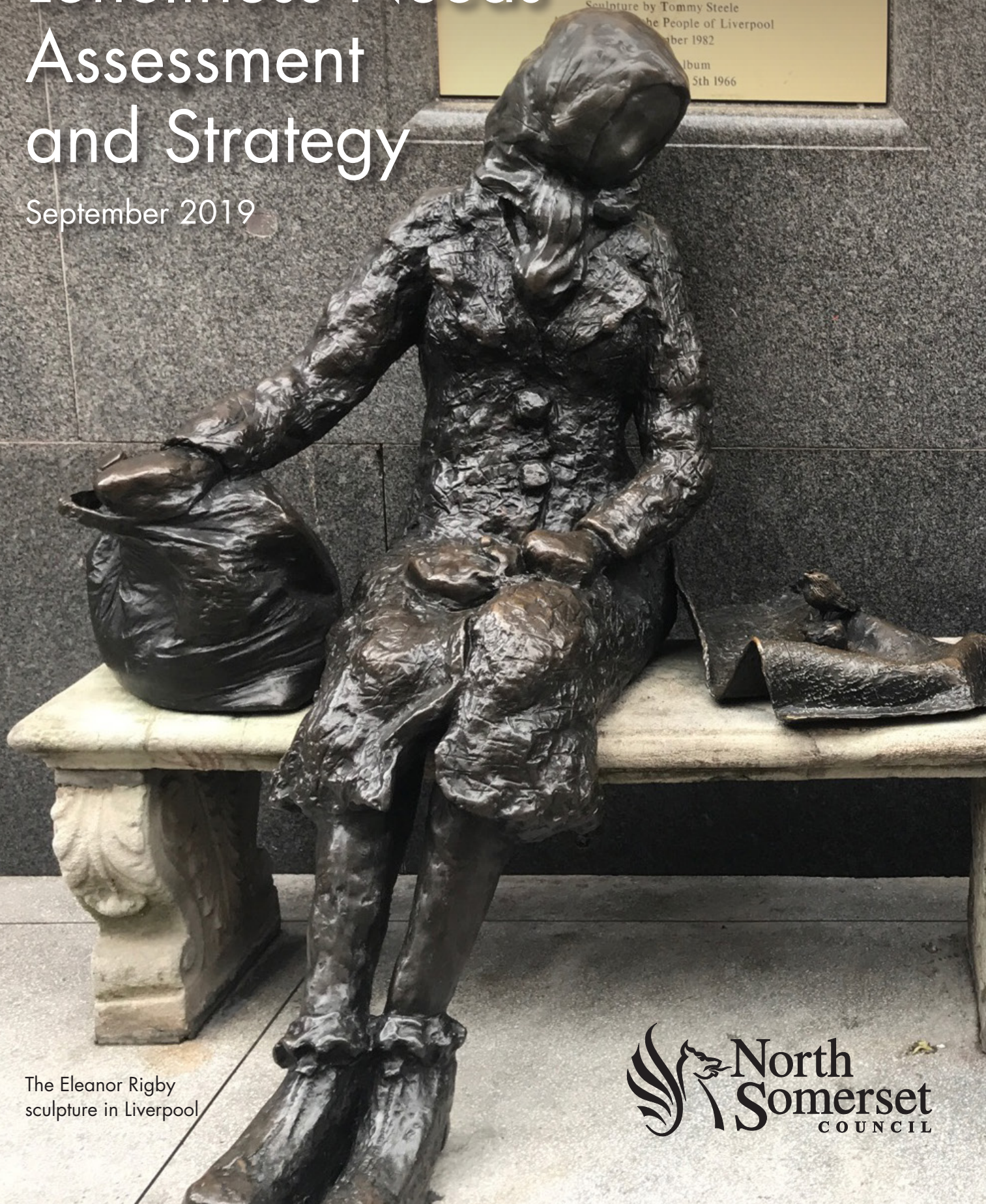


North Somerset Council

Social Isolation and Loneliness Needs Assessment and Strategy

September 2019

ELEANOR RIGBY
"All the lonely people"
Sculpture by Tommy Steele
for the People of Liverpool
unveiled 15th October 1982
Album
15th 1966



The Eleanor Rigby sculpture in Liverpool

Loneliness is about 'Unbelonging'

Social Isolation and Loneliness (SI&L) relates to the feelings of Loneliness and 'unbelonging' that the statue of Eleanor Rigby evokes. Eleanor feels alone.

As you turn the pages of this report, looking at the evidence base for reducing SI&L, it will become apparent to you that the best way of keeping as happy and as well as possible, particularly in the presence of adversity, is greatly enhanced by having good friends, family and/or neighbours.

Therefore, it also follows that a good way within our gift of supporting others to be as well and happy as possible even in the presence of adversity, is to be a good friend, family member and/or neighbour.

In prevention terms, this means that if there's someone you keep meaning to call/pop-in to, then there's no time like the present (and no present like the time).

Sept 2019

Heather Whittle, Strategy and Policy Development Team,
People and Communities, North Somerset Council

CONTENTS

Social Isolation and Loneliness – Plan on a page summary	4-5
List of Figures and Appendices	6
Section 1. Working definitions of Social Isolation and Loneliness (SI&L)	7
Section 2. Introduction	8-12
Section 3. Triggers and Risks along the Lifecourse	13-16
Section 4. Importance of recognising ‘Self-Soothing’ behaviours	17-20
Section 5. Impact of Social Isolation and Loneliness across the lifecourse	21-28
Section 6. Health and Wellbeing in Older Age and effects of SI&L	29-32
Section 7. North Somerset Statistical data related to potential at risk groups	33-37
Section 8. Interventions: Best evidence based practice – informing commissioning	38-47
Section 9. The Core Elements of effective interventions – informing development	48
Section 10. Evaluating the impact of interventions	49
Section 11. Key points to inform Future Action Planning	50-54
Section 12. Recommendations:	55
• First Steps – across the lifecourse	55
• Strategic Recommendations	55
• Education and Training Recommendations	56
• Operational Recommendations	57

Joint Strategic Needs Assessment Social Isolation and Loneliness (SI&L) – Plan

Social Isolation and Loneliness (SI&L) working definitions (*section 1 and 2)	Social isolation – objective lack of contact with family and friends, community involvement or access to services (more about number of contacts/visits and geography/access needs).	Loneliness – subjective sense of lack of companionship. If someone has few or no relationships.
Social isolation and loneliness – the triggers (*section 3 and 4)	<ul style="list-style-type: none"> • Bereavement – death of significant person or animal companion (for example, guide dog). • Loss – affecting body image. • Disability – physical, sensory etc. 	<ul style="list-style-type: none"> • Cognitive – memory loss • Lost social network • Significant relationships
Social isolation and loneliness – physiological impact on individuals (*section 5 and 6)	Early years, children and young adults <ul style="list-style-type: none"> • Adverse childhood experiences (ACEs) significantly increases vulnerability to SI&L. Impact of poor social relationships on mortality is comparable with major established health risk factors	<ul style="list-style-type: none"> • ACEs associated with mental health, development, and physical health
Social isolation and loneliness – impact on services (*section 5)	Socially isolated and/or lonely people are more likely to: <ul style="list-style-type: none"> • visit their GP more often • have higher use of medication • use A&E services more, independent of chronic illness 	<ul style="list-style-type: none"> • have more hospital admissions • use social care services • use mental health services
Potential ‘at risk’ groups with local numbers (total North Somerset population 211,670) (*section 7)	<ul style="list-style-type: none"> • New mothers – 400 • Children in care – 240 • Care leavers – 125 • Young carers – 1,295 • Young people NEET – 95+ • Students living away from home – 450 	<ul style="list-style-type: none"> • 25-64yrs unemployed • 25-64yrs physically disabled • 25-64yrs psychologically disabled • People living alone • 65yrs+ population • 65yrs+ lonely
Reducing SI&L challenges and what works (*section 8,9 and 10)	Three key challenges in supporting access to interventions: <ul style="list-style-type: none"> • Finding socially isolated and lonely people. • Establish, develop and support a strengths-based attachment-informed approach to; <ul style="list-style-type: none"> • Listening and understanding. • Enabling. 	What works: <ul style="list-style-type: none"> • Establish and support a strengths-based attachment-informed approach to develop and support a strengths-based attachment-informed approach to; <ul style="list-style-type: none"> • social group work • volunteering
Recommendations (*section 11 action planning) (*section 12 recommendations)	Strategic <ul style="list-style-type: none"> • Establish SI&L reducing measures in all related policies and strategies across the lifecourse. • Develop wider partnerships nationally with BNSSG partners and with North Somerset Social Prescribing Co-production group, to co-ordinate and inform ‘what works’ activity. • Consider and support application of realistic balance between investment and ‘business as usual’ approaches to service provision. 	Education and training <ul style="list-style-type: none"> • Develop and commission training for staff • Provide opportunities for staff in commissioning • Develop and commission training for staff and impact measurement approach, using a balanced approach, using a balanced support plans.
Outcomes (*section 11 action planning) (*section 12 recommendations)	Strategic – reduced negative impact on services <ul style="list-style-type: none"> • Evidence of SI&L finding, listening, understanding and enabling measures in all relevant policies and strategies. • Wider partnerships established and efforts co-ordinated, to produce local shared plan for Social Prescribing. To include agreed ways of measuring impact. • Better informed, creative, flexible, evidence based commissioning decisions (balanced approach between investment and ‘business as usual’). 	Education and training <ul style="list-style-type: none"> • case finding, support • Awareness raising • Evidence based service delivery • Improved referral pathways applied.
Links to local plans, strategies etc	Bristol, North Somerset and South Gloucestershire (BNSSG) – Sustainability and Transformation <ul style="list-style-type: none"> • Making Every Contact Count (MECC) – STP • Self Care and Social Prescribing – STP • Sustainable Primary Care Programme – STP • Frailty Model – STP • Stroke – STP 	<ul style="list-style-type: none"> • People and Communities • Housing with Health • North Somerset • Team North Somerset • BNSSG Shared

...tive, negative feeling associated with lack or loss of
 ...you feel lonely, you are lonely (more about quality of

People may adopt poor health behaviours (for example, comfort eat or drink), to cope with the emotional pain of SI&L. Such pain needs to be acknowledged and addressed if health improvements are to be supported and sustained.

...emory loss, personality/behaviour changes.
 ...work – moved home, enter care home etc.
 ...relationship change – family disputes, becoming a carer etc.

- Significant lifestyle change – retirement, redundancy, care leaver etc.
- Significant cultural deprivation – BME etc.
- Fear – vulnerable, fearful etc.
- Trapped in unhealthy relationship(s) – being bullied, groomed, domestic abuse etc.

...ed with negative neurological, immunological and hormonal
 ...which has knock-on effect across the 0-90+ years life course.

Working age and older people

- Physiological changes causing harm to body and mind.
- Increase risk of heart disease, type 2 diabetes, anxiety and depression.

...s such as smoking and alcohol, and that of physical inactivity and obesity (Marmot 2010).

...spital visits (other than A&E) and hospitalisation periods
 ...e services more
 ...alth services more

- have earlier admission to a care home
- be less motivated to comply with rehab/healthy lifestyle programme as may not see a future that is worth it.

...mployed – 3,200
 ...ically disabled – 14,485
 ...ically disabled and unemployed – 680
 ...alone 25 and older – 26,430
 ...ation – 49,730 (23% of total population)
 ...sometimes – 15,415 (31% of over 65s)

- 65yrs+ often lonely/always – 3,480 (7% of over 65s)
- 65yrs+ living alone – 12,525
- 65yrs+ adult carers – 6,165
- 65yrs+ admitted to long term adult care – 1,600
- Blue Badge holders – 12,340
- Number of 'bin lifts' (waste management) – 2,870

...support asset based community development (ABCD) and use
 ...d support the building of community capacity i.e.
 ...o activities
 ... (local differentiation between volunteering and helping).

What works

- Establish and support Social Prescribing, using a strengths-based approach.
- Develop and support community connecting services.
- Develop and support befriending for the housebound.

...aining

...deliver awareness raising programme.
 ...tunity to increase knowledge and skills related to 'what works'
 ...ing, contacting and practice development.
 ...deliver information on locally agreed referral, assessment
 ...easurement processes. This will include a strengths-based
 ...ng the three conversations model, and attachment – informed

Operational

- Actively promote and support the development of 'grass roots' partnerships that move forward on what works.
- Support the implementation of agreed referral, assessment and measurement processes, to include strengths-based approach.
- Actively support through 'grass roots' partnerships, client/carer and staff/volunteer feedback, which further informs services/processes. i.e. support that delivers on 'What matters to me'.

...aining – increased knowledge and skills to better inform
 ...port etc and decision making.

...ising programme developed and delivered.
 ...ed interventions are identifiable from procurement through to
 ...y.
 ...rral, strengths-based assessment and measurement processes

Operational – people report on increase in wellbeing through reduction in their SI&L (partnership to agree measurement scale)

- Local 'grass roots' partnerships established to support 'what works' (for example, social prescribing, ABCD etc), strengths-based approaches etc.
- Case finding, listening, understanding and enabling activities, increase appropriate and timely referrals.
- Quantity and quality of services, informed by client/carer and staff/volunteer etc feedback.

Partnership (STP) Healthier Together Plans

...ommunities Strategy
 ...Support Strategy
 ...et Community Partnership Strategy
 ...omerset Partnership
 ...d Local Plan for Social Prescribing

- Town Centre Planning and Place Making (to include rural)
- Sustainable Community Strategy
- Antenatal, Perinatal and Infant Mental Health Pathway
- Children and Families Partnership Plan
- BNSSG Maternity Transformation Plan

FIGURES

Fig 1.	Frequency of loneliness in people aged 25yrs and above in the UK.	13
Fig 2.	Risk factors for SI&L across the lifecourse.	14
Fig 3.	Social Isolation – a contextual overview. Bristol City Council.	15
Fig 4a.	The Wellbeing Spiral – locally developed model/guide to identify potential destructive behaviours and support change.	19
Fig 4b.	Practical application of the Wellbeing Spiral.	20
Fig 5.	Model of Adverse Childhood Experiences (ACES) across the lifecourse.	24
Fig 6.	Cumulative effect of ACES into adulthood.	26
Fig 7.	Isolation among men and women aged 50 and over.	28
Fig 8.	Framework to inform Strategic Whole system approach to addressing loneliness.	39
Fig 9.	North Somerset Check and Connect-Social Prescribing Checklist.	44
Fig 10.	Community Connect Service Pathway.	46

APPENDICES

Appendix 1.		
	1a. The 5 step process for Information, Advice and Support	58
	1b. Loneliness Measurement Scale	67
Appendix 2.		
	Bristol, North Somerset & South Gloucester (BNSSG) A Social Prescribing Framework	68
Appendix 3.		
	Current established local Social Prescribing service provision (pre- implementation of Primary Care Network link worker service) Lealfet inside back cover	
Appendix 4.		
	A Connected Society? Assessing progress in tackling loneliness (Sept 2019) The six key areas for priority actions.	71
Appendix 5.		
	Fulfilling the promise; How social prescribing can most effectively tackle loneliness. The ten areas of action.	73
Appendix 6		
	Qualitative feedback from residents/family members using Voice Activated Assistants (VAA)	74

REFERENCES

84

1) WORKING DEFINITIONS OF SOCIAL ISOLATION AND LONELINESS (SI&L)

- 1. **Loneliness** can be understood as an individual's personal, subjective sense of lacking desired affection, closeness and social interaction with others. (1)
Social isolation refers to an objective lack of contact with family or friends, community involvement or access to services. (1)
- 2. **Loneliness** is a subjective experience, a negative emotion with a perceived gap between the quality and quantity of relationships that we have and those that we want (2). Loneliness is a state of mind that causes people to feel empty, alone and unwanted. People who are lonely often crave human contact, but their state of mind makes it more difficult to form connections with other people.
Isolation is being by yourself. Loneliness is not liking it. (3)
- 3. **Loneliness** is a physiological state. It is a subjective, negative feeling associated with lack or loss of companionship. If you feel lonely, you are lonely. The emotional pain of loneliness is a very personal pain that has been caused by experiences within their own unique journey through their lifecourse. People may adopt poor health behaviours (for example, comfort eat or drink), to cope with the emotional pain of social isolation and loneliness. Such pain needs to be acknowledged and addressed if health improvements are to be supported and sustained.
- 4. There are different types of loneliness:
 - Emotional loneliness is felt when we miss the companionship of one particular person; often a spouse/partner, sibling or best friend. This can also apply to a well loved animal companion.
 - Social loneliness is experienced when we lack a wider social network or group of friends.

Loneliness can be a transient feeling that comes and goes. It can be situations; for example only occurring at certain times like Sundays, bank holidays or Christmas, new year's eve/day. Loneliness can also be chronic; meaning that it is experienced all or most the time.
- 5. **Loneliness is linked to Social Isolation** but it is not the same thing. Isolation is an objective state whereby the number of social contacts or interactions a person has can be counted. One way of describing this distinction is that you can be lonely in a crowded room, but you will not be isolated. Therefore, it is not the quantity of contacts that can reduce SI&L, it is the quality of social contact that is the most effective.

2) INTRODUCTION

KEY POINTS

- a) Social isolation and loneliness are different and as such need different interventions. Loneliness is about 'unbelonging'. Early intervention strategies that help people 'belong' and be part of their communities are vital to improving health and wellbeing.
- b) SI&L can cause actual physiological changes causing harm to body and mind: In adults this can increase the risk of heart disease, type 2 diabetes, anxiety and depression.
In children exposed to adverse childhood experiences (ACES) and the isolation and loneliness that often accompanies this, it has been associated with negative changes in neurological, immunological and hormonal development.
- c) SI&L may negatively affect health behaviours i.e. use of alcohol and food etc., to 'self-soothe'. SI&L needs to be identified and addressed if more constructive behaviour changes are to be successful.
- d) There is a 50% more likelihood of survival for people who have stronger relationships than those who have weaker ones. It is not that people do not get ill if they have strong social networks, it is that they cope better and subsequently use less services than those who do not have the networks.
- e) The impact of poor social relationships on mortality is comparable with major established health risk factors such as smoking and alcohol, and that of physical inactivity and obesity.
- f) There is a need to address the wider determinants of health i.e. housing, education, training to include social skills development and employment. SI&L has a bigger impact on people in deprived areas where the wider determinants are seen.
- g) Need to Support Asset Based Community Development in building community capacity and resilience, as an approach to reducing SI&L.
- h) BNSSG Healthier Together plans, important to recognise positive effect of reducing SI&L on particular projects/programmes i.e. MECC, Self-care and Social Prescribing, Sustainable Primary care, Frailty model and Stroke.
- i) HM Governments Strategy for tackling loneliness sets out key proposals for collaborative work between Depts/Orgs. These Depts/Orgs. Include; Health and social care, Ministry of housing, communities and local government, Digital, culture, media and sport, Arts Council England, Education, Transport, Business, energy and industrial strategy, Public Health England and Sport England.
- j) There is a strong evidence to support that having, and being able to give a sense of security and belonging, can be at least a life enhancer and at best for some, a life saver.

2. Evidence base for Key Points – Introduction

- 2.1 Most of us will either have experienced feelings associated with being Socially Isolated and /or Lonely (SI&L) for ourselves, or have been close to a family member or friend who has. This may have been as a result of bereavement, retirement or redundancy, onset of sudden debilitating illness, sensory impairment, loss of mobility etc. We may have felt or seen how people react in these situations, often expressing in words or actions/inactions, the overwhelming feeling of loss and being lost. It is this sense of disconnectedness, the ‘unbelonging’ that the sculpture of Eleanor Rigby evokes.
- 2.2 This short-medium term disconnectedness can be overcome to a greater or lesser degree over time, if we have good social networks that can support us, and help us get back a sense of belonging in our changed world. This is supported by numerous national and international research evidence, which has identified the negative physical and mental impact of SI&L. This would include the SI&L that can be part of Adverse Childhood Experiences (ACEs), which includes being subject to verbal, physical and sexual abuse, being separated from parent/s, and living in a household where there is drug and/or alcohol abuse etc. on our physical and mental health.
- 2.3 The extent of this SI&L can cause actual physiological changes resulting in harm to our bodies and minds, increasing the risk of heart disease, stroke and type 2 diabetes, anxiety and depression. In the case of children exposed to ACEs and the vulnerability, isolation and loneliness that can bring with it, this has been associated with negative changes in neurological, immunological and hormonal development across the course of their lives into adulthood, thus reaching an ‘allostatic load’/ cumulative effect in adulthood.
- 2.4 Marmot in Fair Society, Healthy lives 2010 (3) stated that SI&L can lead to an increased risk of premature death. Holt-Lunstad et al 2010 (4) established the links between loneliness and physical and mental health in their analytic review of 148 studies of the influence of social relationships on the risk of mortality. This work identified that there is a 50% increased likelihood of survival for people who have stronger relationships compared to those who had weaker ones.
- 2.5 Marmot also stated that; “Individuals who are socially isolated are between two and five times more likely than those who have strong social ties to die prematurely. Social networks have a larger impact on the risk of mortality than on the risk of developing disease, that is, it is not so much that social networks stop you from getting ill, but they help you to recover when you do get ill”
- 2.6 Other research has identified that the impact of poor social relationships on mortality is comparable with major established health risk factors such as, smoking, alcohol consumption, physical inactivity and obesity. This research was also cited in the 2015 Public Health report (5), so its relevance as a precursor to SI&L and its importance as a Public Health priority, is very much recognised at National level.

