Loneliness and social isolation in Gloucestershire

Author: Eddie Parsons, Strategic Needs Analysis Team, Gloucestershire County Council

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Contents

Executive summary

- Loneliness and social isolation affects the physical and emotional wellbeing of large number of people in the county, especially the elderly. Both are important but there is evidence that social isolation has a greater impact on physical health than loneliness.

- However, loneliness is not restricted to older people – reported loneliness in the UK is highest for the 45 to 54 year old age range.

- There is an increasing recognition that reducing social isolation not only improves the lives of those affected but leads to savings in health and social care spending.

- Loneliness and social isolation is widespread in Gloucestershire but varies in intensity and impact geographically and between different social groups.

- The relationship between loneliness, social isolation and health outcomes is complex and a range of initiatives will be required to address need according to the local context.

- Some life events such as limiting illness or disability, bereavement and taking on an intensive caring role are particularly likely to lead to increased social isolation and loneliness.

- A number of approaches are addressing these needs in the county. Particularly important is the existing contribution of the community through family carers, befriending schemes or lunch clubs, for example. More formally, commissioned initiatives such as Village Agents, social prescribing and community hubs are having an increasing impact on social isolation.

- Barriers to reducing social isolation include volunteer shortages, lack of access to transport and digital technology and the availability of timely information and advice connecting those in need with the people and resources that will help them.

- Strengthening social networks and community-centred approaches to health can play an important role in reducing social isolation.

Introduction

Loneliness and social isolation are increasingly seen as key factors in the wellbeing of all and older people in particular. They lead to harmful effects on individuals, their communities and the country as a whole. Research shows that lacking social connections is as damaging to our health as smoking 15 cigarettes a day[1] (Holt-Lunstad, 2010). However, we are at an early stage of understanding the complex relationships between loneliness and social isolation and their associated costs. The Prime Minister recently stated that he recognises "the impact of loneliness and social isolation on older people's health. That is why tackling these problems remains a priority for the Government". He went on to say that "The Department of Health is raising awareness of these issues and helping local health and wellbeing boards and commissioners to improve their measurements of loneliness and social isolation in local communities."[2].

The purpose of this report is to collate the intelligence that exists about loneliness and social isolation in Gloucestershire; show why it is important; outline what we know about its prevalence and summarise the effectiveness of some of the approaches to addressing it.

It is important to recognise the differences between loneliness and social isolation. Social isolation is experienced when we have limited social interaction with others, an objective state where the number of contacts can be counted. Loneliness, in contrast, is a subjective emotion – you can be lonely in a crowded room – which can be temporary or chronic. There is strong evidence that both states can affect people's health though how this works is not yet fully understood and the interactions are complex.

This report starts with a summary of national and international evidence on the prevalence and consequences of loneliness and social isolation. Then the evidence of risk factors and the actual extent of loneliness and social isolation in the county is explored. Finally there is some discussion of what is being done and what more can be done to address loneliness and social isolation in the county.

[1] Holt-Lunstad *et al,* 2010, Social Relationships and Mortality Risk: A Meta-analytic Review, Available at http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1000316

[2] Letter to 'Contact the Elderly', 2015, Available at http://www.contact-the-elderly.org.uk/news/the-prime-minister-writes-letter-of-support-to-contact-the-elderly

National and international evidence

There is a rapidly expanding evidence base about the effects of social isolation and loneliness. The Campaign to End Loneliness has collated a considerable amount of this evidence on their website[3]. This section highlights some of the most relevant research in this area. Bristol City Council also has a useful evidence base available online[4]

Effects on health and wellbeing

The evidence of the negative impact of loneliness and social isolation on health and wellbeing is increasingly strong. A recent study using the English Longitudinal Study of Ageing (ELSA)[5] found that:

- The loneliest and most socially isolated individuals have consistently lower levels of subjective wellbeing than older people who are more socially connected.
- Both the size of an individual's social network and their frequency of contact with that network are positively associated with wellbeing over 6 years of follow up.
- While older people, in general, begin to see a rise in their wellbeing in later life, those who are socially isolated do not.

