Huw Irranca-Davies MS
Chair, Legislation, Justice and Constitution Committee
Senedd Cymru
Cardiff Bay,
Cardiff,
CF99 1SN

9 May 2022

Dear Huw,

Thank you for the Legislation, Justice and Constitution Committee's report laid on 25 April in relation to the Supplementary Legislative Consent Memorandum (Memorandum No. 4) (the SLCM) on the Health and Care Bill (the Bill).

I welcome the Committee's acknowledgement of the prompt tabling of the SLCM, though I appreciate that the lateness of the tabling of the amendment by the UK Government in relation to commercial dealing in organs for transplantation abroad did not provide the Senedd with the scrutiny period it would normally be afforded. I fully acknowledge the importance of full and effective scrutiny by the Senedd of legislation where the Senedd is being asked to agree to the UK Parliament legislating on its behalf in areas which impact on Wales. As you will appreciate, the UK Parliamentary timetable is outside of our control, however, I took steps to lay the SLCM as soon as I possibly could to give as much time as possible to its consideration.

I am copying this letter to Russell George MS, Chair of the Health and Social Care Committee.

Yours sincerely,

M. E. Morgan

Eluned Morgan AS/MS
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Minister for Health and Social Services

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We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

Y Pwyllgor Iechyd a Gofal Cymdeithasol
—
Health and Social Care Committee

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Eluned Morgan MS
Minister for Health and Social Services
Welsh Government

25 March 2022

Dear Eluned

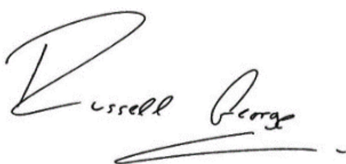
Women and girls' health quality statement and plan

You may be aware that the Committee has identified women's health as a priority issue for the Sixth Senedd. I am writing to ask that, when developing the women and girls' health quality statement and implementation plan, you consider the key issues arising from the evidence session we held with the Women's Health Wales Coalition on 10 March 2022.

The lack of a specific women and girls' health plan in Wales was highlighted by a number of respondents to the consultation we held last summer on priorities for the Sixth Senedd. As you indicated in January that the Welsh Government is developing proposals for women and girls' health, we held a public evidence session with the Women's Health Wales Coalition to explore why a women and girls' health plan is needed, and what it should include. A summary of key issues raised during the session is contained in the attached annex. We would be grateful for a response by 28 April 2022.

As women's health is a priority for us, we will also use the session to help to shape any future work we may undertake.

Yours sincerely



Russell George MS
Chair, Health and Social Care Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

Annex: Key issues arising from evidence session with the Women's Health Wales Coalition

Background

The Health and Social Care Committee has identified women's health as a priority issue for consideration during the course of this Senedd. The lack of a specific women and girls' health plan in Wales was also highlighted by a number of respondents to our summer 2021 consultation on the priorities for the Sixth Senedd.

We held a public evidence session with the Women's Health Wales Coalition ("the Coalition) to explore why a women and girls' health plan is needed, and what should be included in such a plan. We will also use the session to help shape any future inquiry focused on women and girl's health and/or specific women's health issues.

The evidence session took place on 10 March 2022. A transcript is available on our website. This document summarises the key issues we discussed with the Coalition, and raises points that we believe the Welsh Government should consider when developing the women and girls' health quality statement and plan. We would be grateful for a response by 28 April 2022.

A women and girls' health plan

The Coalition told us that women are more likely to experience poorer healthcare than men, with symptoms often being misdiagnosed or untreated. They said women experience delays in diagnosis and care. We are pleased, therefore, that the Minister has given her commitment to ensure standards of healthcare are improved for all women in Wales.

In its report 'Better for Women'[1] published in December 2019, the Royal College of Obstetricians and Gynaecologists recommended that the four UK nations should publish a women's health plan to address areas of unmet need for women's health. The Scottish Government published its women's health plan in August 2021 and the UK Government aims to publish its final strategy for England in the spring of 2022. Women in Wales must not be left behind. We agree with stakeholders that a women's health plan is needed to drive improvements in women's healthcare experiences across Wales. We therefore welcome the Minister's commitment to publish a quality statement in May 2022, followed by a more detailed health plan in the autumn.

1. Can you confirm that the Welsh Government will:

a. engage with Coalition members in the development of the plan, and through sustainable co-production as the plan is implemented, and

[1] Royal College of Obstetricians and Gynaecologists: Better for women

b. ensure that what goes into the plan are actions that can be measured when implemented.

Lack of data

The Coalition told us that, in terms of diseases that impact on men and women, women's experiences are pushed to the periphery:

> *"When we study hearts and we study heart attacks, we're studying male hearts and male heart attacks, and actually, women need to be included in that and we need to think of all of these diseases as being something that impacts both."*

One possible reason for this could be the under-representation of women in clinical trials. Women's bodies, and the conditions that affect them are under-researched, with the causes and treatments unknown. Less is known about conditions that only affect women including common gynaecological conditions that can have severe impacts on health and wellbeing, such as endometriosis, polycystic ovary syndrome, and premenstrual dysphoric disorder.