- 2.7 Expanding on the health and social impact, research shows that SI&L;
 - increases negative lifestyle habits and as such can be as harmful as smoking 15 cigarettes a day, also exceeds risk of alcohol, physical inactivity and obesity in some cases, (4)
 - increases the risk of conditions including dementia or cognitive decline, (25 cited in 5)
 - has a negative effect on the immune and cardiovascular systems, increasing the incidence of high blood pressure risking stroke, heart attack etc., anxiety and depression. (5)
- 2.8 The importance of Public Health giving equal billing to the improvement of health and wellbeing and the reduction of social isolation and loneliness is paramount. Support for smoking cessation, alcohol reduction, physical activity and healthy eating, given this equal billing, is likely to be more successful. Interventions around these may be far less effective if the reasons for unhealthy behaviours (for example, rooted in SI&L), is not recognised and addressed.
- 2.9 With this in mind it could be said that investing our time and effort in nurturing our own social networks and supporting others to do the same, whether that is within our working practice, at home with family and friends, or as members of our local communities, is time well spent. It is something we can achieve, and will have a positive effect on the physical and mental health and wellbeing of ourselves and those around us.
- 2.10 It is not that this alone will prevent illness, but it sets up a social network that we and others can 'belong to'. This helps people find a level of recovery that they can still find 'worthful'. (Moving from feelings of worthlessness to worthfulness) This puts us and others in a better frame of mind to tackle the more challenging aspects of health improvement that we might aspire to, or support rehabilitation for those recovering from illness, moving us into an upward spiral of physical and mental recovery and resilience.
- 2.11 There is also a continuing need to address the wider determinants of health, such as housing, poverty and education and training – to include social skills development, and employment. The Public Health England report in 2015, Local action on health inequalities; Reducing social isolation across the life course (5), which together with Public Health Wales study (6); Adverse childhood experiences and their association with chronic disease and health service use in the Welsh adult population, provides a well-informed picture of the causes and impact of SI&L as affected by life course events. There is also recognition of the value of Asset Based Community Development (ABCD) models that promote programmes that help build individual and community resilience through positive social networks.

- 2.12 We now need to use the evidence that these and other research reports highlight to inform our priorities locally. This means that we need to take full account of the evidence for prioritising SI&L in the Bristol, North Somerset and South Gloucester Sustainability and Transformation plan. These plans are currently being refreshed so there is a timely opportunity to raise SI&L as a priority.

The following BNSSG Healthier Together plans are of particular relevance;

- a) **Making Every Contact Count** (MECC), recognising the effect of SI&L on health behaviours. Work has begun locally on this within the Community Connect 50yrs+ service. The Check and Connect checklist used with individuals to aid signposting and support, has been updated to align with Social Prescribing and MECC compliance. (See appendix 1a. Step 1)
 - b) **Social Prescribing**. Currently, across Bristol, North Somerset and South Gloucestershire (BNSSG), a working group is developing a core model, to be adopted across BNSSG, that equally supports improvements in health and wellbeing and reductions in SI&L. This will inform the BNSSG Shared local plan on social prescribing.
 - c) **Sustainable Primary Care**, role of Social Prescribing in reducing SI&L and contributing to reduction of 27% of GP contacts,
 - d) **Frailty model of care**, creating a balance between health care intervention and 'having worthwhile life' intervention reducing SI&L,
 - e) **Stroke**, quality of life after stroke. Potential for building on past good practice of North Somerset's 'New life, Live It' Community Development-Stroke programme, and incorporating into current reducing SI&L practice i.e. use of 5 ways to wellbeing for stroke victims. (See appendix 1a. Step 5)
- 2.13 Reducing SI&L is a priority for Public Health and Social Care, as reflected in shared indicators across both the public health outcomes framework (7) and the adult social care outcomes framework (8). As the population ages and the number of single person households increases, (single occupancy was 26.3% in 1991 rising to 31% in 2011) SI&L in older age (& other age groups) is becoming a growing Public Health challenge. Therefore wider partnership working, to include the voluntary, community and social enterprise sectors, is crucial if we are to meet the challenges that reducing SI&L poses.

- 2.14 Also of particular relevance is;

- a) HM Government. A connected society. A strategy for tackling loneliness-laying the foundations for change (9a). This sets out key proposals to include;
 - Develop a consistent measurement for loneliness
 - Improve the evidence base around effective developments
 - Dept. of Health and Social care and NHS England's commitment to improving and expanding social prescribing services
 - Ministry of Housing, Communities and Local Government will fund research into innovative community-led housing projects to understand how these can help tackle loneliness and support social connections
 - Create more sustainable community hubs and spaces
 - Dept. for Digital, Culture, Media and Sport will devote up to £1.8 million to helping local communities build social connections through unlocking the potential of underutilised community spaces. The Dept. will also work with Arts Council England to address loneliness through its programmes. Also raise awareness of the role libraries can play.

- Dept. of Education will publish guidance to help schools open up as accessible spaces in the centre of their communities.
- Dept. of Transport to build partnerships with transport providers and community groups, to develop ways of using transport to help tackle loneliness
- Through a campaign, government will explore how best to reduce stigma and raise awareness of the importance of social connections. Also, how we can encourage people to take action through easy-to-understand messages and information. This could include the 5 Ways to Wellbeing model – Connect, take notice, keep learning, give, be active. (See appendix 1a. Step 5)
- Public Health England mental health campaign, will highlight loneliness as potential risk factor for poor mental health, and emphasise importance of strong social connections.
- Dept. for Business, Energy and Industrial strategy will encourage more employers to recognise loneliness and support their employees' social wellbeing through an employer's pledge.
- Sport England will make new grants totalling £1 million from its Active Ageing fund to two programmes which specifically tackle loneliness through sport and physical activity for the over 55yrs.
- From 2019/20 individual government depts. will be required in their single dept. plans to state the progress they are making on this agenda, to include how they are addressing loneliness proactively.

b) Children and young people's experiences of loneliness: 2018. (9b)

This is an analysis of their experiences and suggestions to overcome loneliness.

Their suggestions were;

- Create a culture of openness about loneliness
- Create opportunities to make social connections
- Encourage positive uses of social media to alleviate loneliness and
- Prepare young people to understand loneliness and equip them to deal with it

■ 2.15 Thankfully, the large body of national and international evidence on social isolation and loneliness (SI&L) and its contribution to poorer health outcomes with commensurate increase in costs, the need to prioritise reducing SI&L is receiving increased attention. This attention is supported by the Local Government Association, Age UK and the Campaign to End loneliness in its 2016 publication – Combating Loneliness: A guide for Local Authorities. (10)

■ 2.16 So, after extensive reading of the wise and well informed, there is strong evidence to support that having and being able to give a sense of security and belonging, through the development of individual and community asset based options, which at its heart includes the development of social networks and the like, can be at least a life enhancer and at best in some cases a life saver.

3) TRIGGERS AND RISKS ALONG THE LIFECOURSE.

KEY POINTS

- a) The lifecourse from pregnancy to older age, brings about events and triggers to a greater or lesser degree in people's lives. Adverse events and triggers can give rise to SI&L.
- b) These events and triggers if not addressed can have a cumulative effect causing an allostatic/cumulative load in working life and older age. This has an adverse effect on physical and mental health and wellbeing, resulting in increased use of services.
- c) Currently there is no evidence to suppose that there is a correlation between SI&L and long term conditions (LTC). That is to say that people with LTC's cope better in the presence of good social networks and in relative terms are less likely to use services disproportionately. Whereas, people who are SI&L are more likely to use services disproportionately whether they have a LTC or not.
- d) LGBT+, lesbians and gay men suffer disproportionately from SI&L which increases with age.
- e) Carers, SI&L can compound the negative physical and mental health effects of caring.
- f) Multiple deprivation and the wider determinants of health i.e. poor housing, unemployment etc. are risk factors for SI&L.

3.Evidence base for Key Points – Triggers and Risks

- 3.1 Anyone can experience SI&L. While SI&L is more commonly associated with later life, it can occur at any stage in the life course and can be cumulative. Some research suggests that there is a U shaped curve with highest rates of loneliness in under 25's and over 55's (11) other reports suggest that the highest rates of loneliness are found in those aged 80yr's and over,(12) which is not surprising given the cumulative effect of losing friends and family the older you get. (See Fig 1 reproduced from (26))

Fig 1. Table 1: Frequency of loneliness in people aged 25 and above in the UK

Age	How much of the time in the last week did you feel lonely (%)			
	All or almost all of the time	Most of the time	Some of the time	None or almost none of the time
Under 25	2.3	5.7	28.8	63.3
25-34	0.9	3.8	26.6	68.8
35-44	2.3	4.3	22.1	71.4
45-54	2.8	2.5	21.7	73.0
55-64	3.1	6.4	21.1	69.5
65-74	5.3	3.6	19.7	71.4
75+	5.7	6.5	28.3	57.5

UK sample (2,386 respondents aged 15+)

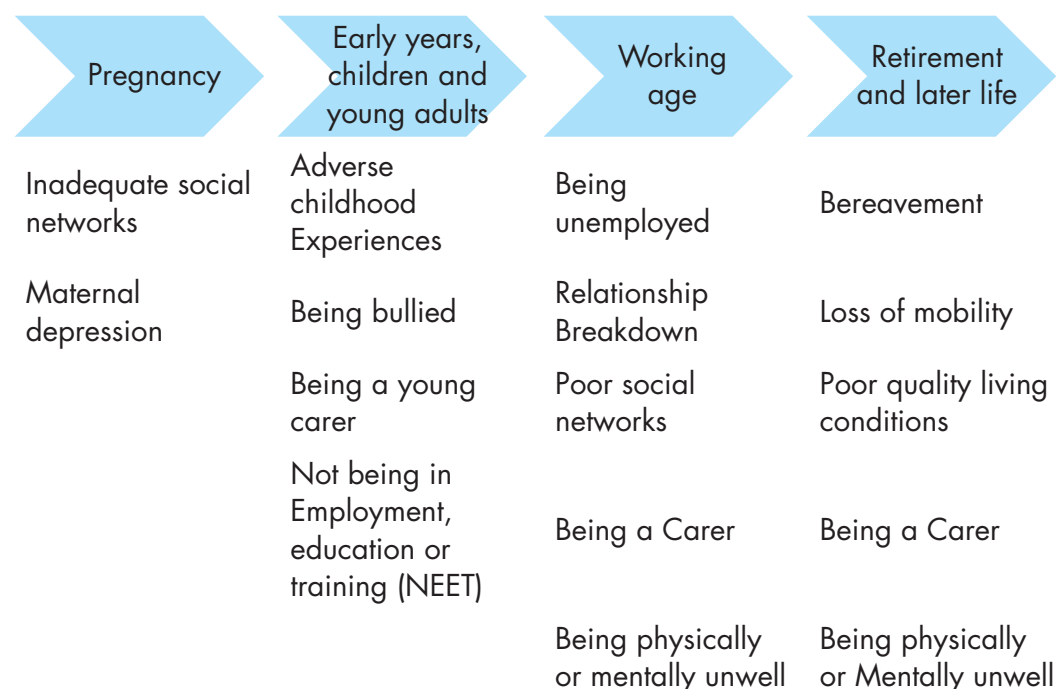
Source: Victor, Data: 2006/07 European Social Survey, UK sample (2,386 respondents aged 15+).45

- 3.2 Triggers/Life events predisposing to SI&L (see appendix 1.a. Step 3 Time4TEA)
TRIGGERS; a change in circumstances reducing confidence/energy/ability to cope.
 1. **Bereavement**; death of significant person or companion (to include animal companions – guide dog etc.)
 2. **Loss**; affecting body image i.e. stroke, cancer treatment, amputee etc.
 3. **Disability**; reduced mobility, chronic disease, sensory loss-sight/hearing etc.
 4. **Cognitive**; memory loss, personality/behaviour changes due to injury/disease
 5. **Lost Social Network**; moved house, entering into sheltered housing or care home, moved area and other reasons related to other triggers
 6. **Significant relationship change** i.e. family disputes, divorce, becoming a Carer, carer role changing.
 7. **Significant lifestyle change**; retirement, redundancy, LGBT+ etc.
 8. **Significant cultural deprivation**; BME etc.
 9. **Fear**; feeling vulnerable and fearful of going out, harassment, crime etc.
 10. **Trapped in unhealthy relationship/s** i.e. being bullied, groomed etc. Domestic abuse – emotional, financial, sexual etc.

■ 3.3 Risks along the life course.

There are particular life events which are recognised as potential trigger points, particularly when they are layered on top of other triggers/risk factors. These are commonly found at particular stages of life.

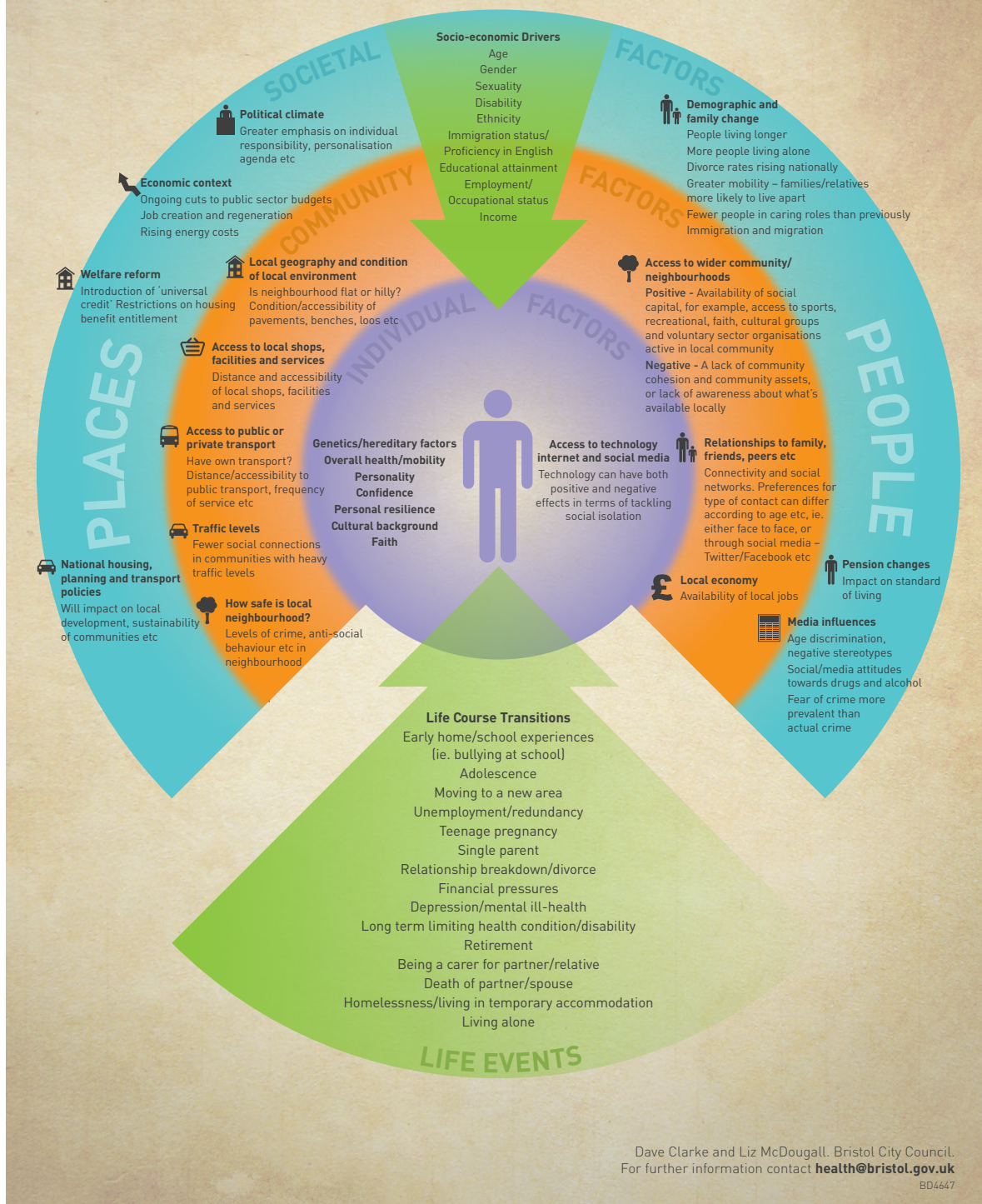
Fig 2. Risk factors for Social Isolation and Loneliness along the life course.



Reproduced from, PHE & UCL, September 2015(5)

- 3.4 As can be seen in Fig 2, SI&L can be felt across the age range, but as we get older risk factors that might lead to loneliness begin to increase and converge. These risk factors are set out in Bristol City Council’s diagrammatic overview.

Social Isolation: A Contextual Overview



Bristol City Council, Clarke D, McDougall E, in their report; Social Isolation in Bristol: Risks, Interventions and Recommendations 2014, put together a very comprehensive diagrammatic overview of the relationship between People, Places and Life Events on Social Isolation and Loneliness. See Fig 3.

Fig 3. Social isolation – a contextual overview

Source: Dave Clarke and Liz McDougall, Bristol City Council.
Figure reprinted with permission

- 3.5 In addition to these risk factors the English Longitudinal Study of ageing (ELSA) revealed a series of other risk factors;
 - a) **Expectation of loneliness**, this can be a predictor of becoming lonely. ELSA found that those who expect to be lonely go on to experience loneliness. This has implications for the acceptance and effectiveness of interventions.
 - b) **Seasons** also have an effect. A common thought is that loneliness is experienced more in winter. ELSA found that the highest levels are in the spring and summer when the days are longer and family members may be on holiday.
 - c) **Depression** has strong associations with loneliness, and may in fact be an independent risk factor for depression. However, no correlation was found between limiting long term conditions (LTC) and loneliness, when all other factors were taken into account. That is to say that people with long term conditions cope better in the presence of good social networks and in relative terms are less likely to use services disproportionately. Whereas, people who are SI&L are more likely to use services disproportionately whether they have a LTC or not.
 - d) **LGBT+**, studies have shown that lesbians and gay men suffer disproportionately from SI&L which increases with age (13)
 - e) **Carers** are another at risk group of SI&L which can compound the negative impact caring has on their health and wellbeing.
 - f) **Multiple deprivation**. Marmot (2010) identified that the presence of multiple deprivations to include the wider determinants of health – poor housing, poverty etc. amongst communities as a risk factor in SI&L.

- 3.6 A 2005 study (14), looking at the prevalence of risk factors for loneliness in later life, considering these risks went on to propose 3 loneliness pathways in later life;
 - a) Continuation of a long established attribute i.e. ‘jug half empty’ person
 - b) Late onset loneliness, as their world potentially gets smaller with retirement, bereavement, reduced mobility etc.
 - c) Decreasing loneliness, as having more time allows the take up of more opportunities

- 3.7 Recognising the presence of these different pathways needs to be taken into account when options around interventions are offered to people. If this is not considered then the undifferentiated options may be neither care effective or cost efficient.

4) IMPORTANCE OF RECOGNISING 'SELF-SOOTHING' BEHAVIOURS.

KEY POINTS

- a) **Need to recognise when destructive to health behaviours are being used to 'self-soothe'** feelings of loneliness i.e. destructive behaviours being used for emotional pain relief i.e. comfort eating/drinking etc
- b) **Need to address SI&L in order to support the person to greater self-awareness**, building their confidence, motivation and determination to tackle wider health issues that are concerning them. The outcome being improved health and greater resilience through increased social networks.
- c) **Tackling the complications of SI&L needs to be done in partnership** with Health and Social Care statutory organisations, the Fire and Police services and the Voluntary, Community and Social Enterprise (VCSE) sectors, faith communities and other cultural/gender/community interest groups.

4. Evidence base for Key Points – Recognising 'self-soothing' behaviours

NB Reference here relates to the more recent take up of new/resurrecting old behaviours-coping mechanisms to 'self-soothe' (in the presence of SI&L triggers) to cope with the emotional pain of SI&L.

It does not relate to long standing and severe destructive behaviours, whereby a more urgent medical/mental health response is needed in the first instance.

- 4.1 Research has further identified that the impact of SI&L is also associated with negative health behaviours. The resultant health problems then translate into longer stays in hospital, a greater number of GP visits and increased dependency on homecare services. However, in relation to drug and alcohol misuse, it has been found that support to change, can be more effectively targeted if loneliness is recognised as a potential contributing factor (15). Therefore there is an economic as well as health related case to be made for tackling SI&L.
- 4.2 Negative health behaviours, whereby individuals adopt new/resurrect old, potentially destructive habits to 'self-soothe' could include;
 - a) Reclusiveness, inactivity/lethargy and weight gain/unintentional weight loss,
 - b) Unhealthy eating habits, comfort eating,
 - c) Increased alcohol consumption, comfort drinking,
 - d) Smoking and increased smoking activity,
 - e) Misuse of over the counter and/or prescription medicines or illegal drug use,
 - f) Becoming involved in unhealthy relationships, which may be compounded by vulnerability to further risky behaviours.
 - g) Onset of or increasing debt, shopping/gambling to self-sooth,
 - h) use of the internet/social media for company while in a vulnerable state, more vulnerable to scams, risky behaviours etc.

- 4.3 It is crucial that the presence of 'self-soothing' factors are recognised and options for addressing are discussed with individuals. For Socially isolated and lonely individuals this is very likely to start with helping them to feel less alone, building their confidence and motivation to try options around re-connecting, and from this building up their determination – 'finding their moment' to make a change, which further helps them to build their personal resilience.
- 4.4 This ground work enables the person to be in a better frame of mind to deal with and consider options to begin to let go of any destructive 'self-soothing' habits they may be using. Identifying options with individuals for interventions, need to take account of the triggers for their SI&L.
- 4.5 Helping them to connect and be confident is a key step in improving their mental health, without it they are likely to fail in tackling any destructive habits, the failure then being more likely to increase these habits. (See Fig 4a & b, The Spiral), The Wellbeing Spiral 4a and b has been developed and is being piloted locally within the Community Connect 50yrs+ service as a model/guide for staff, in identifying destructive behaviours and connecting to services that support more constructive behaviours.