Loneliness and social isolation affect physical as well as mental wellbeing. A recent scoping study[6] states that the most researched outcomes are depression and cardiovascular health and that:

- Loneliness is a key risk factor for depression in old age, controlling for a number of other risk factors[7]

- Social isolation is a predictor of coronary artery disease[8] chronic heart failure[9] congestive heart failure[10] and hospitalisation due to heart failure[11].

Another recent study using ELSA data reports that the relationship between social isolation, feeling lonely and risk of premature death may be complex. The study found that both social isolation and loneliness were associated with increased risk of reduced longevity. However, if demographic factors and initial health were taken into account, loneliness was no longer significantly associated with that risk. There was still a significant link between social isolation and risk of premature death, however, after these other factors and even loneliness

[3] Campaign to End Loneliness, Available at http://www.campaigntoendloneliness.org/loneliness-research/
[4] Bristol City Council, 2015, Social Isolation, available at: https://www.bristol.gov.uk/policies-plans-strategies/social-isolation
[5] ILC-UK, The links between social connections and wellbeing in later life, 2015, http://www.ilcuk.org.uk/images/uploads/publication-pdfs/SOCIAL_NETWORK_WELLBEING_final.pdf
[6] Courtin, Emilie and Knapp, Martin, Social isolation, loneliness and health in old age: a scoping review , 2015, http://eprints.lse.ac.uk/61768/
[7] Cacioppo, Hawkley and Thisted, 2012, Perceived social isolation makes me sad: 5-year cross-lagged analyses of loneliness and depressive symptomatology in the Chicago Health, Aging, and Social Relations Study, Psychology and Aging, Vol 25(2), Jun 2010, 453-463.
[8] Brummett *et al.* 2001
[9] Friedmann *et al*. 2006
[10] Murberg 2004
[11] Cene *et al*. 2012

had been taken into account[12]. A meta-analysis of 70 different research papers containing more than 3.4 million participants found that that people who feel, or are, socially isolated or live alone are at about a 30% higher risk of early death[13]. Once again, social isolation was a better predictor of early death than reported loneliness.

Who it affects

People can be lonely for a variety of reasons. The following have been suggested as potential factors in loneliness[14]:

- Interpersonal engagement, for example, the quality of relationships with family, friends and neighbours
- Life-stage events such as retirement, widowhood, sensory impairment and physical health
- Wider social structures including poverty, the quality of health and social care, ageism
- Social environment, for example.. living arrangements, community connectedness, hobbies and interests, pets, housing, car, holidays and seasons

Characteristics such as personality and sense of identity will affect the degree of impact of these factors on an individual.

The Office for National Statistics (ONS) has released a report that analyses the levels of social capital in the United Kingdom. They define social capital as “social connections and all the benefits they generate”. This report covers four aspects of social capital: personal relationships, social network support, civic engagement and trust.

Among the headline findings from the report are the following:

- 1 in 10 people (aged 18+) in the UK said that they experienced loneliness “all, most or more than half of the time” over the previous two weeks to being surveyed
- 36% of UK residents wished that they could spend more time with family – and the same proportion also said they wished that they “had more social contacts”

The report shows the relationship between numbers of close friendships and satisfaction with life. Of the people who had no close friends, 26% said that they were dissatisfied with their life. This was compared to just 14% of people who had 10 or more close friends and were dissatisfied with life.

The research also found that loneliness has a negative impact on our life experiences and attitudes. Of those who report feeling lonely all the time:

- 48% felt “left out of society”
- 41% said that what they do is “not recognised by others”
- 32% feel that what they do in their life is “not worthwhile”

[12] Steptoe A, Shankar A, Demakakos P, Wardle J. Social isolation, loneliness, and all-cause mortality in older men and women. PNAS. Published online March 25 2013

[13] Holt-Lunstad J, Smith TB, Baker M, et al. Loneliness and Social Isolation as Risk Factors for Mortality - A Meta-Analytic Review. Perspectives on Psychology. Published online March 11 2015

[14] Victor C conference presentation: http://www.campaigntoendloneliness.org.uk/loneliness-conference/

These findings contrast with the figures for people who never reported feeling lonely: only 7% of this group feel left out of society, 17% feel what they do is not recognised and just 5% feel that their life in not worthwhile.