The lack of medical research also means that researchers do not have the opportunity to identify and study sex differences in diseases, and creates assumptions that similar medical treatments will work for both males and females. Diabetes, heart attacks and autism are all conditions that can present differently for males and females.

The Coalition told us:

> *"Women are 50 per cent more likely to receive an initial misdiagnosis for a heart attack, but what we don't know is why that is. And so, we have to speak to women who've had heart attacks and have been misdiagnosed, who tell us that they were initially diagnosed with panic attacks. But that's not something that we can see from the data, so the only way to fill in our [ ] knowledge gaps, is to speak to women with these experiences, speak to [ ] the third sector, which does have a really big part to play here, where we do have those patients whom we speak to."*

The Coalition also told us that where research is happening, it is not disaggregated by sex or gender, so it is not clear why women and girls present with different issues:

> *"Without the data, and without knowing where these patients are and how to support them, we don't have improved services."*

2. Can you confirm that the quality statement and health plan will include a commitment to increasing the representation of women in clinical trials in Wales. This includes funding research on women's health issues across the life course and ensuring studies analyse and publish data on sex and gender differences in diseases.

More than 100,000 responses were submitted to the UK Government when it consulted on its women's health plan for England last year. It's clear from the responses that many women feel they are not listened to by health professionals. The Coalition said that women in Wales have similar experiences.

According to the Coalition:

> *"We are living in this cultural and societal landscape where women's voices and experiences have, traditionally, been unheard, dismissed."*

The Coalition says that what women really want is not to keep having to retell what can often be traumatic stories, but actually to be involved in co-producing the solutions and developing the mechanisms.

It highlighted a project in Betsi Cadwaladr UHB where the Coalition, as patients, co-facilitate and co-chair, with health board clinicians and management in the women's directorate, a forum called Gynae Voices:

> *"Essentially, what it does is it brings clinicians, management and patients together in a safe space, where everybody's voice is heard equally. And we're able to work together on improving local services."*

It also highlighted the importance of involving the third sector and existing networks, who had well established links with healthcare professionals:

> *"We can't possibly have every impairment and every issue, every condition around those tables. But what we can do, or what Welsh Government could do, or health boards, or whoever, is work really hard to identify who those organisations are, who the key advocates are, and then really invite them to be part of the conversation, and to be an equal part of the conversation, from the very beginning, where services are conceived, where they're developed, and part of the oversight and scrutiny as well."*

We agree that co-production must be at the heart of the women and girls' health quality statement and plan.

3. Can you confirm how you intend to take on board the real life experiences of women in developing and implementing the quality statement and plan, and ensure voices for women's health are built into governance and leadership structure in the NHS.

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The COVID-19 pandemic has shone a light on many health inequalities, with disabled people, black and Asian groups, and those living in poor economic conditions, more likely to die as a result of COVID-19. We also heard of the disproportionate expectation and inequality for minority ethnic women when it comes to gynaecological or obstetrical outcomes. That is why intersectionality and hearing the views of different groups of women with lived experience is so important.

4. Can you clarify how services, interventions and funding will be targeted to take existing health inequalities into account.

5. Can you provide details of how the plan will reflect women's multi-layered and intersectional identities and characteristics.

Access to specialist services

The Coalition said that existing models of healthcare provision in Wales have historically not worked for women, because they have not been person-centred or tailored to their specific needs. Those requiring care from different specialties find that they are not adequately joined-up, and there is a lack of collaboration between health boards in developing specialist services and making them universally accessible.

According to Endometriosis UK, on average it takes nine years for women to receive a diagnosis of endometriosis in Wales, with 40 per cent of women needing 10 or more GP appointments before being referred to a specialist. We therefore welcome the recent announcement that specialist endometriosis nurses have been appointed in each Health Board in Wales.

Specialist services to meet women's health needs are not available locally, in every health board. At the moment, some women are not able to access specialist services that are delivered outside their health board (because funds don't follow the patient).

6. Can you confirm that you will address this problem as part of your commitment to improve women's health services.

Information and communication

The recent miscommunication over changes to the cervical screening programme have highlighted the importance of clear and accurate communication.

The Coalition highlighted how the Gynae Voices forum in north Wales is working together to co-produce and improve information given to patients in gynaecology. It says

> *"...at the moment, many patients have their surgery, the consultant will come around and speak to them whilst they're in recovery, so, they're semi-conscious, and they can't remember what's been said to them."*

It said that in north Wales, they had begun to look at how to improve information exchange, so that patients are informed, their concerns answered and they know where to go for further information and assistance, if they need it.

Subject to evaluation of this work, we believe it should be rolled out across Wales. Better communication with women about their care and treatment will help them to make informed choices about their health and care.

7. Can you clarify how the plan will provide for communication with women.

Mental health

A report by the UK's Women's Mental Health Taskforce found that women are more likely to experience common mental health conditions, such as anxiety and depression than men. They say the prevalence is increasing in women, with young women in particular being identified as a high-risk group.