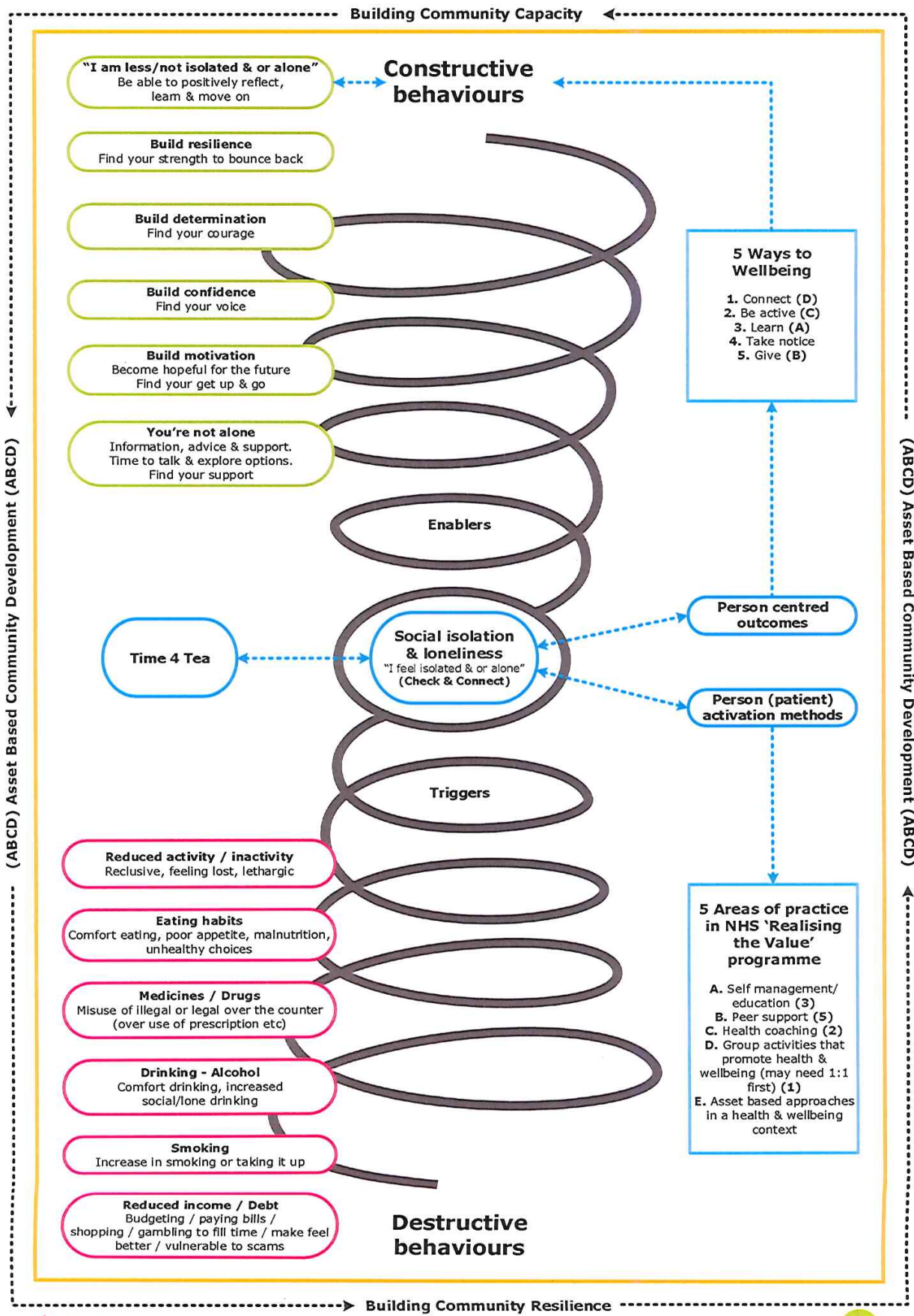


Fig 4a The Wellbeing Spiral –

Practical Applications of the Wellbeing Spiral

SPIRAL GREEN ZONE

Change embraced

Brief information and advice

- Telephone/contact at event/activity, may need 'one off' visit
- 1-4 weeks' support
- Triage Worker / Village Agents

Feeling determined and resilient: brief info/advice

SPIRAL BLUE ZONE

Embracing change

Short/medium-term support

- Telephone/visit
- Miniconnect plan
- 2-6 months support
- Wellbeing Worker or Village Agents

Lacking confidence, a bit unsure: build confidence and resilience, be hopeful

SPIRAL RED ZONE

Unable to embrace change

Medium/longer term support

- Telephone/visits/meet & greet support to get out/engage
- Miniconnect plan +
- 6-9 (+) months support
- Wellbeing Worker

Hopeless, worthless, unbelonging: help to not feel alone, motivate & find moment to embrace change

Evaluate Impact: reviews/case studies

Fig 4b The wellbeing spiral – Practical applications

5) IMPACT OF SOCIAL ISOLATION AND LONELINESS ON SERVICES, AND INDIVIDUALS ACROSS THE LIFECOURSE.

KEY POINTS – EFFECT ON SERVICES

- a) Socially isolated and/or lonely individuals are more likely to;
 - visit their GP more often
 - have higher use of medication
 - use A&E services independent of chronic illness
 - have more hospital visits (other than A&E) and hospitalisation periods
 - be admitted to adult social care
 - use mental health services more
 - have early admission to residential or nursing care
 - be less motivated to comply with rehabilitation/health programme/ service as may not see a future that is worth it
- b) Need to recognise the impact of lifecourse events and Triggers on individuals and target services to those areas/people/groups, to reap the service economic and individual life enhancing benefits that reductions in a) above can bring.

5. Evidence base for Key Points – Impact of SI&L on services

- 5.1 In general, we know from the research evidence that people who are socially isolated and/or alone visit their GP more often and have more hospital visits and hospitalisation periods and are more likely to have early admission to care homes. The presence of SI&L can also be a de-motivating factor in rehabilitation and as such may contribute to longer length of stay, or needing longer post discharge support. People may find it difficult to comply with OT and Physio etc. advice on getting up and around if there is no 'worthful' reason to get up for. (16, 17, 18 & 19 cited in 26)
- 5.2 In 2013 the Campaign to End Loneliness conducted a poll with over one thousand GP practices, they found that;
 - a) 89% of the GPs saw one or more patients every day whose main reason for the appointment was loneliness.
 - b) Over three-quarters said they were seeing up to 5 lonely patients a day.
 - c) 1 in 10 doctors reported seeing between 6-10 lonely patients a day.
 - d) A small minority (4%) said they saw more than 10 lonely patients a day.
- 5.3 There are particular situations and events across the life course that heightens the risk of SI&L and if not recognised, can start a falling domino effect throughout life, the domino load being heaviest in older age.
- 5.4 The following information highlights the impact on the stages of life. A focus will then be taken on the effects in older age because of this cumulative effect.

- 5.5 This is not to convey that this is of more importance than other periods of life course events, but that the need to prioritise the reduction of SI&L needs to form part of the relevant Strategic and operational plans, to include the BNSSG STP. Such plans would include, ante-natal and post-natal care, early years and young adults service provision, carers services, physical and mental health and Frailty plans, issues for those of working age, and the wider determinants of health – housing, poverty, education and training etc.

- 5.6 Pregnancy

KEY POINTS

- a) Maternal depression can impair child development.
- b) Identifying the presence of and addressing SI&L needs to be a core part of ante-natal and post-natal care.

Evidence base for Key Points – effects of SI&L in Pregnancy

- 5.6.1 1 in 5 mothers suffer from a level of anxiety or depression during pregnancy or in the first year after childbirth, they are also unaware of services to help them with this. (5)
- 5.6.2 A new mother who is socially isolated is more likely to suffer from depression and the effects are likely to be worse, she is then at a disadvantage in providing a good start in life for her child at best and at worst the level of maternal depression experienced can impair child development. (5)
- 5.6.3 The incidence of social isolation and lack of knowledge of services to help with depression rises to 1 in 3 in low income households. This shows that SI&L can set up the domino/knock-on effect in transmitting disadvantage through the life course and to the subsequent causes of physical and mental health inequalities'. (5)

- 5.7 Early years, children and young adults – Adverse Childhood Experiences (ACES)

KEY POINTS

- a) There is evidence to support a strong cumulative association between ACES and health harming behaviours and poor mental health across the lifecourse into adulthood and older age/retirement.
- b) ACES are also associated with negative neurological, immunological and hormonal development which can have a knock-on effect across the lifecourse.
- c) Some association between ACEs and use of health care including visits to GPs, hospitalisations and higher annual healthcare costs in adulthood.
- d) The presence of ACES increases the child's vulnerability to adopting destructive to health behaviours such as alcohol and drug use and smoking, habits sometimes used to 'fit-in'/cope. Children who use such behaviours to cope, coupled with the physiological changes resulting from ACES, are at an increased risk of developing non-communicable diseases (NCDs) such as cancer and heart disease earlier in life which can result in premature death.
- e) Data from ChildLine in 2014/15 showed that, 35,244 children under 16 years were counselled about loneliness as their main or additional problem
- f) People with lifetime mental health problems first experience symptoms by the age of 14yrs and three-quarters before their mid-20s.

Evidence base for Key points – effects of SI&L in early years, children and young adults

- 5.7.1 Becoming socially isolated and lonely in this group may be attributed to by the cumulative effect of adverse childhood experiences (ACES), and subsequent destructive behaviours that may have been adopted to help cope with the hurt and sadness. ACES are stressful events occurring in childhood such as being a victim of abuse (physical, sexual and/or emotional), or growing up in a household where adults are experiencing alcohol or drug use problems, mental health conditions, domestic violence or criminal activity.
- 5.7.2 Evidence from a 2016 report from Public Health Wales (6) and internationally has demonstrated a strong cumulative association between exposure to ACES and the adoption of health-harming behaviours and poor mental health across the life course.
- 5.7.3 ACES are also associated with changes in childhood neurological, immunological and hormonal development, all of which will have knock-on effects across the lifecourse. The cumulative effect of ACES over time can result in the child becoming 'locked' into a higher state of alert to threat; adapting physiologically to deal with short-term survival as they become permanently prepared to respond to trauma. This adaptation increases tissue inflammation and longer term wear and tear on the body.
- 5.7.4 Children who have ACES are also more likely to have difficulties in developing secure relationships, this in turn can result in a poor sense of self-image and worth, reducing their confidence dramatically. This can further result in increased risk of anxiety, depression and psychosis, setting off a domino effect of increased risk to self-harm, poor health and non-communicable diseases (NCD). In addition, exposure to ACES can make it more likely to have poor self-control, which can lead to increased levels of use of violence and victimisation later in life.
- 5.7.5 National and international evidence suggests some association between ACES and use of health care including visits to GP surgeries, hospitalisations and higher annual healthcare costs in adulthood. Increased use of services amongst people who have had ACES may be as a direct result of poor physical and mental health, or perceived health needs. Also there is evidence to show that people exposed to ACES have more negative perceptions of health, suggesting that they may perceive a greater need for health care intervention irrespective of actual ill health.
- 5.7.6 The presence of ACES can also make it difficult for children to learn how to control their emotions, control impulses, or manage behaviour. Subsequent reduction in self-control and poorly developed social skills increases the child's vulnerability to adopting destructive behaviours, such as alcohol and drug use and smoking, habits often used to 'self-soothe'/cope. Children who use such behaviours to cope and/or 'fit in', coupled with the physiological changes resulting from ACES, are at an increased risk of developing non-communicable diseases (NCDs) such as cancer and heart disease earlier in life which can result in premature death.
- 5.7.7 Other experiences that can contribute to SI&L are being a young carer, having a long term condition – not because of the condition itself but the potential SI&L that may accompany, or learning disabilities or socially ascribed identities ie gender, ethnicity, sexuality or physical appearance. Children who differ from the general population by appearance, language or behaviour may face difficulties integrating into peer groups at school.

5.7.8 Children considered at risk of becoming SI&L include;

- a) Those experiencing Adverse Childhood Experiences (ACES) i.e. 9 ACES – verbal abuse, physical abuse, sexual abuse, parental separation, household domestic violence, household mental illness, household alcohol abuse, household drug use, and household member incarcerated.
- b) Young carers
- c) Children in care
- d) Care leavers
- e) Those experiencing family breakdown.
- f) Young mothers (those under 20yrs).
- g) Those with language barriers on entering school: the proportion of children in schools who speak English as an additional language (EAL).
- h) Students living away from home for the first time, particularly where from lower socio-economic groups.
- i) Young people not in education, employment or training (NEET).

5.7.9 Data from Childline in 2014/15 showed that 35, 244 children under 16 years were counselled about loneliness as their main or additional problem (defined as low self-esteem, lack of confidence, feeling sad, low mood, lonely) representing 12% of all children counselled by ChildLine that year. (20)

5.7.10 Social isolation & loneliness in childhood has a considerable impact on the whole life course. Children in this situation tend to have lower educational outcomes and lower adult social class. (Based on occupation) & higher risk of smoking, obesity and psychological distress in adulthood, than children who are not SI&L. (15)
Also of those people with lifetime mental health problems, they first experience symptoms by the age of 14yrs and three-quarters before their mid-20s.
The following diagram Fig 5 illustrates the impact of ACES across the lifecourse. Reproduced from (6)

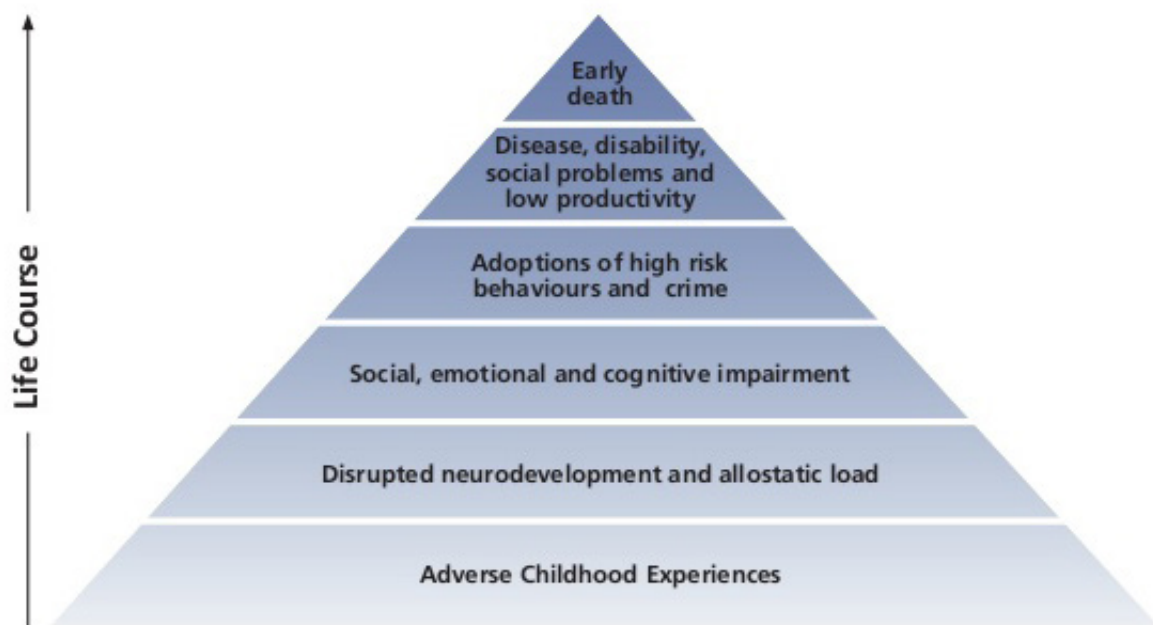


Figure 1: Model of ACE impacts across the life course¹

Fig 5. The impact of ACES across the lifecourse. Reproduced from (6)

- 5.7.11 In the Office for National statistics report (9b) children and young people suggested 4 key areas that could help them reduce loneliness;
- Create a culture of openness about loneliness
 - Create opportunities to make social connections
 - Encourage positive uses of social media to alleviate loneliness and
 - Prepare young people to understand loneliness and equip them to deal with it

5.8 Working age

KEY POINTS

- a) Having fewer local connections disproportionately affects men.
- b) Unemployment increases the risk of SI&L.
- c) Welsh survey reported the effects of ACES on working age adults. The report found that by the age of 49 yrs., 24.9% of individuals with 4 or more Aces reported having been diagnosed with one or more chronic diseases, while the figure for people with no ACES was 6.9%.

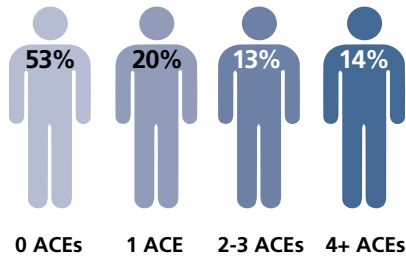
Evidence base for Key Points – effects of SI&L on those of working age

- 5.8.1 Research suggests that having fewer local connections disproportionately affects men and that unemployment increases the risk of SI&L, although it is uncertain whether this could be due to lower income or due to loss of contacts or a combination of both. (21)
- 5.8.2 A survey conducted by the Samaritans in 2013 found that 1 in 4 contacts were from middle aged men, who wanted to talk about issues relating to SI&L. It was also noted that the men most likely affected were mainly from disadvantaged backgrounds. (21)
- 5.8.3 It is also interesting to note that the Welsh survey reported the effects of ACES on working age adults. They found that by the age of 49 yrs., 24.9% of individuals with 4 or more Aces reported having been diagnosed with one or more chronic diseases, while the figure for people with no ACES was 6.9%. (See Fig 6 for illustration).

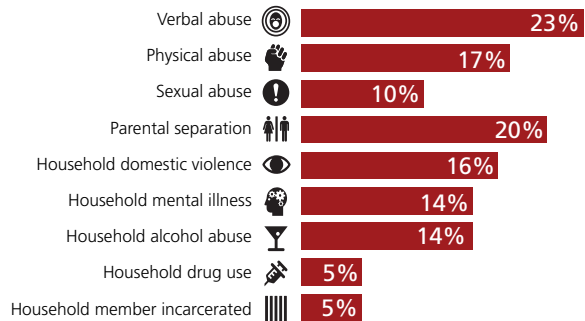
Adverse Childhood Experiences, chronic disease and health service use in Wales

Adverse Childhood Experiences (ACEs) have harmful impacts on health and well-being across the life course. The Welsh ACE Study measured exposure to nine ACEs in the Welsh population and their association with chronic disease development and health service use in adulthood.

47% of adults in Wales suffered at least one ACE as a child and 14% suffered four or more



Proportion of Welsh adults suffering each ACE



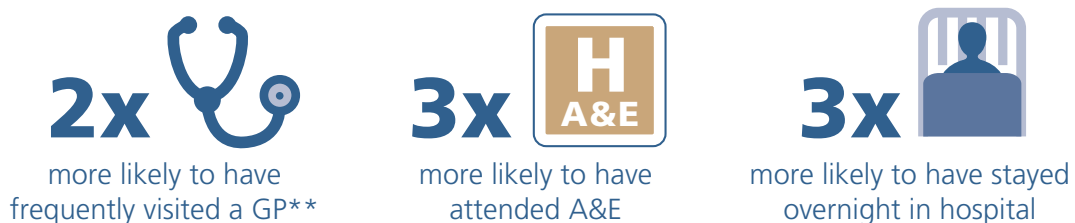
Up to the age of 69 years, those with four or more ACEs were 2x more likely than those with no ACEs to be diagnosed with a chronic disease*⁵

For specific diseases they were:



Levels of health service use were higher in adults who experienced more ACEs*[#]

Over a 12 month period, compared to people with no ACEs, those with four or more ACEs were:



The national survey of Adverse Childhood Experiences in Wales interviewed approximately 2000 people (aged 18-69 years) from across Wales at their homes in 2015. Of those eligible to participate, just under half agreed to take part and we are grateful to all those who freely gave their time.

*After taking age, sex, ethnicity and residential deprivation into account. All data was self-reported.; ⁵Includes Type 2 Diabetes, Stroke, Cancer, Coronary Heart Disease, Liver or Digestive Disease and Respiratory Disease; [#]Excluding reasons relating to pregnancy;

**Visited a GP six or more times over the past 12 months.

Fig 6. ACES – effects on presence of chronic illness in adults of working age and retirement 18 – 69 YRS. Reproduced from (6).

KEY POINTS

- a) Living alone is a contributory factor to SI&L. In England as a whole 53% of all households with people age 65 and over were one person households.
- b) Loneliness rates tend to be higher amongst older people who live in socially disadvantaged urban communities.
- c) Social Isolation and Loneliness can be felt quite acutely when moving into sheltered accommodation or care home. The presence of communal spaces themselves, if not used to promote social connections in a sensitive way will not reduce loneliness and isolation, in some cases where the environment is noisy and busy it may increase it.
- d) Older men are more isolated than women, even though more women than men reported feeling lonely. This is likely to be because of gender differences in expressing emotions. (21)
- e) Older people within ethnic minority groups are more likely to have language barriers and higher levels of poverty than those in the general population. This is further compounded by the less likelihood of accessing older people's services amongst this group.

Evidence base for Key Points – effects of SI&L on Older People

5.9.1 Retirement

In retirement, wellbeing can improve as a result of work pressures reducing and having more free time to pursue activities of choice. However for some the losses are greater than the gains and SI&L can creep in, in particular:

- a) Losing connections with work friends and colleagues
- b) Becoming ill and less mobile,
- c) A partner dying or going into care,
- d) Moving into sheltered accommodation or care home:

In the later retirement years, moving into sheltered accommodation or a care home can result in loss of connections with friends and relatives. Building new friendships as physical and mental health deteriorates is difficult.