Finally, the report looks at whether people in the UK have someone to rely on if they had a "serious problem". Overall, 87% of people said that they could rely on a partner, family member or friend. However, the majority of people were most likely to "rely a lot" on a partner (83%) compared to 62% relying a lot on family, and just less than half of people (45%) relying a lot on friends.[15]

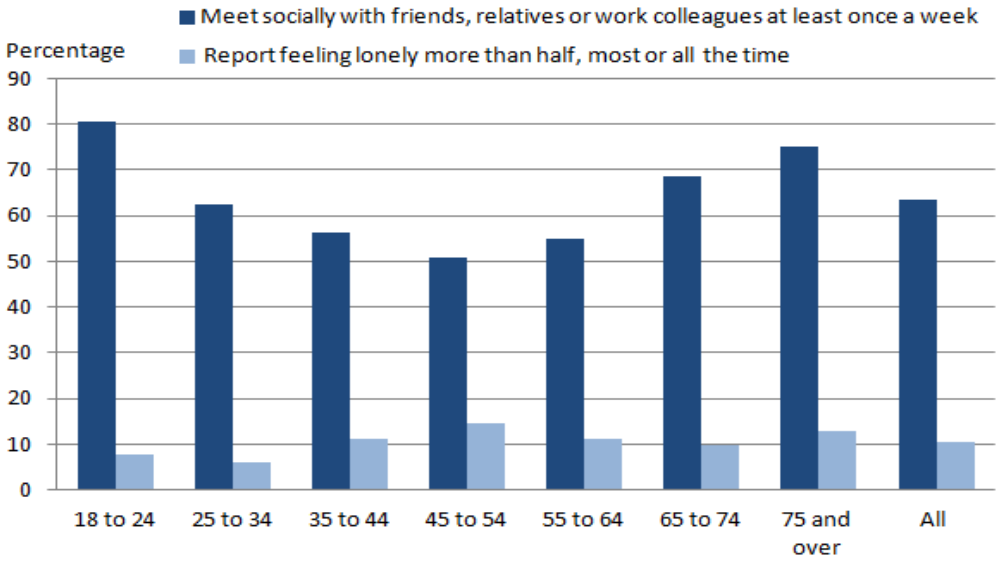
[15] Siegler, V. 2015. Measuring National Well-being, An analysis of Social Capital in the United Kingdom (ONS: London)

Risk factors for loneliness and social isolation

Age

Loneliness and social isolation affect people at all lifestages. An ONS report on Inequalities in Social Capital by Age and Sex[16] stated that people aged 75 and over were the least likely to have at least one close friend with 11% of them reported as having no close friend at all. This compares to 2% of those aged 18 to 24.

The following graph from the report shows that loneliness also varies with age, and is highest for 45-54 year olds. This group also experiences the most social isolation.



Sources: European Social Survey and Eurofound, European Quality of Life Survey

Caring role

Carers UK sought the views of nearly 5,000 carers in the UK as part of a larger piece of research called the State of Caring[17]. Although this was not a truly representative sample of carers it highlighted issues that reflect, at least partially, the findings of the carers survey in Gloucestershire. When they analysed answers given about relationships, friendships and loneliness they found that:

- 8 in 10 (83%) carers have felt lonely or socially isolated as a result of their caring responsibilities
- 57% of carers have lost touch with friends and family as a result of caring and half (49%) of carers say they have experienced difficulties in their relationship with their partner because of their caring role
- 38% of carers in full-time employment have felt isolated from other people at work because of their caring responsibilities

[16] ONS, Inequalities in Social Capital by Age andSex, July 2015, http://www.ons.gov.uk/ons/dcp171766_410190.pdf