It is well documented that the negative impacts of lockdowns, job losses and the burden of caring during the pandemic disproportionately affected women. The majority of unpaid carers are women and the vast majority of lone parents are women. The challenges of balancing childcare, paid work, caring responsibilities, alongside managing the stresses and uncertainties of the pandemic have, and continue to have, a significant impact on women's health.

The Coalition told us that mental health conditions and issues which they believe have a disproportionate impact on women and girls have been incorporated into the draft quality statement they have shared with Welsh Government officials. This includes perinatal mental health, premenstrual dysphoric disorder, eating disorders, self-harm, trauma and complex PTSD.

8. Can you clarify how you see the women and girls' health quality statement and plan fitting with the new Together for Mental Health Plan, due to be published this autumn.

Education and training

The Coalition highlighted as a priority the need for improved training for health and care professionals. It suggested that health professionals' training on women's health, particularly gynaecology and those associated conditions, may only form six weeks of the training programme. It suggested a number of areas for improvement, including improved medical training, specifically for women's health to be prioritised in foundation doctors' training to address unconscious bias and raise awareness. It suggested a number of areas for improvement, including:

- Involving patients with lived experiences in the design and delivery of training for healthcare professionals;

- Investing in continuing professional development for healthcare professionals and incentivising its take-up;
- Education of the wider public to ensure greater awareness of women's health.

9. Can you confirm how training in women's health is covered in medical training syllabuses in Wales.

Preventative health

According to the Coalition, the Welsh Government has committed to a number of actions to support a healthier lifestyle, including improving access to stop-smoking services and working to reduce alcohol consumption.

Promoting health and disease prevention can include ensuring women have information about the benefits of building and maintaining a healthy lifestyle, including being physically active and maintaining a healthy weight.

The Coalition suggested that in many cases alcohol consumption, smoking, etc, were actually coping mechanisms for dealing with other issues in life, including chronic illness. It said that without a better understanding of what is driving girls and women to engage in these behaviours it would be very difficult to design services to meet those needs.

It also highlighted the need to make sure that support for mental and physical health is inclusive of those people who are not able to exercise:

> *"There are lots of us, disabled women, who can't exercise, can't engage in physical activity. So, myself, I used to be really physically active, I used to play sport. When I got ME, if I now exercise, that can create much more harm; it can leave me bed bound."*

We welcome Welsh Government's commitment to introduce legislation to reduce price promotions on the unhealthiest food and drink.

10. Can you provide further information on the timing of this legislation.

11. Can you also clarify whether the women and girls' health quality statement and plan will include a focus on promoting health and disease prevention and how this will fit with Healthy Weight, Healthy Wales.

Cross-government approach

We recognise the case put forward by the Coalition that the plan needs to focus on key clinical issues. However we believe the Welsh Government should work cross-government (i.e. in policy areas that stretch beyond the NHS) to ensure wider systemic changes to tackle women's health inequalities are considered, as well to ensure the plan is joined up with other strategies such as the Violence Against Women, Domestic Abuse and Sexual Violence strategy.

12. Can you confirm whether the women and girls' health plan will take a cross-government approach, and how it will be joined up with other key strategies such as the Violence Against Women, Domestic Abuse and Sexual Violence strategy.

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Eich cyf/Your ref
Ein cyf/Our ref

Russell George MS
Chair, Health and Social Care Committee
Welsh Parliament

SeneddHealth@senedd.wales

11 May 2022

Dear Russell,

Thank you for your letter of 25 March regarding a Women and girls Health quality statement and plan.

I share the views of the Committee that women's health needs to be given a higher priority than has previously been the case. A Healthier Wales makes clear its aim of ensuring person-centred care across the country, however, there is a need to bolster this by ensuring that women can access the care they need when they need it and that the health service is responsive in providing that care. I have therefore instructed my officials to produce a women's health Quality Statement setting out how the NHS in Wales needs to offer high quality services to women and to support NHS colleagues in the development of a Women's Health Plan for Wales which will set out the actions the service will take to meet the expectations within the Quality Statement.

The Plan will take the same life-course approach advocated by RCOG in its *Better for Women* report and is intended to reduce health inequalities, improve equity of service and improve health outcomes for women in Wales. The plan will include short, medium and long-term actions and will be introduced this autumn.

I am grateful for the work undertaken by the Women's Health Wales Coalition as they produced proposals for a women's health quality statement. As officials have already confirmed to the group, this document will be used in the development of the Women's Health Plan. I have been very clear that the Plan should have significant input from service users, including the Coalition, to ensure that women's voices are heard loud and clear and their concerns reflected. Therefore, there will be stakeholder engagement throughout the development of the Plan, in addition to the usual consultation.

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Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

You will appreciate that the plan is still in the early stages of development and so I am unable to confirm the full content at this point in time. However, my officials are considering all the evidence provided in the session with the Coalition and will ensure that this is reflected in the final version of the plan. I can assure you that officials remain in close contact with members of the Coalition and take their concerns very seriously. I will, of course, be happy to provide a more detailed update once the work is more fully developed.

I hope this response has been useful and provides the Committee with reassurance that I see improvements to women's health services as a major priority.

Yours sincerely

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Agenda Item 10

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