Sheltered housing and care home environments and the staff that work within them, need to have the awareness and skills to nurture and build social connections. The presence of communal rooms themselves will not be enough to build new and/or maintain existing connections. The loss of confidence that deteriorating health can bring, needs support if it is to be regained enough to take part in activities, to include intergenerational, to make facing the new day worthwhile.

5.9.2 Gender Differences

Both men and women can be affected by SI&L in older age. However, the English Longitudinal Study (ELSA) highlighted that older men are more isolated than women, even though more women than men reported feeling lonely. This is likely to be because of gender differences in expressing emotions. (21)

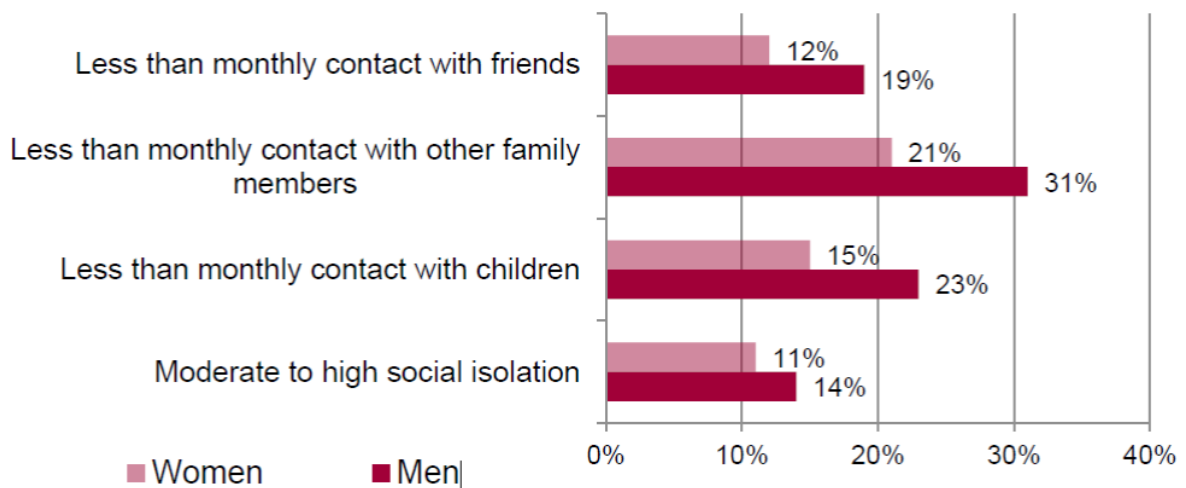


Fig 7 Cited in; Recognising the impact of loneliness: a public health issue. Ms Nuzhat Ali. May 2017 (15)

5.9.3 Ethnic Minority Elders

The Campaign to end loneliness publication 2014; Loneliness and older People from BME groups: Challenging misconceptions and stereotypes (22), found that older people within ethnic minority groups are more likely to have language barriers and higher levels of poverty than those in the general population. One study identified that levels of loneliness are much higher among BME elders (with exception of the Indian population) than for the general population, but that rates are comparable with loneliness reported by older people in their countries of origin. SI&L can be further compounded in this group as they are less likely to access older people's services. (23)

6. HEALTH AND WELLBEING IN OLDER AGE AND EFFECTS OF SI&L.

KEY POINTS

- a) The presence of long term conditions (LTC) themselves is not necessarily an indicator of the presence of SI&L.
- b) The effects of SI&L can lower the survival rate of cancer (24)
- c) People with dementia are at a higher risk of SI&L due to loss of social networks and support (25)
- d) Social Isolation itself has been associated with dementia possibly linked to changes in the brain and/or body that have been found in people who are lonely.
- e) People who are lonely have raised cortisol levels which can contribute to organ deterioration, and are more prone to viruses and disrupted sleep (5)
- f) The risk of developing Alzheimer's more than doubles in older people experiencing loneliness (25)
- g) A survey that engaged older people asking them about fears for their future, found that the top concern was dementia, the second highest fear was becoming incontinent (26)
- h) Issues with continence can be very limiting, with the knock-on effect of them becoming socially isolated and lonely.
- i) Lonely people are more prone to clinically depressive symptoms (5)
- j) Older carers have the physical and emotional strains of caring as well as the strains of their own ageing. These strains have the effect of lowering resistance to stressors and the immune system. Carers can also suffer from chronic tiredness and often non-intentional weight loss or gain. All of these factors together increases the risk of SI&L which further compromises their health.
- k) Planners need to 'future proof' the environment for all ages and abilities. Failure to do this increases SI&L as connecting with their community becomes difficult.
- l) Mental ill health, including dementia, and disability are factors that can heighten the risk of home fires for those living alone (Cited in 27)
- m) Fear of crime – Older people in ever changing urban communities may feel trapped by the 'unknown' around them, being afraid to communicate for fear of response.
- n) People of all ages in fuel poverty can become SI&L as not able to afford social activities and don't feel able to invite people into a cold home.

6. Health and wellbeing in older age and effects of SI&L

6.1 Disease and Long Term Conditions.

Over the decades research has continued to show that disease rates are higher in more deprived groups. The least affluent have a 60% higher prevalence of chronic disease than those in the highest socio-economic group. This is further compounded by the fact that the least affluent have a 30% increase in the severity of disease present.

The presence of long term conditions (LTC) themselves is not necessarily an indicator of the presence of SI&L. People with LTC's may well remain the best they can be for longer in the presence of a good social network. It is the absence of social networks, along with the coping strategies that these can provide, that makes it more likely that people with LTC will use services more and may have earlier entry into care. (3)

6.1.1 **Cancer.** The physical and psychological effects of cancer can limit mobility, increase loneliness and decrease social support networks for some people. A report by Macmillan in 2013, found that half of cancer patients who experienced SI&L skipped meals and did not eat properly because of lack of support at home. Also more than 1 in 6 had not been able to collect their prescription and more than 1 in 10 had missed a hospital or GP appointment. A consequence of this is that SI&L can lower the survival rate of cancer (24, 28)

6.1.2 Dementia.

An Alzheimer's Society report in 2013 found that people with dementia were at a higher risk of SI&L due to loss of social networks and support. Also they found that 70% of people with dementia stopped doing things they used to because of lack of confidence, 68% said they stopped doing things because worried about getting confused, 60% because worried about getting lost and 60% because of loss of mobility.

The report also found that loss of friends because of the dementia was a key factor in their SI&L, with 28% of people saying they had lost friends very soon after diagnosis. (25) Social Isolation itself has been associated with dementia possibly linked to changes in the brain and/or body that have been found in people who are lonely. (5)

Loneliness creates changes in the brain and/or body which contribute to or precipitate ill health. People who are lonely have raised cortisol levels which can contribute to organ deterioration, and are more prone to viruses and disrupted sleep. Loneliness also produces changes in the body that increase the risk of heart disease and lonely middle aged and older adults are at a higher risk of high blood pressure.

The links between cognitive decline and dementia are now known, with the risk of developing Alzheimer's more than doubling in older people experiencing loneliness. (25)

6.1.3 Continence.

A survey that engaged older people asking them about fears for their future, found that the top concern was dementia, the second highest fear was becoming incontinent. Issues with continence can be very limiting, making the person afraid to go out and mix with people in case they have an 'accident'. This fear may make the person self-exclude themselves from social settings and activities and withdraw, with the knock-on effect of them becoming socially isolated and lonely. (25)

6.1.4 Depression.

Lonely people are more prone to depression and the more chronic the loneliness has become, the more likely they are to have clinically depressive symptoms. Loneliness is a common experience, with a U shaped population distribution, with people under 25yrs and those over 55yrs having the highest levels of loneliness. A national study in 2005 (29) Examining the prevalence of Loneliness in older people in Britain, interviewed 999 people aged 65yrs or more living in their own homes. This sample was broadly representative of the population in 2001. The study found that;

- 61% of 65's and over reported 'never' being lonely
- 31% rated themselves as being 'sometimes' lonely
- 7% reported feeling lonely 'often' or 'always'.

Living alone is one of the factors contributing to SI&L. Office for National Statistics (ONS) 2012 data showed a higher number of people between 45-65yrs living alone than ever before. In England as a whole 53% of all households with people age 65 and over were one person households. Also loneliness rates tend to be higher amongst older people who live in socially disadvantaged urban communities.

6.1.5 Being a Carer.

The effects of caring across the life course have been highlighted in Fig 2. For older carers, they have the physical and emotional strains of caring as well as the strains of their own ageing. These strains have the effect of lowering resistance to stressors and the immune system. Carers can also suffer from chronic tiredness and often non-intentional weight loss or gain. All of these factors together increases the risk of SI&L which further compromises their health.

6.1.6 Living Conditions – in and out of the home.

An increasing number of older people are staying in their own homes for longer and the ties to hearth and home are strong. However, increasing frailty may mean that their home is no longer 'fit for purpose' i.e. increased risk of falls, difficult to affordably heat and maintain etc. Also urban and rural planning can hinder older peoples movement around outside due to lack of accessibility, rest areas etc. Planners need to 'future proof' the environment for all ages and abilities. Failure to do this increases SI&L as connecting with their community becomes difficult.

6.1.7 Dwelling Fire Risk.

Risk of dwelling fire occurs disproportionately more often in deprived areas. Frail older people living alone are more vulnerable to its harm or death, potentially causing secondary harm to others living close. Mental ill health, including dementia, and disability are factors that can heighten the risk of home fires for those living alone. (Cited in 27)

6.1.8 Actual Crime and Fear of Crime.

Older people in ever changing urban communities may feel trapped by the 'unknown' around them, being afraid to communicate for fear of response. Increasing frailty makes getting out and about difficult, which in some instances increases their vulnerability to actual crime.

6.1.9 Fuel Poverty – heat or eat.

The majority of households in fuel poverty are those of older people. People of all ages in fuel poverty can become SI&L as not able to afford social activities and don't feel able to invite people into a cold home. Also for some the choice is whether to heat or eat, the resulting poor nutrition or warmth causes anxiety and feelings of hopelessness, predisposing to SI&L.

6.1.10 Cumulative effects of causes of SI&L in older age.

It is the size and diversity of social networks and frequency of social contacts that increases or decreases the presence of SI&L.

In retirement and older age social networks can shrink with loss of work colleagues, friends and relatives. Also reduced income may limit ability to join in activities, particularly for those on lower incomes. Decreased mobility can be a factor particularly for some, if they have given up driving. The cumulative effect of some or all of the above in section 6, can result in unmet healthcare needs and premature death, as identified in the Marmot Review. (3)

7. NORTH SOMERSET STATISTICAL DATA FROM THE BUSINESS ANALYSIS TEAM;

Detailing potential local at risk groups across the lifecourse.

KEY POINT

The numbers in this section present a picture of the number of people locally who are potentially at risk of Social Isolation and Loneliness.

Total Population of North Somerset is211,681

7.1 Pregnancy

1 in 5 mothers suffer from depression, anxiety etc during pregnancy and/or in 1st year. 1 in 5 mothers lack support networks. These figures rise to 1 in 3 in low income households.

Number of pregnancies.

Number of mothers, registered with a North Somerset GP, who gave birth in year 1 Sep 2016 to 31 Aug 2017 is 2,024. 20% of that is 405. Source: NHS GP data

Number of pregnancies in low income households.

346 (or 17% of the 2,024 mothers) live in a neighbourhood ('LSOA') which is among the most deprived 25% of neighbourhoods in England. One third of 346 is 115.

188 (or 9% of the 2,024 mothers) live in a neighbourhood ('LSOA') which is among the most deprived 10% of neighbourhoods in England. One third of 118 is 63.

Source: NHS GP data and IMD 2015 (Combined IMD score)

7.2 Children and young people.

Number of children in care.

236 as at 28/12/2017 (Source: NSC, Declarations Desk)

Number of care leavers.

125, age 16 to 24 only, that we actively support (Care Leaver: Qualifying, Relevant or Former Relevant) NSC, April 2017.

Number of young mothers under 20yrs.

84 (who are registered with a North Somerset GP) Source: NHS GP data

Number of young carers.

The number of carers on our system (or provider Carers systems) is a very small proportion of carers as identified in the census. The census figures given here are from 2011, as no re-estimate of carers has been done. That says that there are 468 people aged 0 to 15 providing unpaid care (any number of hours per week). There were another 827 aged 16 to 24. This is set against the carer population (all ages) of 22,313.

LC3304EW - Provision of unpaid care by age

[Download \(.xlsx\)](#) - or [older .xls format](#)

Table population: All usual residents

Age by Carer

Units: Persons

Date 2011

Geography North Somerset

Measures value

	All categories: Provision of unpaid care	Provides no unpaid care	Provides unpaid care: Total	Provides 1 to 19 hours unpaid care a week	Provides 20 to 49 hours unpaid care a week	Provides 50 or more hours unpaid care a week
All categories: Age	202,566	180,253	22,313	15,172	2,577	4,564
Age 0 to 15	36,652	36,184	468	395	33	40
Age 16 to 24	18,421	17,594	827	635	118	74
Age 25 to 34	21,054	19,807	1,247	833	149	265
Age 35 to 49	42,999	37,900	5,099	3,650	573	876
Age 50 to 64	40,807	32,324	8,483	6,311	916	1,256
Age 65 and over	42,633	36,444	6,189	3,348	788	2,053

In order to protect against disclosure of personal information, records have been swapped between different geographic areas. Some counts will be affected, particularly small counts at the lowest geographies

Source: Census 2011, Crown Copyright courtesy of ONS. Table LC3304EW

Number of young people not in Education, Employment or Training (NEET).

95 people in academic years 12 and 13, Jan 2018 (North Somerset Client Caseload Information System). NB this is probably an underestimate as there are 232 for which we have very limited information)

Number of students, 19yrs and under living away from home

There are 6,292 full-time students in North Somerset. Of these 5,841 (i.e. 93%) live with parents. The other 451 students live in various settings as below e.g. 34 live alone.

DC6108EW - Economic activity of full-time students by student accommodation by age

[Download \(.xlsx\)](#) - or [older .xls format](#)

Table population: All full-time students aged 16 and over

Student accommodation by Age

Units: Persons

Date 2011

Geography North Somerset

Measures value

	All categories: Age 16 and over	Age 16 to 19	Age 20 to 24	Age 25 and over
All categories: Student accommodation	8,543	6,292	1,180	1,071
Living with parents	6,664	5,841	669	154
Living in a communal establishment: Total	192	158	25	9
Living in a communal establishment: University (for example halls of residence)	36	15	17	4
Living in a communal establishment: Other	156	143	8	5
Living in all student household	567	72	282	213
Student living alone	188	34	51	103
Living in a one family household with spouse, partner or children	600	35	88	477
Living in other household type	332	152	65	115

In order to protect against disclosure of personal information, records have been swapped between different geographic areas. Some counts will be affected, particularly small counts at the lowest geographies

Source: Census 2011, Crown Copyright courtesy of ONS. Table DC6108EW.....

7.3 Working Age.

ONS use many terms to cover 'unemployed'. E.g is a retired person to be counted as unemployed? A home-maker? Or someone who is too disabled to work?

The definition used here is 'economically active: unemployed (including fulltime students)'. This is based on the idea that, in the week before the census they were not in work but were available and looking for work or waiting to start a job, or a Full Time student

Number of people unemployed aged 25-34yrs	919
Number of people unemployed aged 35-49yrs	1,314
Number of people unemployed aged 50-64yrs	965

Source: Census 2011, Crown Copyright courtesy of ONS. Table DC6107EW

Number of claimants of Job Seekers Allowance (JSA) aged 25-34yrs	150
Number of claimants of Job Seekers Allowance (JSA) aged 35-49yrs	260
Number of claimants of Job Seekers Allowance (JSA) aged 50-64yrs	260

Source, Crown Copyright courtesy of ONS. May 2017. ("This dataset is based on 100% of claims so is not subject to any sampling error. In outputs figures are rounded to the nearest 10 ")

Number of physically disabled people aged 25-34yrs	1,534
Number of physically disabled people aged 35-49yrs	4,797
Number of physically disabled people aged 50-64yrs	8,152

Source: Census 2011, Crown Copyright courtesy of ONS. Table LC3101EWIs. Definition of disabled is people saying that their day-to-day activities are limited (a lot or a little).

There were 677 people who were both a) unemployed and b) disabled (day-to-day activities limited a lot or a little).

Source: Census 2011, Crown Copyright courtesy of ONS. Table LC6302EW

Mental Health

The GP patient survey (January-March 2017), below. This suggests that anxiety/depression is not heavily linked to age.

Number of carers of working age	See Table LC3304EW above.
Number of people living alone aged 25-34yrs	2,406
Number of people living alone aged 35-49	5,106
Number of people living alone aged 50yrs and over	18,916

Source, Crown Copyright courtesy of ONS. 2011 census. Table LC1109EW

7.4 Older People.

North Somerset number of 65yrs+ population	49,726
	(23% of total population)

Extrapolate 31% (based on National figure) of over 65s as being lonely 'sometimes'	15,415
------------------------------------------------------------------------------------	--------

Extrapolate 7% (based on National figure) of over 65s as being lonely 'often/always'	3,481
--------------------------------------------------------------------------------------	-------

Universe
 Clinical Commissioning Group (CCG): North Somerset CCG
 Break-down variable 1: Age group
 Break-down variable 2: « None »
 Break-down variable 3: « None »
 Weighted data

Crosstables
 Question: Q34e. State of health today...Anxiety/Depression
 Base: All

	18 to 24		25 to 34		35 to 44		45 to 54		55 to 64		65 to 74		75 to 84		85 or over	
I am not anxious or depressed	68%	117	83%	245	69%	338	81%	357	67%	317	70%	329	65%	177	53%	63
I am slightly anxious or depressed	11%	20	24%	95	19%	91	24%	140	19%	90	20%	94	20%	58	27%	32
I am moderately anxious or depressed	14%	25	9%	35	9%	44	10%	58	11%	53	9%	42	14%	38	18%	21
I am severely anxious or depressed	*	*	4%	14	*	*	3%	20	*	*	*	*	*	*	*	*
I am extremely anxious or depressed	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Total	171		389		487		582		475		471		273		119	

Source, Crown Copyright courtesy of ONS. Mid-Year Estimate 2017 (shows population at mid-2016)

Number of 65yrs and over in single households 12,523

(Source, Crown Copyright courtesy of ONS. 2011 census)

Number of 65yrs and over in single households in the top 20% of those most deprived neighbourhoods (LSOAs) 1,618
 (or 13% of all those aged 65yrs and over in single households)

Number of 65yrs and over in single households in the top 10% of those most deprived neighbourhoods (LSOAs) 1,035
 (or 8% of all those aged 65yrs and over in single households)

These areas (most deprived) account for 10% and 8% respectively of all North Somerset residents. In other words people aged 65+ in 1-person households are slightly 'over-represented' in the more deprived areas.

Source, Crown Copyright courtesy of ONS. 2011 census and IMD 2015 overall (combined) deprivation score per LSOA

Number of North Somerset residents with Blue Badge.....12, 339

Source is NSC records.

Number of 65yrs and over admitted to long term care As of 31 March 2017, there were 1,600. These figures have been fairly stable (equivalent was 1,590 12 months previously).

Source our SALT return to government LTS001b available at <https://digital.nhs.uk/catalogue/PUB30122>

Number of 65yrs and over who are carers 6, 165

(Source, Crown Copyright courtesy of ONS. 2011 census)

- 7.5 Number of assisted bin lifts (from Waste Management team) 2,870

These are people who do not have a friend or relative nearby who they could ask for help or have a neighbour who they would feel comfortable with asking for help. This may be a useful consideration when assessing levels of SI&L in the community.

8. INTERVENTIONS – BEST EVIDENCE BASED PRACTICE – INFORMING COMMISSIONING.

Focusing on those related to older people.

Interventions fall broadly into three groups:

- i) **Connecting** individuals and communities through Information, advice and support/Social Prescribing type roles i.e. Signposters/Community Navigators, Wellbeing workers, Village Agents, Primary Care Network (PCN) link workers etc, which help people identify 'what matters to them' and what the options are for support.
- ii) **Befriending**, both face to face and telephone services'
- iii) **Healthy Lifestyle**; Development of and participation in accessible and welcoming social and healthy lifestyle activities,

- 8.1 The Public Health England and UCL 2015, Local action on health inequalities: Reducing social isolation across the lifecourse, evidenced that adequate (in terms of quantity and quality) social networks can promote health and wellbeing through four possible intervention pathways;
 - i) Providing individuals with a sense of belonging and identity, connecting with people and community.
 - ii) Providing information, advice and support to increase knowledge about how to access services that people need.
 - iii) Influence the behaviours of individuals, for example through support to quit smoking, reduce alcohol intake, access health care when needed etc.
 - iv) Providing social support that enables individuals to cope with stressors across the lifecourse, which for older people include retirement, bereavement, reduced income and mobility, caring responsibilities etc.
 - v) PHE and UCL 2015 also endorsed the adoption of a whole systems approach to addressing SI&L. While this approach is harder to evaluate, it will have greater impact, with more mutually supportive and resilient neighbourhoods and communities.

However, there is a need to enhance assessment practice in supporting people, in that if destructive to health behaviours are being used to 'self-soothe', then the underlying cause needs to be addressed alongside other interventions. If this is not done then it is likely that support to quit etc. will be less effective at best and at worst, increase destructive habits to cope with feelings of failure. In PHE presentation, recognising the Impact of loneliness: a Public Health Issue 2017 (14) Ms Nuzhat Ali identifies the wider benefits of public health interventions, in particular:

"Drugs and Alcohol: efforts to tackle drug and alcohol misuse can be more effectively targeted if loneliness is recognised as a potential contributing factor"

This recognises the 'self-soothe' aspects of destructive behaviours and the need to recognise SI&L as a contributing factor, and the need to address this if changes to more constructive behaviours are to work.