[17] Carers UK. 2015. Alone and caring: Isolation, loneliness and the impact of caring on relationships. Carers UK: London. Available at: http://www.carersuk.org/for-professionals/policy/policy-library/alone-caring

- Carers who have reached breaking point as a result of caring are twice as likely to say that they are socially isolated because they are unable to leave the house

Living alone

A person living alone is not necessarily lonely or socially excluded. However, research shows that those who do live alone are more likely to experience social exclusion. The following table summarising ELSA data shows that 65.6% of 50 to 64 year olds and 77.2% of those aged 80 or more living alone experience some social exclusion. Living with other people does not necessarily reduce social exclusion, in itself. Those living with other people who were not their own children or partner experienced higher levels of social exclusion than those living alone. Living with a spouse or partner does make a substantial difference. Less than 40% of 50 to 79 year olds living with their spouse experience any social exclusion[18].

		Respondent lives completely alone	Respondent lives with other persons not own child or spouse	Respondent lives with own children and/or others	Respondent lives with spouse/ partner only	Respondent lives with spouse/ partner and others and/or own children	Respondent lives with spouse/ partner and own children	Total
50 to 64 years old	Not excluded at all	34.4	30.8	35.8	64.4	54.1	64.7	58.2
	Excluded in one dimension	33.6	37.0	36.2	25.4	31.0	25.7	27.4
	Excluded in two dimensions	18.0	15.0	16.5	7.7	11.1	7.6	9.7
	Excluded in three or more dimensions	14.0	17.1	11.5	2.5	3.8	2.0	4.7
	Total weighted count	721	117	203	2630	182	1432	5286
	Total unweighted count	742	109	204	2672	170	1328	5225
65 to 79 years old	Not excluded at all	38.4	21.6	35.3	60.5	[55.7]	57.0	52.2
	Excluded in one dimension	30.7	43.5	34.2	27.4	[40.7]	24.4	28.9
	Excluded in two dimensions	19.4	16.6	24.5	8.7	[3.6]	13.1	12.7
	Excluded in three or more dimensions	11.5	18.3	5.9	3.5	[.0]	5.5	6.2
	Total weighted count	1035	56	127	2070	48	165	3502
	Total unweighted count	1075	55	124	2185	46	170	3655
80 years old or older	Not excluded at all	22.8		30.0	40.6			28.6
	Excluded in one dimension	29.5		27.1	30.1			30.1
	Excluded in two dimensions	26.5		26.8	18.0			23.6
	Excluded in three or more dimensions	21.2		16.0	11.3			17.6

[18] Panayotes D, 2008, Being socially excluded and living alone in old age. Finding from the English Longitudinal Study of Ageing (ELSA), Available at: http://www.elsa-project.ac.uk/publicationDetails/id/4218

Bereavement

People often find themselves living alone for the first time because of bereavement which is perhaps the most likely life event to lead to increased loneliness. One study examined the link between loss and stress levels in older adults, and the subsequent implications for the health of the person[19].The research found that bereavement has a number of physical and mental consequences. Because of heightened levels of cortisol in the body, older adults were left vulnerable to increased risk of illness and infection.

Gender

In overall terms men appear to experience social exclusion less than women - 44% of men aged over 50 and 49.3% of women. However, this will partly reflect the fact that men are likely to die before their partners and so are less likely to live alone. Nevertheless, 72% of men aged 80 or more who live alone experience social exclusion compared with 88.8% of women in this age range[20].

Mental health problems

Research shows that lonely people are more likely to experience depression and the lonelier a person is, the more likely they are to experience increased depressive symptoms [21]. The causality has been determined – loneliness leads to increased depressive symptoms[22]. Specifically, the brains of lonely people become more vigilant for social threats and more focused on self-preservation. As a result, lonely individuals can be less attentive to what other people are feeling and what they might actually need. Lonely people also perceive negative interactions to be more negative and positive interactions with others to be less positive. Both these effects inevitably have an impact on relationships[23].39

Loneliness can also be linked to cognitive decline and dementia in older people. There is evidence that socially engaged older people experience less cognitive decline and are less prone to dementia. The risk of Alzheimer's disease more than doubles in older people experiencing loneliness[24].