Locally, North Somerset has recognised the importance of identifying destructive behaviours being used to self-soothe, and has developed a 5 Step process (see [appendix 1a.](#)) eg

Step 1 – The Postcard identifying need.

Step 2 – The Pathway, triaging referrals.

Step 3 – Identifying the triggers, Time4TEA conversation guide.

Step 4 – The Well Being Spiral and application, assessing needs.

Step 5 – Supporting change, the Connect Plan using the Five Ways to Wellbeing.

for Community Connect staff initially, to identify this and address the loneliness in the first instance. Using a strengths-based approach, it is anticipated that the individual will become more self-aware and when they are more confident and motivated, will be able to 'find their moment' to tackle the changes needed and be signposted if not already, to more specific support to address destructive to health behaviours as necessary.

- 8.2 **The Campaign to end loneliness** together with Age UK have developed the following framework to inform strategic, whole systems approaches to addressing loneliness. (2) (See Fig 8)

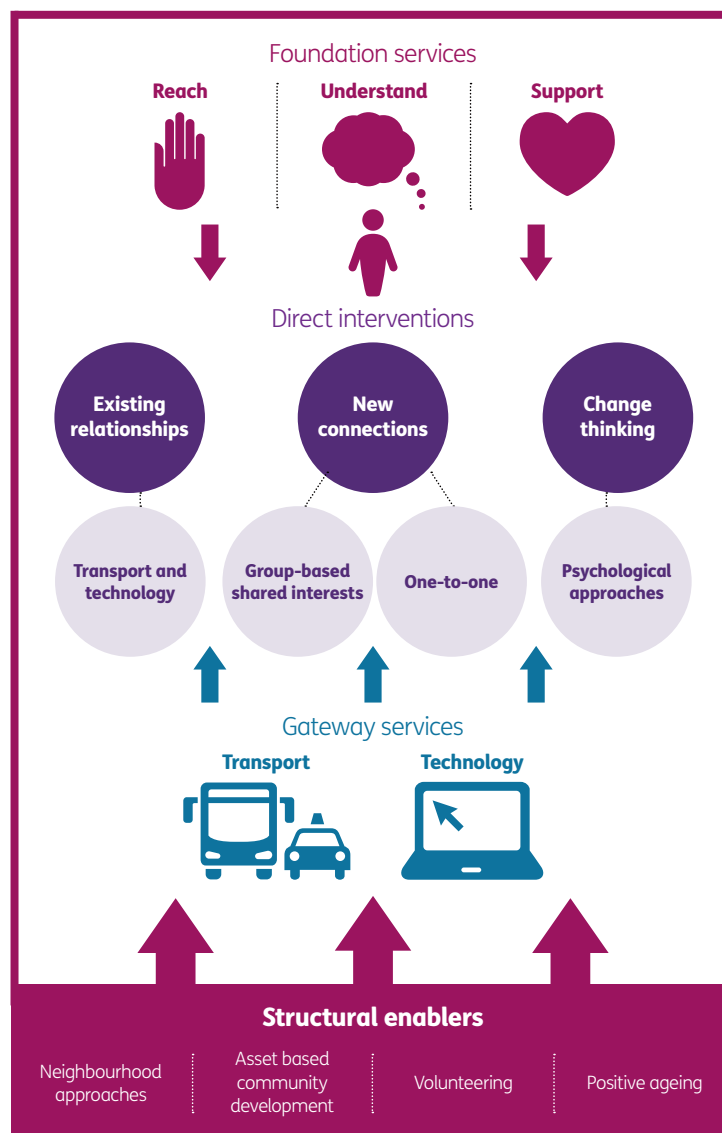


Fig 8. Reproduced from Campaign to End Loneliness and Age UK 2015 (2).

Fig 8 sets out four independent categories of intervention provision (together these categories put the meat on the bones of the intervention pathways in 8.1):

- a) **Foundation services:** reach; understand; support access – services to reach and understand the specific needs of those experiencing SI&L, and to access appropriate interventions.

The development of Community Connector/Village agent type roles, working alongside and within communities, along with the development of Social Prescribing – Wellbeing worker type roles within GP practices, able to give more structured support to those most affected by SI&L, will be key to the development of foundation services. Working at these community and individual levels is best placed to build individual and community resilience.

- b) **Direct interventions:** support and maintain existing relationships; foster and enable new connections (1:1 and group based); psychological interventions. – a menu of services that directly improve the number and/or quality of relationships people have, through supporting and maintaining existing services and supporting new social connections. This would also include the more targeted psychological support i.e. Cognitive Behavioural Therapy (CBT) and Mindfulness.

In order to offer a menu of activities, opportunities and services that give people choice, development work needs to take place at very local levels to build community capacity. With tight and decreasing budgets, communities need support to turn to themselves to build community capacity to offer some of these choices. This is best done through an Asset Based Community Development (ABCD) approach.

- c) **Gateway Services:** transport and digital inclusion – improving transport and technological provision to help retain connectedness and independence. The evidence base for the impact of computer/internet based initiatives are mixed. There is limited evidence to support internet access as a way of reducing SI&L. Using IT to keep in touch with known family and friends spread geographically, making regular visits difficult, is favoured where IT use is accessible. However, the use of IT in making new contacts has mixed reviews, whereby some older people report that the IT training course itself, enabling them to do this was more enjoyable, as was seen as a social face-to-face event in itself. It is vital to include internet safety information, as with the usefulness of increased access comes potential increased vulnerability, particularly if using to reduce SI&L.

Service development considerations – There is a recognition that transport is vital to connectedness and that, similarly to IT courses, transport to day activities can provide an 'excuse' for new contacts. With both IT courses and days out, it would seem easier and possibly feel safer for people to develop contact with new friends using IT and/or telephone, if they first meet in person.

- d) **Structural Enablers** – create the right structures and conditions in a local environment to reduce those affected by, or at risk of, SI&L. This might include Asset Based Community Development (ABCD) approaches, identifying with communities their needs and aspirations and volunteer/helper assets to develop local opportunities to meet needs etc.

Development of age positive approaches like Dementia friendly communities, along with improvements in Environmental conditions, helping people maintain social connections i.e. having safe public spaces, accessible public toilets, with accessible pavements, good lighting and rest areas etc.

■ 8.3 Effectiveness of interventions: outcomes effectiveness and economic benefits of services aimed at preventing SI&L.

8.3.1 Prevention is broadly defined to include a wide range of services that:

- i) Promote independence
- ii) Prevent or delay the deterioration of wellbeing resulting from ageing, illness or disability

iii) Delay the need for more costly and intensive services.

8.3.2 Preventative services represent a continuum of support ranging from the most intensive, 'tertiary services' such as enablement services, down to 'secondary' or early intervention and finally 'primary prevention' aimed at promoting wellbeing.

8.3.3 Effectiveness of specific interventions and potential economic benefits. (reviews are appended to 27)

The Social Care Institute for Excellence (SCIE) reviews explored the impact of different intervention types across three outcomes:

- i) Loneliness
- ii) Health and wellbeing (including mental health) and
- iii) Health service use.

The evidence around interventions aimed at tackling SI&L is mixed. However there appears to be some consistency around the effectiveness of particular types of approaches and interventions. This section will concentrate on those, which are:

a) **Strengths based approaches to working with individuals include (30,31,32);**

a.1) acknowledging that people are more than their care needs, are experts in their own lives and take the lead in their own care i.e. 'What matters to me'

a.2) drawing upon a person's resources – strengths, talents and connections

a.3) working collaboratively, developing a relationship of two equals, using reflective conversations to recognise each other's contribution and understanding concerns. Encouraging them to make sense of where they are and to make meaningful choices about how they would like to be supported.

a.4) recognising the relative power of hope and be 'hope-inducing'.

a.5) Use of the 3 Conversations model in implementing a strengths-based approach. To include using a loneliness measurement scale (33).

b) **Asset based Community development (ABCD)** approaches – engaging with people to build local services/activities, to build community capacity creating more services to refer people into.

b.1) There is widespread agreement that for SI&L interventions to be effective, consultation is important. An ABCD (Co-production) approach supports the involvement of local older people in the planning, development, delivery and assessment of interventions. It can also support a more 'grow your own' approach to identifying community assets – people (volunteers/helpers and/or movers and shifters in terms of getting things going in communities), places to meet and resources to help access, transport options etc. Rather than a more traditional volunteer recruitment process, better suited when aligned to specific ring fenced services i.e. befriending volunteers, advocacy volunteers etc.

b.2) This approach to ensuring community involvement can lead to more sustainable, relevant and equitable use of resources. However this level of community involvement is not free: consultation events, training, volunteer/helper coordination, project management/facilitation and set-up costs are all legitimate expenses and need to be factored into community engagement work.

b.3) Using social return on investment (SROI) methodology, an analysis of community development in local authorities reported a return of £2.16 for each pound invested, and the value of volunteers running activities was almost £6 to a pound invested. (34, 35)

- c) **Signposters/Community Navigators, Wellbeing workers, Village Agents, PCN link worker etc. roles**
- c.1) These roles typically take opportunities to provide information, advice and support – the latter direct or through identifying a community link, to services in the community that can help individuals build their social contacts/networks/friendship groups.
- c.2) Community Connector type schemes may have a higher initial cost, but the evidence shows that the economic benefits are estimated to be higher. The cost of such a service may be around £300 per person, but the economic benefits are approximately £900 per person in the first year. The continuing potential for better mental health and quality of life, could provide greater economic benefits in the following years.
- c.3) Community Connector type services provide very local Information, advice, signposting and support. ‘Ear to the ground’ finding people or taking opportunities when identified through other services i.e. fire, police etc. to signpost the lonely and isolated. Of all the interventions, there appears to be the most consistency of agreement about the value of these types of roles/services in reducing SI&L, in relation to realising potential cost benefits.
- d) **Befriending** (with good matching and support of volunteers) best targeted at frailer housebound people.
- d.1) The reviews (27,34) looked at befriending to include, group and 121, and intergenerational and telephone befriending. Evidence of effectiveness is mixed. This can be particularly successful for people who are frail and housebound. Also, if the recipient and befriender have enough in common to build a genuine relationship, or there are common interests in group befriending.
- d.2) Befriending services are considered to be relatively low cost, and by targeting at risk groups i.e. older people who live alone being discharged from hospital, they can potentially offer worthwhile returns on investment. Knap et al 2010 (35) found that a typical befriending service could be estimated to cost (2013 rates) £80 per older person in the first year, providing around £35 of ‘savings’ in reduced need for treatment and support for mental health needs, which could continue in subsequent years. Factoring in additional quality of life improvements through reductions in wellbeing aspects i.e. depression, the monetary value of savings went up to approx. £300 per person per year.
- d.3) A local observation through the community meals service is that the opportunity for the recipient and befriender to eat together can provide a shared experience to ease initial tension and also improve eating habits. It can also improve appetite and enjoyment of food, as eating alone can be joyless and exacerbate feelings of loneliness. There is also evidence that poor nutrition contributes to falls, susceptibility to illness and poorer recovery. (36) Therefore, Lunch buddies as part of a befriending service, has the potential to improve physical and mental health and wellbeing.
- e) **Social Group Interventions**, this can include, lunch clubs, leg clubs, community cafes, particular interest and/or gender targeted groups – gardening, ex-servicemen/women groups, BME related groups, Women’s Institute, Men in Sheds etc. or health related social groups i.e. Osteoporosis, Macular degeneration, leg clubs etc
- e.1) Where longitudinal studies recorded survival rates, older people who were part of a social group intervention for SI&L, had a greater chance

of survival than those who had not. Evidence also suggests that usage of such an intervention gives positive results in terms of lessening demand on services. Also users report high satisfaction with group services, benefitting by increasing their social interaction and community involvement, taking up or going back to hobbies and taking part in wider community activities.

- e.2) In relation to those taking part in group interventions, one study showed the total cost of health service use (hospital bed days, hospital appointments) was £1,117 per person per year in the intervention group, compared with £1,809 in the control group. The difference being £692 per person cheaper in the intervention group. The average cost per person per year of the intervention was £647, giving a saving of £45 per person in the intervention group.
- e.3) Of course social group intervention costs vary considerably from what and where its provided and what is included, from a lunch club held in a community venue, run by volunteers, use of low cost community transport where participants pay for transport and their meal, a raffle may be held with donated gifts to cover hall hire, other outings etc. To an activity and lunch club for significantly disabled and dementia participants, whose needs are high needing paid staff support and specialist transport services, secure environment etc. However, for the latter although costs per person may be significantly higher, the alternative with no such intervention, the evidence appears to be consistent, in that participants do significantly less well and likely to need more costly interventions i.e. more hospital bed days, appointments and earlier entry into a care home.
- f) **Volunteering/helping**. This is not a 'free' service, volunteers/helpers need recruiting, training and support, all of which needs funds.
 - f.1) The most effective volunteers to support the lonely and isolated are those with experiences of these in their own lives and have 'come out the other end' finding enjoyment and companionship in life again. The evidence shows that Volunteering positively impacts on SI&L, however volunteers need to be well supported to avoid burnout and stress. Also cost effectiveness needs to be considered in setting up. However, if volunteering/helping to set up social group interventions can be facilitated through a funded ABCD approach, then this may keep costs down and may be more sustainable in the medium-longer term. Also, Volunteering/helping in a social group may lessen burnout and stress as tasks to run groups can be shared. Volunteers are more likely to experience burnout and stress in the 121 role of befriending, so funded support structures need to be in place to avoid this.
 - f.2) However, as Council budgets decrease and more and more is expected of the voluntary and not-for-profit sectors, all needing volunteers from the same local pool, attracting volunteers is more difficult. Locally, North Somerset within its Community Connect over 50's service, is differentiating between volunteer and helper roles, as starting involvement as a 'helper', i.e. involved in group activities making the tea, organising venues, finding materials for activities etc., may be a more gentle way into voluntary work and give a taster before committing to 121, DBS checked volunteer role. This 'helper' opportunity may be more attractive to a wider group of people to include younger people.
- g) **Social Prescribing**. The outcomes of social prescribing have been found to include reducing SI&L, particularly as it is likely that a significant number of people referred will have one or more of the triggers for SI&L ([Triggers, See appendix 1a Step 4](#)). However the services that are socially prescribed into need to be tailored for that purpose, and be flexible and adaptable enough to cater for individual needs.

- g.1) Also in identifying need Age UK caution the use of the 'L' word (loneliness) as it is sensitive and people may choose not to identify in that way. A more creative approach to finding those suffering needs to be used.
- g.2) Locally, we have taken this into account and updated our over 50s Check and Connect checklist (the first step of the 5 Step process, see appendix 1a) to be MECC and Social Prescription compliant which identifies SI&L issues under Enjoyment of life.



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We're open weekdays, 9am-5pm

Opening the door to

local services for over 50s
Community Connect is a **free service**



SOCIAL PRESCRIPTION CHECK AND CONNECT CARD

Please use this check and connect card to see how Community Connect can assist you, or someone you support or care for. You don't need to send us the form – either fill it in or use it as an aide-memoir before giving us a call to see how we can help.

How to use this card

1. If you're filling in this form on behalf of someone else, please get their agreement before contacting us
2. Tick all boxes that apply
3. Call one of the numbers overleaf with details
4. If you're filling in this form on behalf of someone else, tell them that an advisor will be in contact

Staying safe and independent, safety and security

- Fire, smoke or carbon monoxide alarms
- Gas/electric wiring or equipment concerns i.e: blankets/heaters
- Help to feel safe in home/community
- Fear of crime or anti-social behaviour, including scams

House and home

- Concerns about suitability of accommodation
- Home or garden maintenance concerns
- Concerns about needing to move
- Equipment to help you stay in your home i.e. bath rails/toilet seats/walking aids

Keeping warm

- Problems with draughts, condensation or damp
- Insufficient heating provision
- Advice on reducing energy bills

Accident and falls prevention

- Concerns about steps in/out of your home, climbing stairs, getting out of your chairs or using the bathroom

If you can answer yes to any of the following, you may be at risk of trips/falls.

Do you have concerns over:

- I have fallen in last 12 months
- I feel unsteady at times
- I take 4 or more medications daily
- I have had a stroke or have Parkinson's Disease

Money

- Managing your income or reducing your debt so you can afford essentials like food/rent/heating
- Benefit entitlement

Daily living

- Support when you need it or have a crisis
- Access to an alarm to use in an emergency
- Need help with day to day routines that you used to cope with
- Help with worries about memory loss

Enjoying life and living healthier

Would you like any help or information about any of the following from health workers.

Lifestyle

- Stop smoking
- Reduce the amount of alcohol you drink
- Eat healthier
- Take more exercise
- Help to reduce/stop drug use
- Manage use of prescription drugs
- Access to the flu jab
- Access to the pneumococcal vaccination
- Help managing any health conditions i.e. diabetes, heart or mobility issues, hearing, sight loss etc

Enjoyment of life

- Help getting out of the house including shopping, seeing friends and activities
- Help to fill your time/be on your own less
- Help to manage feeling sad or depressed
- Help to rediscover an old interest or hobby
- Do something new that you've always wanted to do
- Find out what is available to do locally

Do you look after someone?

- Information or advice about what support might be available

Helping out in your community

- Information about how you can help in your community and give back some time and skills

August 2017

Fig 9. North – Somerset Check and Connect Social Prescribing Checklist.

- h) **Developing a pathway** – bringing interventions together.
- h.1) In needs identification and service delivery, Social Prescribing services and an ABCD approach to community capacity building are inextricably linked.
- h.2) It also follows that development of social group interventions to reduce SI&L is inextricably linked to an ABCD approach.

- h.3) The thread that ties social prescribing, Asset Based Community Development, development of social group interventions and the community assets needed to support interventions, are the roles of Community Development Coordinator – community asset builder, and the role of Community Connector – finding the SI&L people, listening and understanding, and enabling. (See Figure 10)
- h.4) North Somerset has developed a Community Connect 50yrs+ service 5 Step Process (see appendix 1a), which brings referral, signposting, assessment, interventions and support together.
- h.5) Locally, the Bristol, North Somerset and South Gloucester (BNSSG) CCG have agreed a core Framework for Social Prescribing.
The Framework identifies five distinct activities (see appendix 2);
- 1) Social Prescribing entry points
 - 2) Signposting
 - 3) Social Prescription
 - 4) Asset Based Community Development
 - 5) Creative Impact Assessment

- h.6) North Somerset has a Social Prescribing Co-production group. Currently the membership includes;

- Representation from each of the 3 current contracted social prescribing services
- BNSSG CCG
- Public Health
- Public involvement/engagement
- Local resident representation
- VCSE key providers; Citizens advice North Somerset (CANS), Voluntary Action North Somerset (VANS)-linking into the West of England Civil Society Partnership, the latter includes wider BNSSG VCSE involvement
- North Somerset Council lead on Social Prescribing and Social Isolation and Loneliness
- NHSE regional rep (working within the University of the West of England)

This group acts as a conduit for BNSSG wide and Local North Somerset work on developing and implementing good practice around social prescribing, this includes working on the NHSE BNSSG Local Shared Plan on Social Prescribing. This is in line with The Primary Care Network (PCN) Directed Enhanced Service (DES) contract requirement that;

- PCNs work in partnership with commissioners, social prescribing schemes, local authorities and voluntary sector leaders to create a shared plan for social prescribing

The development of social prescribing through PCNs is moving on a pace, the need for information and advice to support this is crucial. NHSE's Social Prescribing and community-based support summary guide is helpful (37). Also, more recently in April 2019, a Social Prescribing Support Pack for Primary Care Networks in South Yorkshire and Bassetlaw (38) was produced. This offers very practical information and ideas for moving forward, to include what can be done within the DES contract i.e. subcontracting social prescribing/link worker role to the voluntary sector is possible.

The North Somerset Social Prescribing Co-production group is forming links with the new PCNs of which we will have three, offering our years of experience in delivering social prescribing within the VCSE sector.