Additionally, living alone increases the risk of suicide for young and old alike[25].

Deprivation

Researchers in Glasgow found that people who were living alone or who had a long-term health condition were more likely to experience loneliness in deprived communities[26].

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[19] Vitlic, A., Knanfer, R., Lord, J. M., Carroll, D. and Phillips, A. C. 2014. 'Bereavement reduces neutrophil oxidative burst only in older adults: role of the HPA axis and immunesenescence', Immunity and Ageing, 11: 13. Available at: www.immunityageing.com/content/11/1/13

[20] *Ibid*

[21] Cacioppo JT, Hughes ME, Waite LJ, Hawkley LC, Thisted RA (2006). Loneliness as a specific risk factor for depressive symptoms: crosssectional and longitudinal analyses. Psychology and Aging 21(1), available at http://www.ncbi.nlm.nih.gov/pubmed/16594799

[22] Cacioppo JT, Hawkley LC, Thisted RA (2010). Perceived social isolation makes me sad: cross-lagged analyses of loneliness and depressive symptomatology in the Chicago Health, Aging and Social Relations Study. Psychology and Aging 25 (2): http://www.ncbi.nlm.nih.gov/pubmed/20545429

[23] Cacioppo JT conference presentation

[24] James BD, Wilson RS, Barnes LL, Bennett DA (2011). Late-life social activity and cognitive decline in old age. Journal of the International Neuropsychological Society 17(6) http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3206295/

[25] O'Connell, H., Chin, A., Cunnigham, C and Lawlor, B. 2004. Recent developments: Suicide in older people British Medical Journal 29 pp.895–9

Appropriate Housing

A recent report compared the experiences of older people living 'out in the community' with those resident in extra care housing. The latter group experienced half the amount of loneliness compared to those elderly residents living in the community. They also felt safer and that they had a 'stronger sense of control over their daily lives'[27].

Ethnicity

Research has been conducted examining loneliness among different groups who migrated to the UK in the 1960s, 1970s and 1980s, including Indian, African, Chinese, Caribbean, Bangladeshi and Pakistani communities. This shows that levels of loneliness among ethnic minority elders are generally higher than for the rest of the population – 15% reporting that they always or often feel lonely[28]

Costs

An American study found that chronic loneliness is associated with increased visits to physicians (US GPs) but not to hospitalisation[29]