Community Connect Service Pathway

A model for Social Prescribing

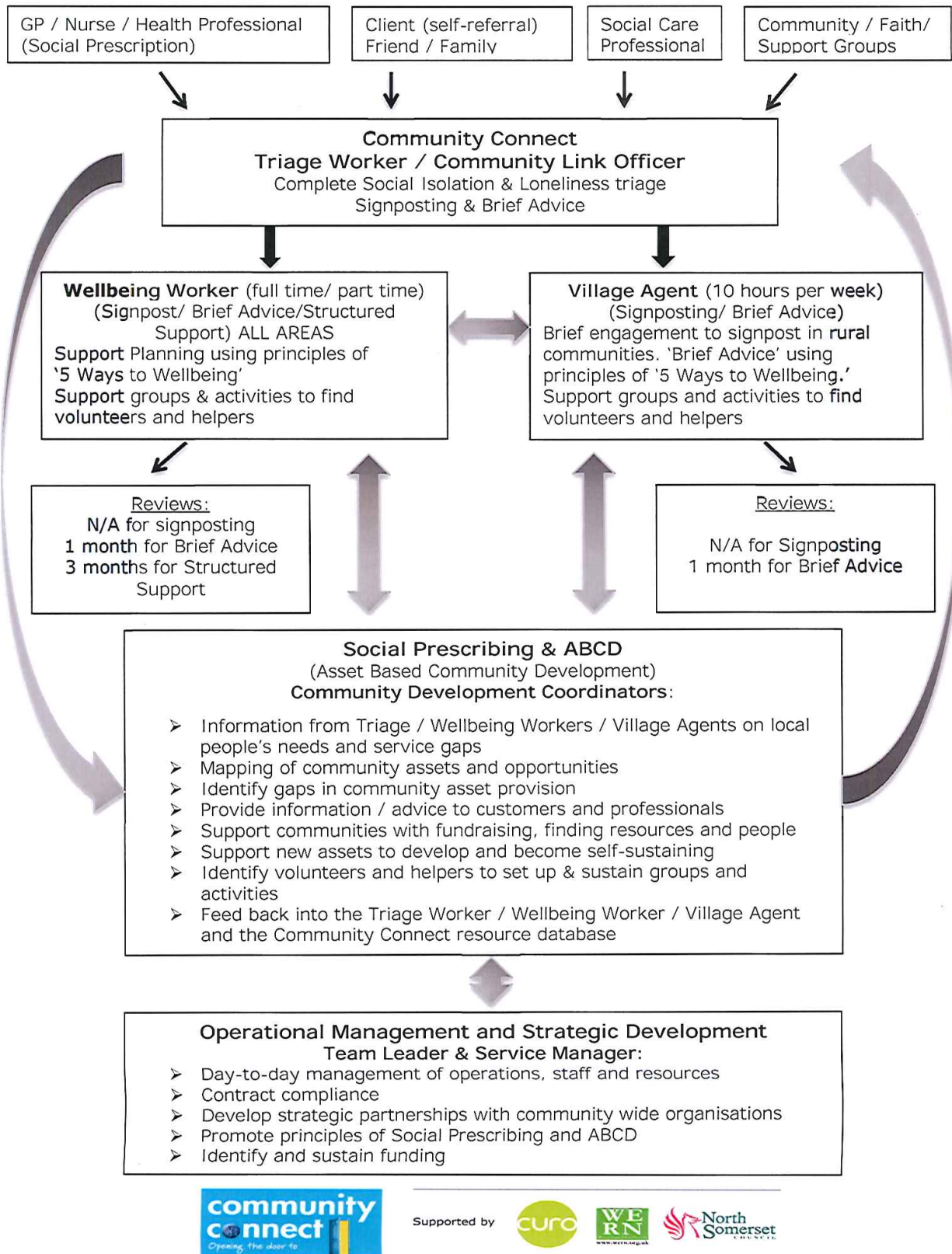


Fig 10. Community Connect Services Pathway

h.6) PCN's will be employing link workers/social prescribers either direct or through sub-contracting to current social prescribing services in the VCSE sector, through their Directed Enhanced Service (DES) contract.

The BNSSG CCG Social Prescribing sub-group is putting together a support pack for PCN's to help them implement their new responsibilities i.e. link workers, community pharmacy, physio etc. To assist this locally the North Somerset Social Prescribing Co-production group have put together information on current social prescribing services and how they work with GP practices, Adult social care, the public etc. (See appendix 3 inside back cover)

■ 8.4 Technology as an intervention to improve health and wellbeing – a Local Initiative.

8.4.1 By providing an opportunity to reconnect with friends and family or make new connections, technology can support interventions to reduce social isolation in older adults.

8.4.2 An innovative technology project implemented locally over recent months has produced a range of outcomes.

8.4.3 This project included issuing voice activated assistants (VAA) and touch screen devices (tablets) to a cohort of residents within an extra-care housing scheme in North Somerset.

8.4.4 The aim of the project was to explore how technology can help people remain independent for longer, develop new skills, make new connections with friends and family and improve their health and wellbeing. Individuals were supported through regular group meetings and 1 to 1 sessions, to identify and capitalise on their own strengths to implement technological interventions with individual meaning.

For example;

- a) using a VAA to work on speech and language skills with therapist input, to improve verbal communication in social situations
- b) to play games and quizzes to keep the brain active, and be a topic of conversation with others in a group-call, breaking the monotony of living alone for all involved
- c) to regularly video-call grandchildren who have moved away, previously impossible because of loss of hand function
- d) to have some fun surprising care staff by a voice coming 'out of the blue' when they are working in another room and,
- e) playing music on demand, increasing feelings of enjoyment, choice and control over their lives regardless of limiting physical function.

These examples illustrate how they can support rehabilitative interventions and assist in reducing social isolation and loneliness.

8.4.5 A validated outcome measure, the Shortened Warwick Edinburgh Mental Well Being Scale has been used to measure the impact of these interventions on the individuals involved. The results show an increase of 40% in relation to feelings of wellbeing, qualitative data has also been collected (see appendix 6). These results could be attributed to increased feelings of connectedness as a result of the interventions described above. The value of the shared experience of group participation, leading to feelings of connectedness and belonging should not be underestimated in this situation.

8.4.6 Keeping the needs of individuals at the heart of planning interventions is an important factor in reducing social isolation. Technology needs to be seen as an effective tool within a range of options, for addressing social isolation and loneliness.

9) THE CORE ELEMENTS OF EFFECTIVE INTERVENTIONS – CHECKLIST, INFORMING INTERVENTION DEVELOPMENT

- 9.1 **Formally link SI&L recognition and reducing interventions into Social Prescribing Health and Wellbeing improvement models and frameworks.** It is likely that a person referred for a Social Prescription will have one or more of the SI&L triggers, therefore any developments in Social Prescribing locally must include this within the model/framework i.e. Social Prescribing to improve health and wellbeing and reduce SI&L.
- 9.2 **One-to-one support** with clear outcomes of building confidence, motivation etc. to move on to take part in interventions of their choice i.e. post bereavement support etc.
- 9.3 **Group interventions** with an education focus or provide targeted support activities i.e. leg clubs, falls reduction exercise classes, healthy eating cooking classes etc.
- 9.4 **Activities targeted towards specific groups**, such as women, men, unpaid carers, the widowed, ethnic elders, LGBT+, dementia sufferers etc. For example, lonely men relate better to specific activities related to long standing interests i.e. sport, gardening, music etc., and respond less well to loosely defined social gatherings, which tend to be of more interest to women.
- 9.5 **Flexible and adaptable**, welcoming newcomers who may be less confident, or whose social skills are a little rusty, and involve participants in developing activity programmes.
- 9.6 **Has strong partnership arrangements** in planning services to reduce SI&L, in order that developments can be sustained. This includes a focus on partnerships between health and social care statutory organisations, the voluntary/community/not-for-profit sectors, to include Faith communities, and the fire and police services etc. Key actions to facilitate sustainability would include commissioning informed by current best practice, tendering to include key tasks that are outcomes and output focused for service users and the service, and longer-term funding.
- 9.7 **Recognition in service delivery that Social Isolation and Loneliness are different** and may require different responses. An older person experiencing isolation may need practical support such as transport provision options. Whereas, an older person who has been recently bereaved and experiencing loneliness may need social support to grieve and gain the motivation and confidence to be supported to find companionship.
- 9.8 **Community Engagement**, involving users in the identification of local needs, planning, implementation and evaluation of any developments to address need, improves outcomes and ensures that services are matched to needs.
- 9.9 **Build on existing valued and effective services**, know what the community resources are and make best use of them to extend valued services and develop new ones to address gaps.

10) EVALUATING THE IMPACT OF INTERVENTIONS TO REDUCE SI&L.

In evaluating impact it is important to:

- a) Demonstrate the impact on target areas i.e. effect of interventions on SI&L individuals, and on targeted at risk groups i.e. men, LGBT+, bereaved etc.

Also the effect of Social Prescribing using a strengths-based approach on reducing SI&L, reducing GP contacts, improving health and wellbeing and effect of ABCD on building community capacity etc.

- b) Work in partnership to identify and disseminate good practice
- c) Justify any additional investment needed and identify potential sources.

- 10.1 **Measuring SI&L.** Service development should include as a matter of course, measurement activities to ensure that relevant data is collected from the start i.e. for individual's measurement Office of National Statistics (ONS) Loneliness scale is finding favour nationally (see appendix 1.b)). The public health outcomes framework 2019/20 (33) is adding an indicator for loneliness, using the ONS scale. Locally, the wording of this scale is being updated to reflect a more strength-based approach, and is being trialled. It is important that a scale is agreed across local Social Prescribing services to aid comparability and learning.
- 10.2 **Five Ways to Wellbeing Framework** – Locally, within the Community Connect 50yrs+ service, we use this framework within a 'Connect Plan' with older people who need more structured support to reduce SI&L. The older person is supported to set their own goals and review progress. We are able to use progress to document Case Histories, to show what works well and what could be improved. This learning can then be shared to continually improve practice. We are also identifying any negative health behaviours used to self-sooth/cope. The plan would include sign posting/ timely intervention support for improvements (see appendix 1a) – Step 5).
- 10.3 **Quantitative data collection** – Social Isolation can be measured through assessments of aspects of social networks i.e. diversity of network, frequency of contacts, frequency of participation in social activities etc.
- 10.4 **Qualitative data collection** – Loneliness can be assessed in conversations about how a person feels about their circumstances and the lack of social networks and support. These conversations can be difficult and sensitive and take time. The Time4TEA conversation guide (see appendix 1a) – Step 3) to identify SI&L triggers and how the person has been affected by them, and how they may be enabled to feel less SI&L, has been developed within our Community Connect over 50's service.

11. KEY POINTS TO INFORM FUTURE ACTION PLANNING.

The government's appointment of a ministerial lead on loneliness to the cabinet office has raised the profile of SI&L. This has enabled a cross-governmental approach to tackling loneliness. This culminated in the publication in October 2018 of HM Government, *A connected society, A strategy for tackling loneliness – laying the foundations for change* (9a). Depts./Orgs involved in implementing the key proposals include; Health and social care, Ministry of housing, communities and local government, Digital, culture, media and sport, Arts Council England, Education, Transport, Business, energy and industrial strategy, Public Health England and Sport England. (see 2.14 a for key proposals)

Also, The Office for National Statistics in December 2018 in its article on Children's and young people's experiences of loneliness (9b), summarised 4 suggestions from children and young people themselves in tackling loneliness;

- Create a culture of openness about loneliness
- Create opportunities to make social connections
- Encourage positive uses of social media to alleviate loneliness
- Prepare young people to understand loneliness and equip them to deal with it

11.1 Define;

Social Isolation and loneliness are different issues requiring different interventions. They are also important, cross-cutting, public health issues and therefore need a wider strategic partnership approach to any future work.

11.2 Reaching and Targeting;

A lifecourse approach offers opportunities to intervene at different life stages, targeting and tailoring interventions to 'at risk' individuals and groups. Providing further opportunity to lessen the cumulative effect and its commensurate increased use of services, bringing potential economic and quality of life benefits.

– need to address three key challenges prior to supporting access into interventions:

- a) FINDING – Reaching lonely individuals i.e. creative ways to identify i.e. those not in education, employment or training, number of 'bin lifts', community groups/activities – whose stopped coming/who haven't you seen for a while etc
- b) LISTENING and UNDERSTANDING, using a strengths-based approach – what the nature of an individual's SI&L is and developing a personal response i.e. when 121 and/or group interventions appropriate, need for specific contact i.e. men's groups, LGBT+ groups, young and adult carers, care leavers, BME/cultural groups, post-natal Mums/Dads groups, victim support, etc
- c) ENABLING – Support for SI&L individuals to access appropriate support, building on the strengths-based approach i.e. 'What matters to me' – help with transport, affordable options, accessible venues, meet and greet service for newcomers etc

■ 11.3 **Fostering the right attitude to addressing the emotional pain of loneliness – Quantity versus Quality;**

We need to approach the reduction of SI&L in a similar way to how we approach pain relief, in that the pain of loneliness and the pain of life changing conditions both have physical and emotional elements, hurting as much as the person says it is, occurring when they say it is, experiencing a level of relief that is satisfactory to them when they say it does. It is not just about increasing medication or social contact, it has to be the right medication and the right match and quality of contact.

Good physical and emotional pain relief is life enhancing, and the evidence points towards reduction in service use as a result. Some individuals may adopt destructive lifestyle behaviours to 'self-sooth' or provide emotional pain relief. The use of the Wellbeing Spiral (Fig 4a & b) as a staff guide to identifying self-soothing and more constructive behaviour levels, may help to support and signpost people to the most timely and appropriate services i.e. addressing their SI&L first if appropriate, then they will be better placed to cope with changing a lifestyle to a healthier one.

■ 11.4 **Evidence base for resourcing interventions to reduce SI&L;**

The evidence seems clear that reducing SI&L pays in terms of potential reductions in hospital and community service usage. It is also apparent that recognising the presence of and addressing SI&L in people whose lifestyle is destructive to their health and wellbeing, may improve their uptake and compliance with lifestyle advice and rehabilitation programmes, thus making their interventions more care and cost effective. Also the potential increase in individuals' social networks to reduce their SI&L can provide ongoing community support for longer term health behaviour improvement and rehabilitation.

■ 11.5 **Whole systems approach;**

Causal pathways and triggers are complex and multi-factorial, requiring wider partnership working.

There are opportunities for health and social care organisations to actively encourage partnership working between themselves and the Police and Fire services and the voluntary/community and not-for-profit sectors, to include the Faith community, to engage in a 'whole system' approach in activating strategies to reduce SI&L and its impact on wider partner services i.e. pressure on capacity.

■ 11.6 **Local Application;**

The work of the Bristol, North Somerset and South Gloucester (BNSSG) Sustainability and Transformation Partnership – Healthier Together plans provides real opportunities to take a whole systems approach to reducing SI&L in tandem with improving health and wellbeing, with in the delivery of a BNSSG wide Social Prescribing core/model.

In particular plans for Prevention and Early Intervention – Making Every Contact Count (MECC), Social Prescribing, Self-Care, and in integrated care – Sustaining Primary care to include a 27% reduction in GP contacts, also in Long Term Conditions, Stroke and Frailty services.

Also, nationally the government's strategy for tackling loneliness and the NHS long term plan have both identified Social Prescribing as a key support function.

11.7 Evidence based interventions – What works – informing Commissioning priorities;

There appears to be a consensus within the research that the following interventions are key in reducing SI&L:

- a) **Adopting a strengths-based approach** to working with individuals (30,31,32) entails listening and understanding;
 - what's important to them
 - their strengths and talents
 - what's working well and what they want to change
 - what they'd like to achieve
 - how they'd like to be supported
- b) **Asset Based Community Development** (ABCD) approaches to working with communities – engaging with people to build local services/activities, to build community capacity creating more services to refer people into
- c) **Signposter/Community Navigator**, Wellbeing worker, Village agent, PCN link worker etc type roles

These roles typically take opportunities to provide information, advice and support – the latter direct, or through identifying a community link to services in the community that can help individuals build their social contacts/networks/friendship groups. Lonely individuals are likely to need extra support initially, the use of the 5 Ways to Wellbeing Framework helps them to see progress and gain confidence to move on.

- d) **Befriending**, although evidence on effectiveness is mixed, there is a consensus that with good matching and support of volunteers, befriending services whether that be by phone or face2face, is a particularly good service for frailer, housebound people.

Befriending services are considered to be relatively low cost, and by targeting at risk groups i.e. older people who live alone being discharged from hospital, they can potentially offer worthwhile returns on investment. Also those who live alone more often than not eat alone, this can have a detrimental effect on appetite and ultimately nutrition, with knock-on effects of difficulty in keeping warm and well and further effects of risk of falls. In re-commissioning a befriending service locally, there is an opportunity to look at 'lunch-buddy' befrienders working in partnership with Community Meals services.

- e) **Social Group Interventions**, this can include, lunch clubs, community cafes, particular interest and/or gender targeted groups – gardening, ex-servicemen/women groups, Women's Institute, Men in Sheds etc. or health related social groups i.e. Osteoporosis, Macular degeneration, leg clubs etc

- f) **Volunteering/helping**. This is not a 'free' service, volunteers/helpers need recruiting, training and support, all of which needs resourcing.

Locally we have made a distinction between Volunteers who may carry out 121 work (needing DBS check) and helpers who carry out administrative/supporting tasks i.e. book venues for activities, set room up and make the tea etc (not requiring a DBS check). Recruiting to helper role can be a way in to Volunteering, giving people a 'taster' of what's involved, thus not wasting time and money on DBS checks to later find that the Volunteer does not feel it is for them. It can also divide the work needed to set up a community activity into more manageable tasks for volunteers and helpers, which can aide recruitment and retention.

The most effective volunteers to support the lonely and isolated are those with experiences of these in their own lives and have 'come out the other end' OK and finding enjoyment and companionship in life again. The evidence shows that Volunteering positively impacts on SI&L.

- g) **Social Prescribing.** It is unsurprising that the outcomes of social prescribing have been found to include reducing SI&L, since many referrals to include health related are likely to have a SI&L element. Also locally the development of Social Prescribing is a key feature in the BNSSG Healthier Together plans, and has the potential to contribute to the 27% reduction in GP contacts called for. However the services that are socially prescribed into need to be tailored for that purpose, and be flexible and adaptable enough to cater for individual needs. The development of such services is linked to an ABCD approach to building community capacity as is the recruitment of Volunteers/helpers.

- h) **Developing a pathway** – bringing interventions together.

In needs identification and service delivery, Social Prescribing services and an ABCD approach to community capacity building are inextricably linked.

It also follows that development of social group interventions to reduce SI&L is inextricably linked to an ABCD approach.

The thread that ties Social Prescribing, Asset Based Community Development, development of social group interventions and the community assets needed to support interventions, are the roles of Community development coordinator – community asset builder, and the role of Community Connector – finding, listening and understanding and enabling, the latter role in all its guises.

■ 11.8 **Importance of Monitoring and evaluating;**

Research provides evidence to develop best practice, further developments need to build in evaluation methods from the start to include individual, community and cost benefits. Monitoring and evaluation methods need to be agreed and adhered to in order to make output and outcome comparisons.

■ 11.9 **Development and cost – a balancing act**

It is important to strive to better inform commissioning decisions, particularly in the current austere climate. Using the evidence of best practice provided establishes a standard from which to start.

The development of services need to be flexible to meet differing and changing needs. Developments also need to be creative, recognising added value opportunities within a 'business as usual' approach, but also alongside this, making informed decisions about the need for investment in prevention and early intervention services.

■ 11.10 **Working collaboratively with the Voluntary, Community and Social Enterprise Sector (VCSE)**

Working with The West of England Civil Society Partnership, is crucial to supporting the development of local community capacity and resilience.

The closeness by which this sector works with local people in need, means that it is best placed to offer flexible and creative options to reducing SI&L. However, this needs resourcing and supporting, which needs to be taken into account with the development of Social Prescribing locally ([See appendix 2](#)).

This support will also necessitate a more creative and developmental approach to Commissioning, than has been traditionally taken by Health and Local Authorities.

New, more facilitative approaches to Commissioning will need to be taken. With an emphasis on identifying and sharing the learning, to better inform strategic and operational decisions on service development.

11.11 Working across BNSSG and making local links.

NHSE has tasked areas across England to produce a local shared plan for the implementation of social prescribing. The North Somerset Social Prescribing Co-production group is linked into this local work and regionally with the NHSE social prescribing network.

The new Primary Care Networks – Directed Enhanced Service (DES) contract requires that:

- PCN's work in partnership with commissioners, social prescribing schemes, local authorities and voluntary sector leaders to create a shared plan for social prescribing.

The Co-production group acts as a natural local conduit for best practice information and to support developments. This group includes current VCSE sector contracted social prescribing services, BNSSG CCG, NHSE, LA etc (see Section 8, 8.3.3 h.6) for current group membership) These services have developed evidence based practices. (see appendices 1a & b,2 and 3). Sharing good practice to include discussing subcontracting PCN social prescribing activities, will support partnership working as per DES contract.

12. RECOMMENDATIONS TO REDUCE SOCIAL ISOLATION AND LONELINESS (SI&L)

12. In order to begin meeting the challenges, awareness needs to be raised on the causes and impact that SI&L has on individual's health and wellbeing.

12.1 First Steps – across the lifecourse:

- a **BNSSG to develop a wider partnership approach to reducing SI&L across;**
 - statutory Health, Social Care, Transport, Housing, Education, Environmental planning, Community Policing, fire prevention and Ambulance services etc.
 - and – Voluntary, Community and Social Enterprise sector to include Faith, Interest, gender, ethnicity based etc groups,Supporting initiatives and effective responses to reduce SI&L across the lifecourse. This partnership approach is important in ensuring parity with other public health SI&L JSNA's and Strategy's in Bristol and South Gloucester. This is in-line with the amendments to the Public Health Outcomes Framework 2019/20: consultation and government response report July 2019 (33) report, which introduces a new indicator to be used to measure loneliness.
- b **Agree a working definition** of SI&L, and understand the triggers and local impacts across the Lifecourse.
- c **Community Engagement**
Work collaboratively with key VCSE groups/organisations and individuals, including those experiencing or at risk of SI&L in planning and commissioning to include, mapping local assets, determining responses and co-producing solutions.
- d **Agree a plan of action** to raise awareness of SI&L across the lifecourse.

12.2 Strategic Recommendations – older people focus (but can apply across the lifecourse):

- 12.2.1 **Measures to reduce SI&L are actively considered in all policy and strategy areas across the lifecourse/age groups.** From 2019/20 individual government depts. will be required to highlight in their single dept. plans, the progress they are making on the key proposals, to include how they are addressing loneliness proactively (see 2, 2.14 for list of key proposals).
- 12.2.2 **Current Health and Social Care commissioned services**, through contract monitoring and review processes, need to identify the presence of/ explore the potential development of the following areas, to ensure services continue to develop effective responses to need;
 - a) Foundation services – reach, inform and support individual's to make meaningful connections.
 - b) Gateway services – transport, rest areas, public toilets, etc
 - c) Direct interventions – group activities, one-to-one support, helping people to maintain/re-connect, make new connections, and feel that they belong.

- d) Structural supports to enable foundation, gateway and direct service development are in place;
 - **Strengths-based approaches** to working with individuals (conversational assessment practices identifying 'what matters to me') and communities (Asset Based Community Development-ABCD)
 - **Co-ordinated Social Prescribing services**, built on existing good practice, to include using attachment-informed and strengths-based approaches (40)
 - **Resourcing of the VCSE sector** to deal with the extra activity needed to support reductions in SI&L, particularly through increased Social Prescribing activity.

12.2.3 Future Commissioning of Health and Social Care services to reduce SI&L must be informed by evidence of current good practice on what works i.e.

- a) Asset Based Community Development. Building social capacity and resilience.
- b) Social Prescribing – Signposters/Community Navigators, Wellbeing worker, Village agent, Primary Care Network (PCN) link worker type roles, to find SI&L people, listen and Understand their issues and enable them to develop contacts/friendships.
- c) Befriending services targeted at the frail housebound.
- d) Social group interventions, tailored to needs i.e. interests, gender, BME, LGBT+, carers etc.
- e) Volunteering/helping.

12.2.4 Work collaboratively with the VCSE Sector to identify and agree creative approaches to measuring impact, that facilitates learning and better informed decisions on service development.

12.2.5 Promote 'proportionate universalism' in reducing SI&L and their commensurate health inequalities i.e.

- a) target 50+ age group interventions at the most deprived 10-20%, and the bottom 10%, but also in 'asset rich-cash poor' areas.
- b) Also target interventions around triggers i.e. bereavement, becoming a carer, LGBT+, BME etc.
- c) Continually review where effort needs to be directed.

12.2.6 Partners need to inform each other of and coordinate Community and Neighbourhood development/regeneration activities/programmes, and use these opportunities to promote the ABCD approach to reducing SI&L.

12.2.7 Public Health in partnership with community health, social care and older peoples provider services, develop as part of the BNSSG local shared plan 2019/2020 for social prescribing, a workable model based on national and existing local good practice initiatives. This would need to include adoption of the ONS loneliness scale. (This scale will be a new indicator in the Public Health Outcomes framework 2019/20). (see appendix 1b))

■ **12.3 Education and Training Recommendations – older people focus (but can apply across the lifecycle).**

12.3.1 Public Health in partnership with Social care, develop and deliver an awareness raising programme of the triggers, impact and current good practice interventions to reduce SI&L to in-house strategic and operational staff. Linking this programme into training on 'Supporting older people using attachment-informed and strengths-based approaches' (40).

- 12.3.2 **Work in partnership to agree delivery of programme** to wider partners i.e. Community Police, Fire and Ambulance services relevant personnel, and current VCSE sector providers.
- 12.3.3 **Working collaboratively with the VCSE Sector to agree a plan of action** to increase public awareness in the physical and mental health risks of SI&L and provide information on points of contact for help.

■ **12.4 Operational Recommendations – older people focus (but can apply across the lifecycle).**

12.4.1 **Operational services implement good practice**, building into assessment initiatives supported through education and training the identification, assessment and support needs of individuals to reduce their SI&L.

12.4.2 **Practitioners are supported** by the availability of preventative options/services, which are informed by evidence based good practice that they can refer into.

12.4.3 **Practitioners actively support** through ‘grass roots’ partnerships, client/carer and staff/volunteer feedback, which further informs services/processes. Enabling them to move forward on what works.

12.4.4 **Implementation of ONS loneliness scale**

The House of Commons briefing paper, Tackling loneliness, August 2019 (39), in Measuring loneliness and knowledge sharing, states that – the Office of National Statistics (ONS) is developing a package of measures that could be used to measure loneliness nationally. The government is committed to using this package and its standard way of measuring loneliness and is encouraging other organisations to do the same. Any education and training around SI&L would need to include the use of the ONS loneliness scale. Local use of this scale would enable identification of level of need and comparability of effectiveness of support.

N.B. **latest Sept 2019 information further informing recommendations**

Appendix 4: A Connected Society progress report – 6 priority actions.

Appendix 5: Fulfilling the promise – social prescribing to tackle loneliness – 10 areas of action

Loneliness is about ‘Unbelonging’

If there was someone you kept meaning to call/
pop-in to, have you made that call?.



The 5 step process for Information, Advice and Support (Community Connect over 50's service)

The 5 Step Process

For Information, Advice and Support for the

Community Connect

Over 50s Service

STEP 1. Postcard: referral checklist identifying initial needs (used as an 'aide-memoir' and rung in to Community Connect)

STEP 2. Pathway: triaging referrals (the pathway also includes Community Development Coordinators who use an Asset Based Community Development [ABCD] approach to develop activities to socially prescribe to)

STEP 3. Time4TEA: conversation guide to identify Triggers, Enablers and Actions

STEP 4. The Wellbeing Spiral: a service guide for staff assessing needs. It includes presence of 'self-soothing' behaviours for relief of the emotional pain of loneliness

STEP 5. Mini-Connect Plan: supporting changes of the person's choice, using the 5 Ways to Wellbeing

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We're open weekdays, 9am-5pm



Opening the door to

local services for over 50s

Community Connect is a **free service**

Funded by:



Delivered by:



Social Prescription Check and Connect Card

Please use this check and connect card to see how Community Connect can assist you, or someone you support or care for. You don't need to send us the form – either fill it in or use it as an aide-memoir before giving us a call to see how we can help.

How to use this card

1. If you're filling in this form on behalf of someone else, please get their agreement before contacting us
2. Tick all boxes that apply
3. Call one of the numbers overleaf with details
4. If you're filling in this form on behalf of someone else, tell them that an advisor will be in contact

Staying safe and independent, safety and security

- Fire, smoke or carbon monoxide alarms
- Gas/electric wiring or equipment concerns i.e: blankets/heaters
- Help to feel safe in home/community
- Fear of crime or anti-social behaviour, including scams

House and home

- Concerns about suitability of accommodation
- Home or garden maintenance concerns
- Concerns about needing to move
- Equipment to help you stay in your home i.e. bath rails/toilet seats/walking aids

Keeping warm

- Problems with draughts, condensation or damp
- Insufficient heating provision
- Advice on reducing energy bills

Accident and falls prevention

- Concerns about steps in/out of your home, climbing stairs, getting out of your chairs or using the bathroom

If you can answer yes to any of the following, you may be at risk of trips/falls.

Do you have concerns over:

- I have fallen in last 12 months
- I feel unsteady at times
- I take 4 or more medications daily
- I have had a stroke or have Parkinson's Disease

Money

- Managing your income or reducing your debt so you can afford essentials like food/rent/heating
- Benefit entitlement

Daily living

- Support when you need it or have a crisis
- Access to an alarm to use in an emergency
- Need help with day to day routines that you used to cope with
- Help with worries about memory loss

Enjoying life and living healthier

Would you like any help or information about any of the following from health workers.

Lifestyle

- Stop smoking
- Reduce the amount of alcohol you drink
- Eat healthier
- Take more exercise
- Help to reduce/stop drug use
- Manage use of prescription drugs
- Access to the flu jab
- Access to the pneumococcal vaccination
- Help managing any health conditions i.e. diabetes, heart or mobility issues, hearing, sight loss etc

Enjoyment of life

- Help getting out of the house including shopping, seeing friends and activities
- Help to fill your time/be on your own less
- Help to manage feeling sad or depressed
- Help to rediscover an old interest or hobby
- Do something new that you've always wanted to do
- Find out what is available to do locally

Do you look after someone?

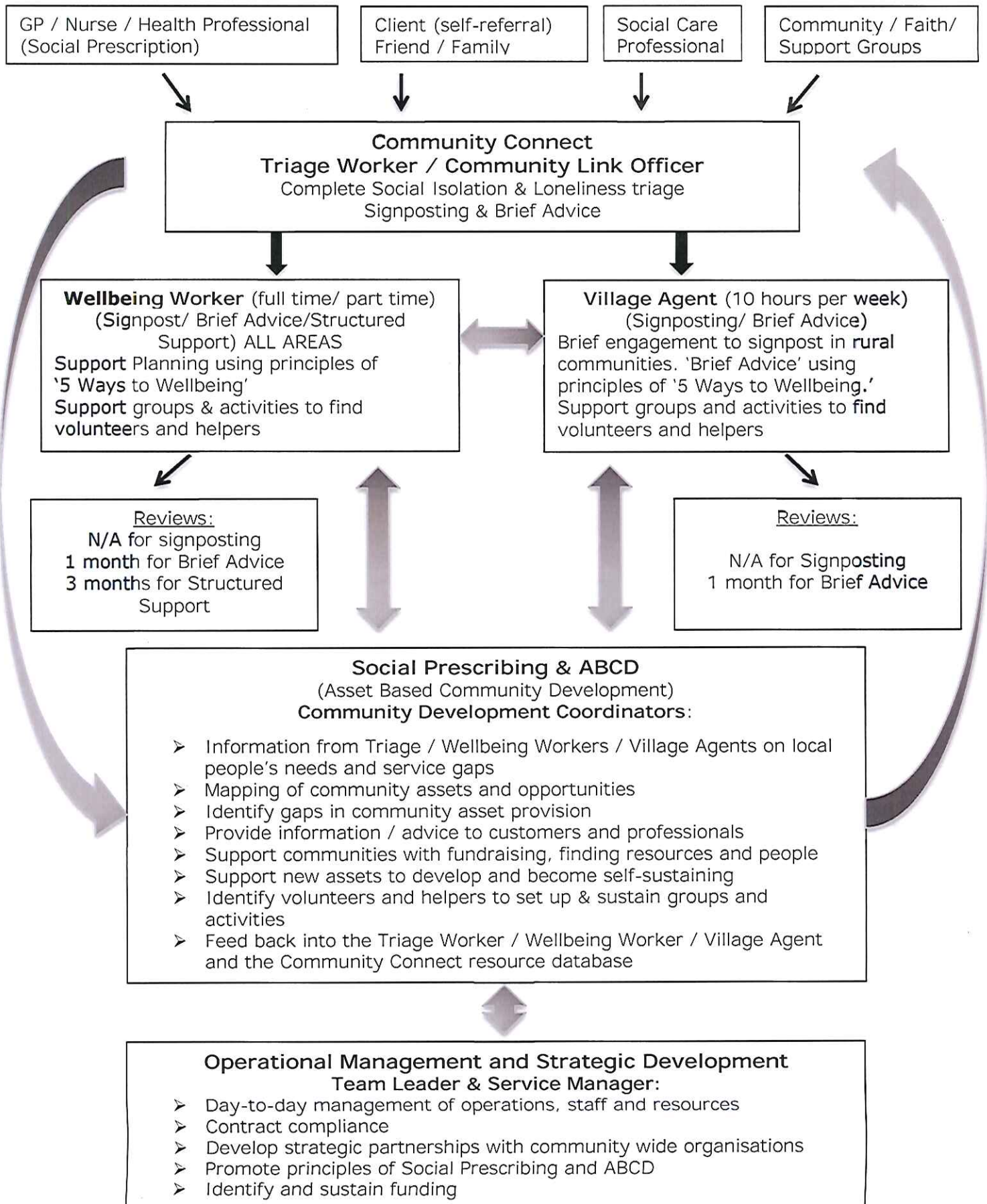
- Information or advice about what support might be available

Helping out in your community

- Information about how you can help in your community and give back some time and skills

Community Connect Service Pathway

A model for Social Prescribing



Time4TEA – Conversation Guide

(Assessment and Actions for SI&L)

TRIGGERS; a change in circumstances reducing confidence/energy/ability to cope.

- 1. Bereavement;** death of significant person or animal companion (guide dog etc)
- 2. Loss;** affecting body image i.e. stroke, disfiguring treatment – cancer, victim of crime, wounded from Armed Forces, amputee etc
- 3. Disability;** reduced mobility, chronic disease, sensory loss-sight/hearing, etc
- 4. Cognitive;** memory loss, personality/behaviour changes due to injury/disease
- 5. Lost Social Network;** moved house, leaving Merchant or Armed forces, entering into sheltered accommodation or care home, moved area, and other reasons related to other triggers
- 6. Significant relationship change** i.e. family disputes, divorce, becoming a carer, carer role changing, etc.
- 7. Significant lifestyle change;** retirement, redundancy, LGBT+ etc
- 8. Significant cultural deprivation;** BME, asylum seekers etc
- 9. Fear;** feeling vulnerable and fearful of going out, harassment, crime etc
- 10. Trapped in unhealthy relationship/s** i.e. being bullied, groomed, controlled etc. Domestic abuse – physical, emotional, financial, sexual

ENABLERS; 5 key factors that the person may need help with to enable actions of choice to reduce their SI&L.

1. Physical and Emotional/Mental Health. National research has identified that SI&L increases vulnerability to ill health and ill health increases vulnerability to SI&L producing a vicious circle. Enabling actions may include referrals for improved pain management, equipment/adaptations to help get around, memory loss support – memory clinics, cafes, safeguarding support etc

2. Money. Reduced income contributes to SI&L as less able to afford to get out and about. May need financial assessment/benefit advice, access to more affordable choices.

3. Transport. Reduced mobility, loss of driver status/car, reducing ability to get out and about. May need accessible local transport options, bus training/bus buddy if unused to public transport.

4. Built Environment. Need pedestrian/mobility aid friendly areas with safe seating at regular intervals. Also fully accessible public buildings and facilities needed. May need help identifying accessible environment for activities. Help to access safer environment/place of safety etc.

5. Social Environment. Age, Dementia, Disability friendly-physical, sensory, learning etc Emotional/mental health difficulties friendly etc May need help identifying befriender/buddy, meeters and greeters to help people access services, and build their confidence so they can socialise and make friends/develop social network.

ACTIONS; basing options offered around 80% listening and 20% taking note of key points to act on.

a) Identifying triggers and help needed with enabling factors. Use this to give options and identify actions needed to take up options of choice.

b) Actions to identify what the person is going to do and what the assessor is going to do to help.

c) What is the dominant factor in terms of difficulty the person is having? Generally research strongly suggests that;

c.1) the socially isolated and lonely respond better to supported group activities – so give them options (information and advice) to choose from and enable access as needed and they will be more able to take up choices themselves.

c.2) whereas, the emotionally isolated and lonely, confronted by emotional hurdles to jump, but lacking the confidence and emotional strength to take the first steps, **initially respond better to 121 support**, building confidence and self-esteem, to then move onto taking part in wider activities of choice.

ACTIONS Summary:

1. Offer options (according to dominant factor)
 - supported group activities, info and advice and/or
 - 121 help to access activities/support etc
2. Document using the 5 Ways to Wellbeing.
3. Offer enabler support as needed
4. Be clear about who is going to do what, when etc. Include follow up support, how, when, etc.
5. GP/Adult care referrals - feedback to referrer i.e. key actions (these actions make up the 'Social Prescription')

"I am less/not isolated & or alone"
Be able to positively reflect,
learn & move on

Constructive behaviours

Build resilience
Find your strength to bounce back

Build determination
Find your courage

Build confidence
Find your voice

Build motivation
Become hopeful for the future
Find your get up & go

You're not alone
Information, advice & support.
Time to talk & explore options.
Find your support

Enablers

Time 4 Tea

Social isolation & loneliness
"I feel isolated & or alone"
(Check & Connect)

5 Ways to Wellbeing
1. Connect (D)
2. Be active (C)
3. Learn (A)
4. Take notice
5. Give (B)

Person centred outcomes

Person (patient) activation methods

Triggers

Reduced activity / inactivity
Reclusive, feeling lost, lethargic

Eating habits
Comfort eating, poor appetite, malnutrition,
unhealthy choices

Medicines / Drugs
Misuse of illegal or legal over the counter
(over use of prescription etc)

Drinking - Alcohol
Comfort drinking, increased
social/lone drinking

Smoking
Increase in smoking or taking it up

Reduced income / Debt
Budgeting / paying bills /
shopping / gambling to fill time / make feel
better / vulnerable to scams

Destructive behaviours

5 Areas of practice in NHS 'Realising the Value' programme
A. Self management/ education (3)
B. Peer support (5)
C. Health coaching (2)
D. Group activities that promote health & wellbeing (may need 1:1 first) (1)
E. Asset based approaches in a health & wellbeing context

Practical Applications of the Wellbeing Spiral

SPIRAL GREEN ZONE

Change embraced

Brief information and advice

- Telephone/contact at event/activity, may need 'one off' visit
- 1-4 weeks' support
- Triage Worker / Village Agents

Feeling determined and resilient: brief info/advice

SPIRAL BLUE ZONE

Embracing change

Short/medium-term support

- Telephone/visit
- Miniconnect plan
- 2-6 months support
- Wellbeing Worker or Village Agents

Lacking confidence, a bit unsure: build confidence and resilience, be hopeful

SPIRAL RED ZONE

Unable to embrace change

Medium/longer term support

- Telephone/visits/meet & greet support to get out/engage
- Miniconnect plan +
- 6-9 (+) months support
- Wellbeing Worker

Hopeless, worthless, unbelonging: help to not feel alone, motivate & find moment to embrace change

Mini Connect Plan

For Social Isolation and Loneliness (SI&L): TRIGGERS:	
<input type="checkbox"/> Bereavement	<input type="checkbox"/> Significant relationship Change
<input type="checkbox"/> Loss	<input type="checkbox"/> Significant Lifestyle Change
<input type="checkbox"/> Disability	<input type="checkbox"/> Significant Cultural Factors
<input type="checkbox"/> Cognitive	<input type="checkbox"/> Fears (perceived or actual)
<input type="checkbox"/> Lost Social Network	<input type="checkbox"/> Unhealthy Relationships

Coping Mechanisms:
<input type="checkbox"/> Reduced Activity/Withdrawn
<input type="checkbox"/> Eating
<input type="checkbox"/> Medicines/drugs
<input type="checkbox"/> Drinking
<input type="checkbox"/> Smoking
<input type="checkbox"/> Reduced income/debts

Customer's Name:

Wellbeing Worker:

	Personal Goals	Enablers 1. Physical and emotional health 2. Money 3. Transport 4. Built environment 5. Social environment	ACTIONS (Who can help & by when)	Customer's Desired Outcomes
CONNECT (Socialise, talk and listen, etc.)				
TAKE NOTICE (Using time for yourself positively, remember the simple things that make you happy)				

	Personal Goals	Enablers 1. Physical and emotional health 2. Money 3. Transport 4. Built environment 5. Social environment	ACTIONS (Who can help & by when)	Customer's Desired Outcomes
KEEP LEARNING (Have a go at something new, see opportunities, listen to talks...)				
GIVE (Your time, your words, your presence, to family/friends, help out/volunteer)				
BE ACTIVE (Getting out and about, do what you can, enjoy what you can)				

Customer signature:

Date:

APPENDIX 1b)

ONS – recommended measures of loneliness in adults		Curo – Community Connect over 50s service, local strengths-based interpretation	
UCLA	Measure	Curo	Measure
How often do you feel that you lack companionship?	Hardly ever or never, Some of the time, Often	How often do you see your friends and family?	Hardly ever or never, Some of the time, Often
How often do you feel left out?	Hardly ever or never, Some of the time, Often	How much time do you spend on your own each day/week?	Hardly ever or never, Some of the time, Often
How often do you feel isolated from others?	Hardly ever or never, Some of the time, Often	How many times a week do you socialise?	Hardly ever or never, Some of the time, Often
ONS	Measure	Curo	Measure
How often do you feel lonely?	Often/always, Some of the time, Occasionally, Hardly ever, Never	How often do you feel lonely?	Often/always, Some of the time, Occasionally, Hardly ever, Never

UCLA – University of California Los Angeles. 3 Item loneliness scale.

ONS – Office for National Statistics. 1 direct measure of loneliness.

UCLA and ONS questions taken from, and/or informed by:

- (1) ONS measuring loneliness: guidance for use of the national indicators on surveys (2018).
- (2) Campaign to end loneliness, measuring your impact on loneliness in later life.

Notes

- 1 Age UK in its work on loneliness with the Campaign to End Loneliness states that using the 'L' word (Lonely) is difficult as it carries a stigma and people may be reluctant to talk about it.
- 2 The use of social prescribing is a key element in supporting people to be less isolated and lonely. As such, a measure is needed that promotes a sensitive approach, while at the same time enabling measurement and comparability of options or services offered.
- 3 The use of a strengths-based approach that aids conversations and enables measurement of the impact of support, needs consideration. The local interpretation of the UCLA questions are a result of that. Community Connect over 50s service will be trialling this.

Healthier Together – BNSSG Social Prescribing* (SP) Framework

1. NHS England (Making Sense of Social Prescribing Guide) supports the premise that people’s health and wellbeing is determined primarily by a range of social, economic and environmental factors.
2. This SP Framework identifies how people can be enabled to access a range of local/wider services, that provide different levels of Information, Advice and Support (IA&S). Such services need to take account of any social, economic and environmental factors that are negatively impacting on people’s health and wellbeing.
3. The following diagram illustrates the 5 key activities-as put to the BNSSG Healthier Together Integrated Care Steering Group for endorsement in August 2018. These are essential core elements, across BNSSG, in delivering their ambition for Social Prescribing and Self-Care.
4. The 5 activities may not be present in each SP provider service, but they will have to be present and formally connected to the wider spectrum of SP services

Level 1. *Signposting. Immediate-short term help.*
INITIAL - Information and Advice.

Level 2. *Individuals needing information/signposting, advice and medium-term support, as may lack confidence.*
INTERMEDIATE - assessment and supported signposting.