Prevalence of social isolation Gloucestershire – risk factors

Living alone

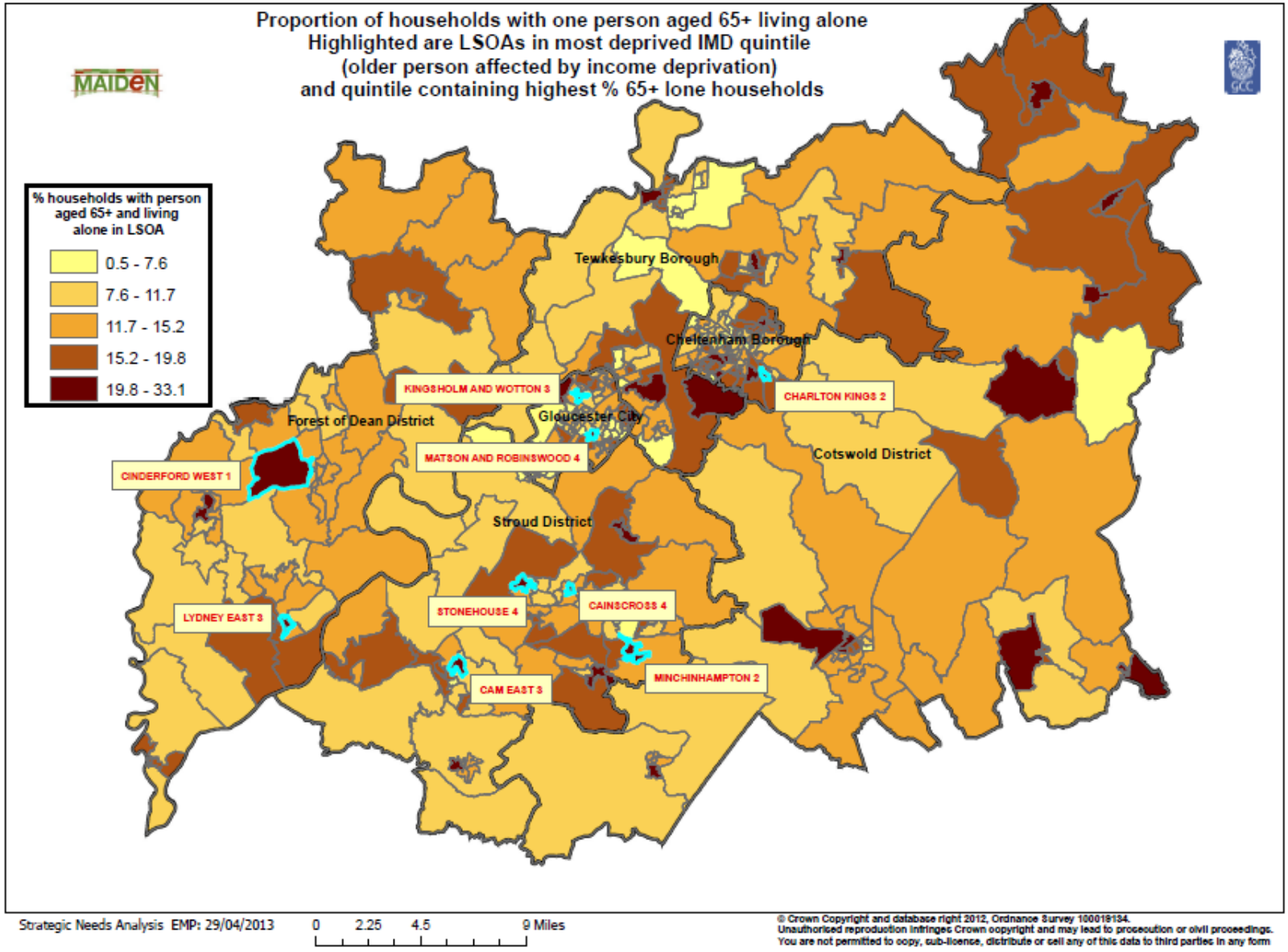
Living alone in itself does not mean that people will be lonely or socially isolated. However, as noted above, research has shown that living alone is associated with higher levels of premature death and other negative outcomes. The following map, using data from the 2011 Census, shows in which areas in the county older people are more likely to be living alone. Those areas that are characterised by both high rates of deprivation and high levels of older people living alone are highlighted.

[26] Kearnsa, A., Whitley, E., Tannahillc, C. and Ellaway, A. 2015. Loneliness, social relations and health and well-being in deprived communities. Psychology, Health and Medicine 20(3): 332-344. Available at: http://www.tandfonline.com/doi/pdf/10.1080/13548506.2014.940354

[27] http://www.ilcuk.org.uk/images/uploads/publication-pdfs/Village_Life_ILC-UK_Report.pdf

[28] Victor C conference presentation: http://www.campaigntoendloneliness.org.uk/loneliness-conference/ See also: Victor C R, Burholt V, and Martin W (2012) Loneliness and ethnic minority elders in Great Britain: an exploratory study, Journal of Cross-Cultural Gerontology 27 (1) http://www.springerlink.com/content/6q4302657026jk27/

[29] 1.Kerstin Gerst-Emerson, Jayani Jayawardhana. Loneliness as a Public Health Issue: The Impact of Loneliness on Health Care Utilization Among Older Adults. American Journal of Public Health, 2015; e1 DOI: 10.2105/AJPH.2014.302427