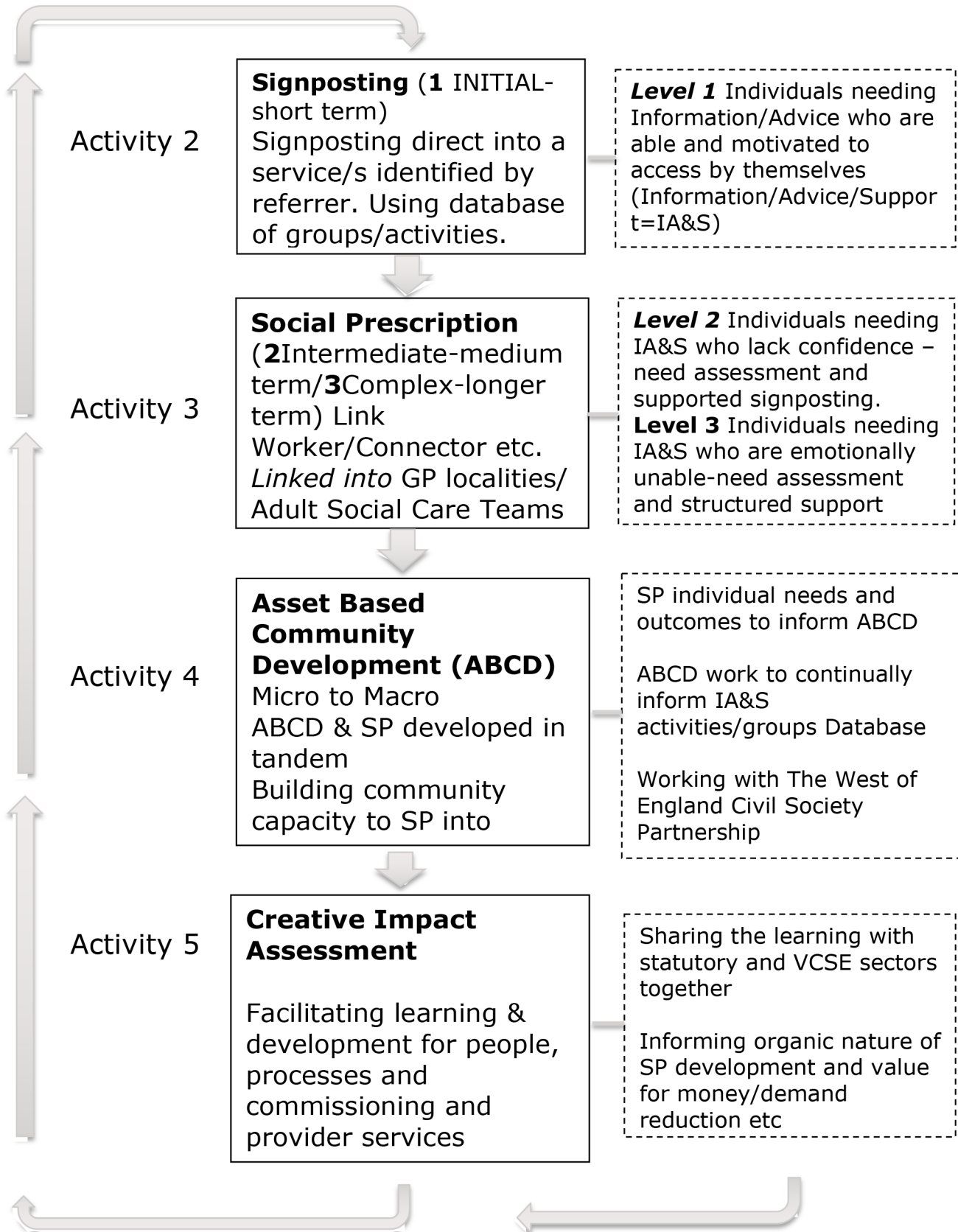
Level 3. *Individuals needing information/signposting, advice and more structured longer-term support, to take small incremental steps to achieve their goals.*
COMPLEX- assessment and structured social prescription using the 5 Ways to Wellbeing, offering/utilising multiple info/advice services/activities.



July 2018, updated Jan 2019.

Healthier Together - Social Prescribing (SP) Framework

Activity 1 **SP Entry Points** - - - - - Referral systems and processes
Open/Focussed/Closed. TRIAGE



APPENDIX 3

See inside pocket

APPENDIX 4

Extract from;

A Connected society? Assessing progress in tackling loneliness. A shadow report for the loneliness action group.
September 2019. Loneliness action group, British Red Cross and Co-op partnership project.



Supporting

BritishRedCross

Loneliness Action Group



A connected society?

Assessing progress in tackling loneliness

A shadow report for the Loneliness Action Group

September 2019

There are six key areas for priority action:

1. Sustain and fund action across government:

We need a renewed commitment to tackling loneliness across government departments. The government must deliver on its pledge to create a Loneliness Test for policy. Plans for sustained action and investment across government should be published alongside the first annual report.

2. Measure impact: Government must measure the impact of its activity on loneliness, including through the Public Health Outcomes Framework (PHOF) and ensuring that where public money is spent on tackling loneliness, the impact is evaluated using recommended measures.

3. Move from development to delivery: In the next phase of the Strategy, government should build on the learning from pilots and identification of good practice, making plans to embed successful interventions in policy and investing in the replication of effective schemes across the country.

4. Invest in the infrastructure communities need to stay connected: Social connection depends on local community infrastructure. Government should invest in the provision of community space, and support and activities to enable connection. We also need to ensure that transport policy and investment are loneliness-proofed, and that housing policy supports social connection and participation.

5. Ensure social prescribing delivers for loneliness: Government must continue to deliver on its commitment to tackling loneliness through social prescribing. It can do this by ensuring staff are trained in understanding and addressing loneliness, assessing the impact of schemes using

recommended loneliness measures, and funding the services and support that communities need to enable people to reconnect. PCNs should be encouraged to draw on learnings from existing schemes, including the Connecting Communities programme delivered by the British Red Cross and Co-op partnership.

6. Build capacity to address loneliness among children and young people:

The pledge to teach children about loneliness in schools must be backed with a robust support offer to teachers. Continued investment will be needed to find out what works in addressing loneliness among children and young people, and to roll out effective approaches across the country.

The Loneliness Action Group has been proud to work alongside government through the first year of implementation of this world-leading Loneliness Strategy. Much has been achieved. But there remains much to do. As we move into the next year of implementation, a wide range of stakeholders across business and civil society, working alongside the APPG on Loneliness, is committed to providing continued support and challenge to government as it takes forward this ambitious agenda and vital work.

Next steps

To continue the work of this report in assessing the progress made in tackling loneliness, the APPG on Loneliness will be conducting an inquiry throughout the year ahead.

For more information and to stay in touch with the work of the APPG, please contact LonelinessAction@redcross.org.uk

APPENDIX 5

Extract from;

Fulfilling the promise: How social prescribing can most effectively tackle loneliness. Shared learning report 2.
2018. Kaleidoscope, British Red Cross and The Co-op.



Supporting



KALEIDOSCOPE



Fulfilling the promise How social prescribing can most effectively tackle loneliness

Shared learning report 2

Fulfilling the promise: 10 areas of action

Making social prescribing effective in reducing loneliness requires concerted effort from individuals, professionals and organisations across England. We have focused on action required from three groups, identifying ten specific actions to help fulfil the promise of social prescribing.

National policymakers

1. Build understanding of loneliness among link workers

- **NHS training for link workers should include specific modules or information on loneliness** – these modules should include spotting the signs of loneliness, how to communicate with someone who might be experiencing loneliness, how to support them into services/activities, and how to use the new national loneliness measures.
- **Connect the link workers** – it will be important to develop a way to enable link workers to network, in order to share best practice and learn from one another.

2. Ensure referrers are supported to identify and respond to loneliness

- **Deliver a programme of targeted communications and mandatory training for those referring to social prescribing (initially GPs, but also others as referral routes are expanded)** – this should focus on how to identify people experiencing loneliness and support them into the social prescribing pathway.
- **NHS England needs to encourage PCNs to support referrals into social prescribing from across sectors** including local government and the VCSE sector.

- **“Supporting meaningful connections” should be built into the Making Every Contact Count agenda** – this will encourage people and organisations across the health and care local government and VCSE sectors to use their everyday contacts with people to support positive relationships as part of the wider effort to prevent poor health and wellbeing.

3. Evaluate impact on loneliness

- **The NHS England Outcomes Framework for social prescribing should include measures of loneliness** – to understand the impact of social prescribing on loneliness, it is essential that loneliness is measured using consistent tools across all schemes, drawing on new guidance from the Office for National Statistics. Data from across schemes should be brought together to enhance the evidence around what works in tackling loneliness. This should also be used to develop clearer benchmarks around how these schemes work in tackling loneliness and over what timescales changes should be expected.
- **NHS England should encourage the collection of qualitative data alongside loneliness measures** to enrich the evidence and ensure that early impacts can be identified.

National policymakers (continued)

4. Take ownership of the biggest risk to social prescribing – the impact on the VCSE sector

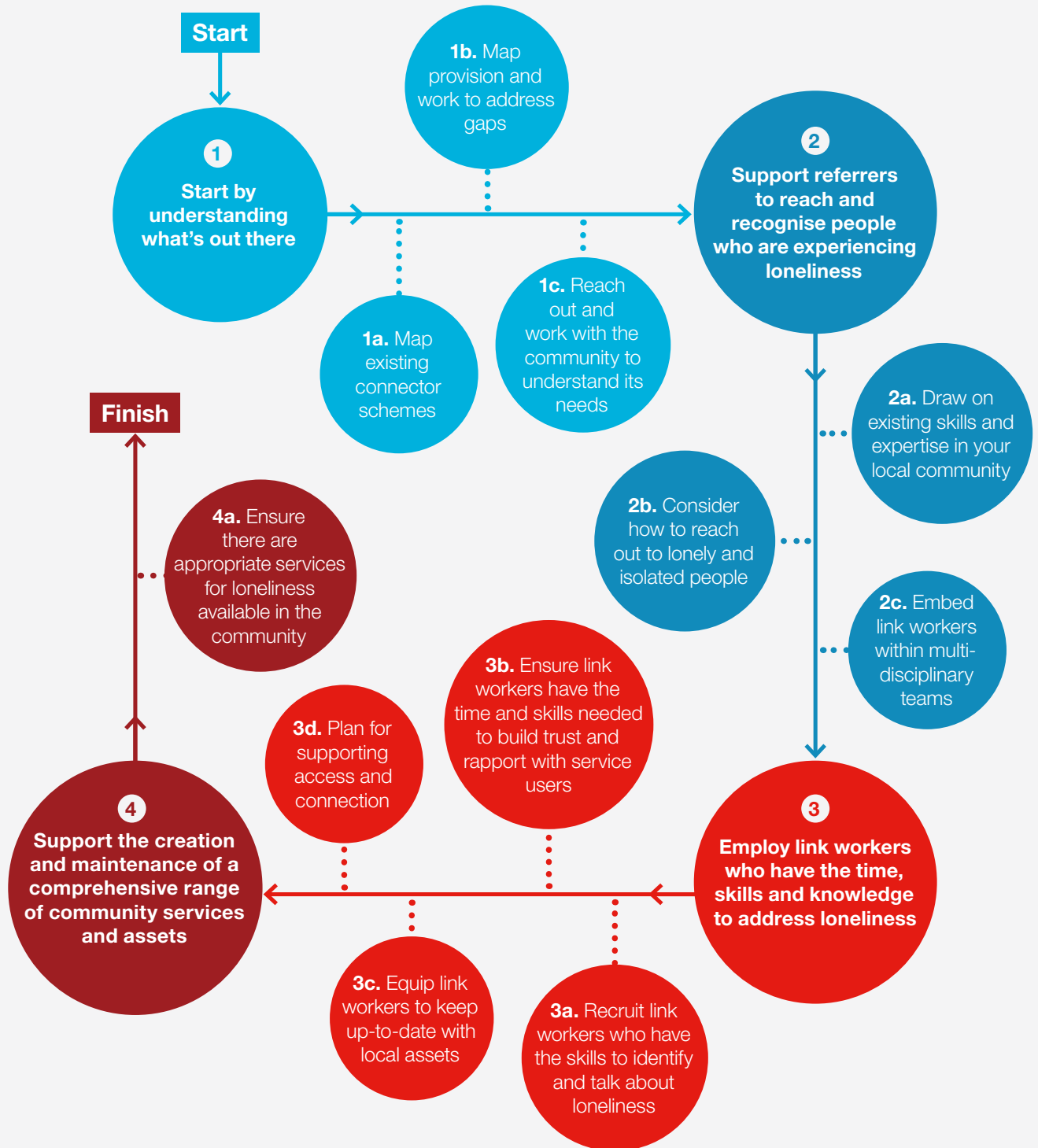
- **Work with government to monitor and act on the impact on the VCSE sector** – social prescribing schemes will rely upon a range of VCSE sector organisations to provide the advice, support and activities which will enable people to connect. As a result, it is likely some organisations within the VCSE sector will see increased demand. It is positive that NHS England has committed to monitoring this impact as part of the Common Outcomes Framework for social prescribing, but it must also commit to regular reporting on these impacts – potentially as part of annual reporting on the loneliness strategy. NHS England must then work with government to ensure that action is taken to address issues which emerge, including by enabling the transfer of resources to support services which are having a clear positive impact on individuals' health and wellbeing.

Focus on: **Rotherham Social Prescribing Service: funding model**

In Rotherham, Voluntary Action Rotherham (VAR) delivers two social prescribing programmes on behalf of Rotherham CCG. VAR manages the programme and micro-commissions activity from the VCSE sector, in the form of contracts, spot purchases and grants. The model was co-produced between Rotherham CCG, the VCSE sector and service users.

Social prescribing link workers (in this case known as 'advisors') meet referred people to assess individual social needs including practical, social and emotional support. An action plan is agreed. VAR also supports the VCSE sector to deliver options and solutions to meet people's needs. It's a resourced intervention, so it does not place additional burdens on already stretched VCSE services. VAR works with VCS groups alongside service users to help secure additional funding, and volunteers, to diversify income, support new activities, and increase citizen engagement, independence and resilience. This system helps to support VCSE sector sustainability.

Flowchart: Primary Care Networks, CCGs and GP practices



Primary Care Networks, CCGs and GP practices

5. Start by understanding what's out there

- **Map existing connector/link worker schemes** – in most communities there is some form of existing link worker schemes, though this is not always linked to primary care, or labelled as a “social prescribing” scheme. Some schemes are run by the VCSE sector, some have been set up through local authority adult social care departments, and others are linked to hospitals or mental health trusts. It makes sense to build upon existing expertise, networks and capacity so it's important to start by understanding what's out there.
- **Map provision and work with the commissioners, funders and the VCSE sector to address gaps** – social prescribing schemes can only be effective if they are able to tap into wider assets in the community – from formal services, to groups and associations, to the strengths of the individuals who live in the area. To do this it will be important to understand what is already out there in the community and where the gaps might be. It will then be important to work with a range of organisations to think about how any gaps can be filled.
- **Reach out and work with the community to understand its needs** – from one PCN to the next, needs within the community are likely to differ. Some areas, for example, might have a particularly deprived population, whereas others might have particularly large numbers of older people. Local authorities should already have data on local needs, gathered through the Joint Strategic Needs Assessment (JSNA). The local Healthwatch should be invited to contribute and should have a thorough understanding of their local networks and communities. Patient Participation Groups are also a natural place to engage. PCNs also need to ensure that they have good connections with marginalised communities. Once needs are identified, link workers should be recruited to bring skills which are appropriate for the needs of the community. Likewise, there needs to be appropriate services or activities within the VCSE sector to accommodate the specific needs of the community.



6. Support referrers to reach and recognise people who are experiencing loneliness

- **Draw on existing skills and expertise in the local community** – in most communities there are already organisations with experience in working with lonely and isolated individuals, so it will be worth tapping into this expertise. Why not ask local experts to talk to those making referrals into link workers and give their tips on recognising the signs of loneliness?
- **Consider how to reach out to lonely and isolated individuals** – e.g. through providing outreach and encouraging referrals from other local agencies and individuals – not everyone experiencing loneliness will be in contact with their GP or will access GP services when issues are affecting them. Loneliness is an individual experience so a range of routes of access are needed. To help with this, proactive outreach is necessary, as is enabling a range of agencies to refer people to social prescribing schemes (including self-referral) and making the referral process as easy as possible.
- **Embed link workers within multi-disciplinary teams** – individuals will often have additional needs that contribute to or compound their feelings of loneliness, but can't be addressed by a loneliness-specific service. Link workers will need to be full and valued members of multi-disciplinary teams supporting people with complex additional needs, to ease the referral process and ensure both clinical and non-clinical needs are met.

Primary Care Networks, CCGs and GP practices (continued)

7. Employ link workers who have the time, skills and knowledge to address loneliness

- **Recruit link workers who have the skills to identify and talk about loneliness** – for example, when people are feeling lonely or isolated, often they don't want to admit they're feeling this way. It's therefore better to avoid checklist approaches that only identify loneliness by asking people: "Do you feel lonely?". There are lots of different schemes that do the job of connecting people to communities – and not all of these are called "social prescribing" schemes – people who have worked in these schemes are likely to bring valuable skills.
- **Ensure link workers have the time and skills needed to build trust and rapport with service users** – particularly for people experiencing loneliness it is vital that the link worker has excellent relationship-building skills, and can empower people who may lack confidence to unpack complex issues. Finding people with these skills will be a vital consideration at the recruitment stage. But even the best workers won't be able to build trust if appointment times are very short, or link workers are not able to flex the amount of time / number of sessions they have with people. Link workers also need to be flexible in how they work – they may need to make home visits, or meet people away from health settings in places that their clients will feel comfortable.
- **Equip link workers to keep up-to-date with local assets** – while initial mapping will be important, things change quickly. Link workers will need to keep up with what's available in the local community and build strong relationships with the agencies into which they may refer people. There is little substitute for individual networking and relationship-building across organisations, so link workers need time to do this. However, digital resources can also help; for example, Croydon CCG has an e-marketplace for VCSE sector organisations, which is kept up to date by the organisations themselves.
- **Plan for supporting access and connection** – it's rarely effective simply to refer someone who has been chronically lonely for a long time to a new social group in order for them to connect. Successful social prescribing link workers often accompany people to new activities or work alongside volunteer supporters who can help them do so.

8. Support the creation and maintenance of a comprehensive range of community services and assets

- **Ensure there are appropriate services for loneliness** – while people experiencing loneliness may benefit from accessing a wide range of groups and activities available in communities, there may also be a need for specialist services designed to respond to the particular challenges of loneliness. These include:
 - Support with resilience and emotional wellbeing
 - Relationship support
 - Support with psychological barriers to connection
- While link workers should be equipped to provide low-level support around confidence and relationship-building, some chronically lonely people may need intensive help.



Focus on: **Health Connections Mendip: Community Connectors**

In Somerset, Health Connections Mendip¹⁷ has worked to ensure that even the most isolated people can access their 'Health Connectors' social prescribing scheme by training up local people to act as eyes and ears on the ground – understanding the signs of loneliness and sensitively referring people to support. Known as 'Community Connectors', these people get locally tailored training and are part of the Health Connections Mendip service. Anyone who is interested can be a Community Connector for Mendip. So far they have trained hairdressers, taxi drivers, drug and alcohol workers, care workers, CAB teams, adult social care workers, primary care staff, sixth form students, church congregations, peer support group members and hundreds of members of the public.



Image © Holly Butcher/BBC.

¹⁷ A full outline of the Health Connections Mendip model can be found here: <https://healthconnectionsmentip.org/wp-content/uploads/2017/01/HCM-foldout-A5v4AW.pdf>

Voluntary and community sector organisations

9. Understand what's been promised

- Over the next few months local health system leaders will be ramping up activity around social prescribing. It will be important to understand what's been promised by the government and the NHS – across the government's loneliness strategy, the NHS Long-Term Plan¹⁸, and Universal Personalised Care commitment¹⁹ – so that you can ensure these pledges are being delivered as effectively as possible in your community.

10. Work with local NHS partners

- **Get to know the local PCN** – PCNs are newly formed partnerships based on GP registered lists, typically serving communities of around 30,000 to 50,000 people. Every GP practice is being encouraged to join a PCN, and they will be the lead organisation recruiting link workers for social prescribing. VCSE sector organisations are fundamental to the operation of social prescribing, therefore it is important that the sector is included in discussions around either building new social prescribing models or enhancing existing work in your area. PCNs are being encouraged to reach out to local organisations and may be doing this through existing networks. In Croydon for example, a local alliance between the CCG, mental health services, GP surgeries, the local authorities, Age UK and other VCSE sector organisations works to create system transformation. However, because PCNs are new, local organisations shouldn't assume PCNs will know about their work – so it's worth reaching out.
- **Support local mapping at PCN level** – PCNs will ideally start work on social prescribing by mapping existing schemes, as well as of wider services and capacity in the community. As local VCSE organisations provide vital links to the community they should support this process by sharing their on-the-ground knowledge of what's available. National organisations can further support by convening local groups and facilitating knowledge sharing.

¹⁸ NHS England (2018). NHS Long Term Plan. Available at: www.longtermplan.nhs.uk
¹⁹ See: www.england.nhs.uk/personalisedcare/upc

APPENDIX 6

Qualitative feedback from residents/family members using Voice Activated Assistants (VAA)

"Brilliant, and although I struggle, I'm determined to keep practising. There's an improvement in my speech and four different people have noticed. At the end of the day everything that helps me, I will do. Having the Alexa has made a difference, because it's there I'll use it. If it wasn't there, I wouldn't make the effort"

"What I like is being able to play my music whilst lying in bed, if it wasn't for Alexa I wouldn't be able to do that"

"I feel better when I've video-called my family"

"She def loves it but it's def the reminders that keep her on her toes"

"The reminders & video calling are very useful I found so far personally"

"I really like it, as I used to be organised and she helps me do that"

"It's great as she reminds me to have a drink, and I can shout at her to stop!"

"We can check out the Lidl app to look for bargains if we miss the leaflet"

"I've missed having Alexa to talk to, I'd like to have her back"

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