Proportion of households with one person aged 65+ living alone
Highlighted are LSOAs in most deprived IMD quintile
(older person affected by income deprivation)
and quintile containing highest % 65+ lone households
MAIDeN
% households with person aged 65+ and living alone in LSOA
0.5 - 7.6
7.6 - 11.7
11.7 - 15.2
15.2 - 19.8
19.8 - 33.1
Tewkesbury Borough
Cheltenham Borough
KINGSHOLM AND WOTTON 3
CHARLTON KINGS 2
Forest of Dean District
Gloucester City
MATSON AND ROBINSWOOD 4
Cotswold District
CINDERFORD WEST 1
Stroud District
LYDNEY EAST 3
STONEHOUSE 4
CAINSCROSS 4
MINCHINHAMPTON 2
CAM EAST 3
Strategic Needs Analysis EMP: 29/04/2013
0 2.25 4.5 9 Miles
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Modelled social isolation in Gloucestershire

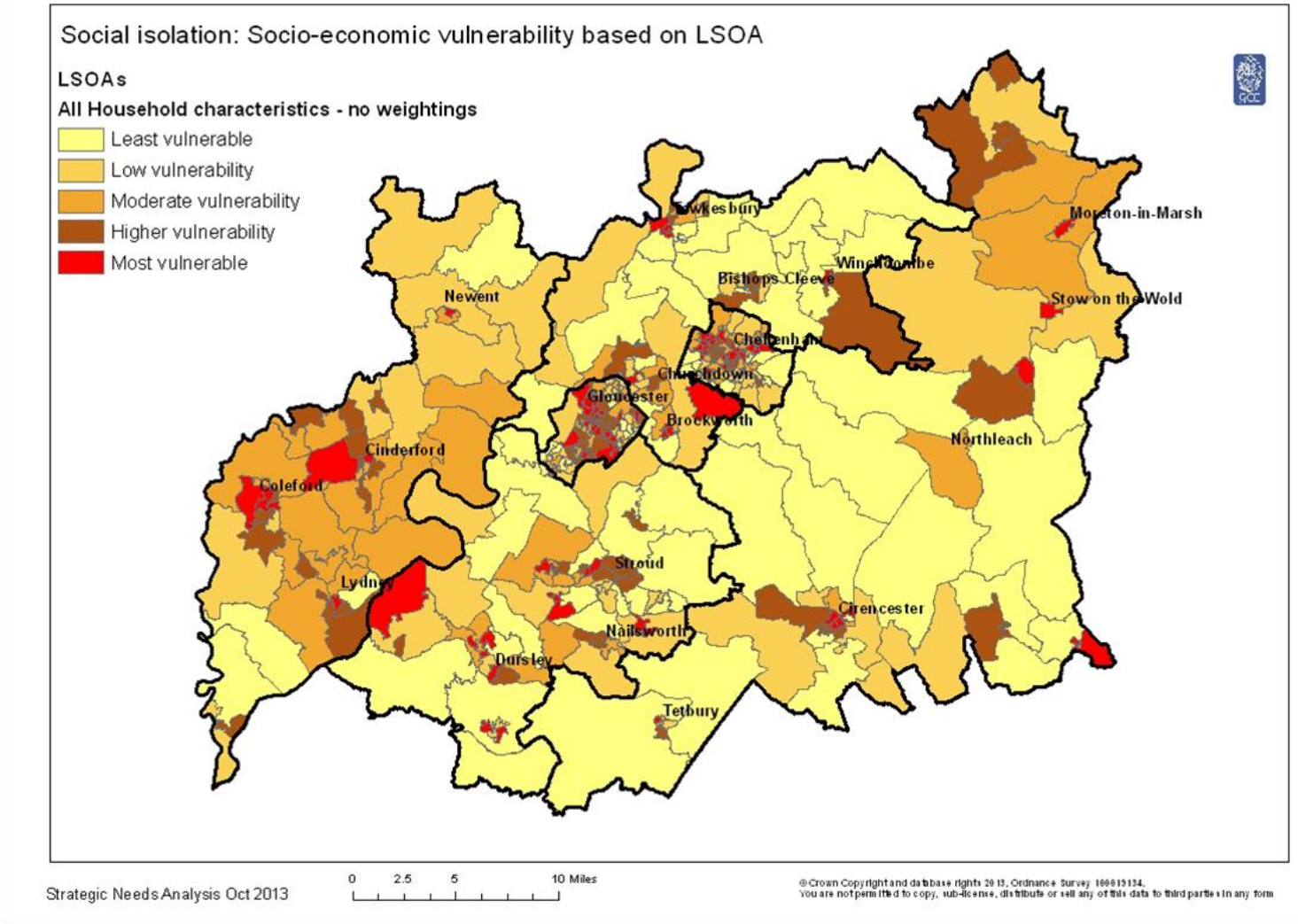
Building on previous work by Essex County Council our Strategic Needs Analysis Team used social isolation risk factors to develop a model to show where it is most likely be present in the county[30]. The Acorn customer segmentation tool was used to map where the socially isolated were most likely to live at local area and household level. As in Essex a number of social isolation risk measures were combined to create an 'isolation index'. The measures were:

Selected Variables Household based (LSOA and individual household)
Age - Head of household:65-74
Age - Head of household:75+
Household Size:Household size : 1 person
Highest Level of Qualifications:No formal qualification
Highest Level of Qualifications:GCSE / O levels / CSE / School Certificate
Highest Level of Qualifications:ONC / BTEC / apprenticeship
Highest Level of Qualifications:A-levels/ AS levels or Higher
Health Indicators:Mental illness/anxiety/depression/nerves
Car Ownership:Number of Cars 0
Isolation:Frequency of talking to neighbours: < once a month or never
Isolation:Have someone who will listen: No-one
Isolation:Have someone to help in a crisis: No-one
Isolation:Have someone you can relax with: No-one
Contentment:Not satisfied with: social life
Household Annual Income:£0-£20,000
Internet -Never used

The model has been successfully used elsewhere in the county as a starting point in exploring loneliness and social isolation locally. There is scope for further work to develop the model – for example data on bereavement rates, a significant risk factor for loneliness, was not available when the index was compiled.

The following map shows where the risk of social isolation is greatest in the county at local area level. As can be seen, there is some agreement between this map and that of older people living alone but also some variation.

[30] Gloucestershire County Council Strategic Needs Analysis Team, 2013, available here: http://www.gloucestershire.gov.uk/inform/index.cfm?articleid=94013


Social isolation: Socio-economic vulnerability based on LSOA
LSOAs
All Household characteristics - no weightings
Least vulnerable
Low vulnerability
Moderate vulnerability
Higher vulnerability
Most vulnerable
Tewkesbury
Moreton-in-Marsh
Winchcombe
Bishops Cleeve
Newent
Stow on the Wold
Cheltenham
Churchdown
Gloucester
Brockworth
Northleach
Cinderford
Coleford
Stroud
Lydney
Cirencester
Nailsworth
Dursley
Tetbury
0 2.5 5 10 Miles
Strategic Needs Analysis Oct 2013
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Actual local need

Surveys

The Barnwood Trust has carried out a survey of over 1,100 Gloucestershire residents with an over-representation of people of all ages with impairments including individuals with a wide range of disabilities and health conditions. A forthcoming report summarising analysis of this survey finds that isolation and shrinking social networks pose a particular challenge for older residents[31].

Whilst overall wellbeing levels among older residents compared positively to younger age groups, among the oldest respondents (aged 85+), levels of satisfaction with social life and relationship with friends were significantly lower. Further analysis suggested that older residents had less social support than younger residents.

Older respondents were more reliant on family members forming part of their social circle. Among those aged 70–84, 24% indicated that over half their social circle consisted of family members, and this figure rose to 37% among those aged 85+.

Respondents in the oldest age group were those least likely to be visiting their friends at least weekly (54%). They were also the age group most likely to indicate that there would be nobody to call on for help should they be ill in bed and in need of help (17%).This isolation appeared to be in part driven by the increased likelihood of these individuals living alone. Isolation at home was significantly associated with lower wellbeing levels. Around two thirds (61%) of those aged 85+ were living alone and over a quarter (28%) of those aged 70–84.

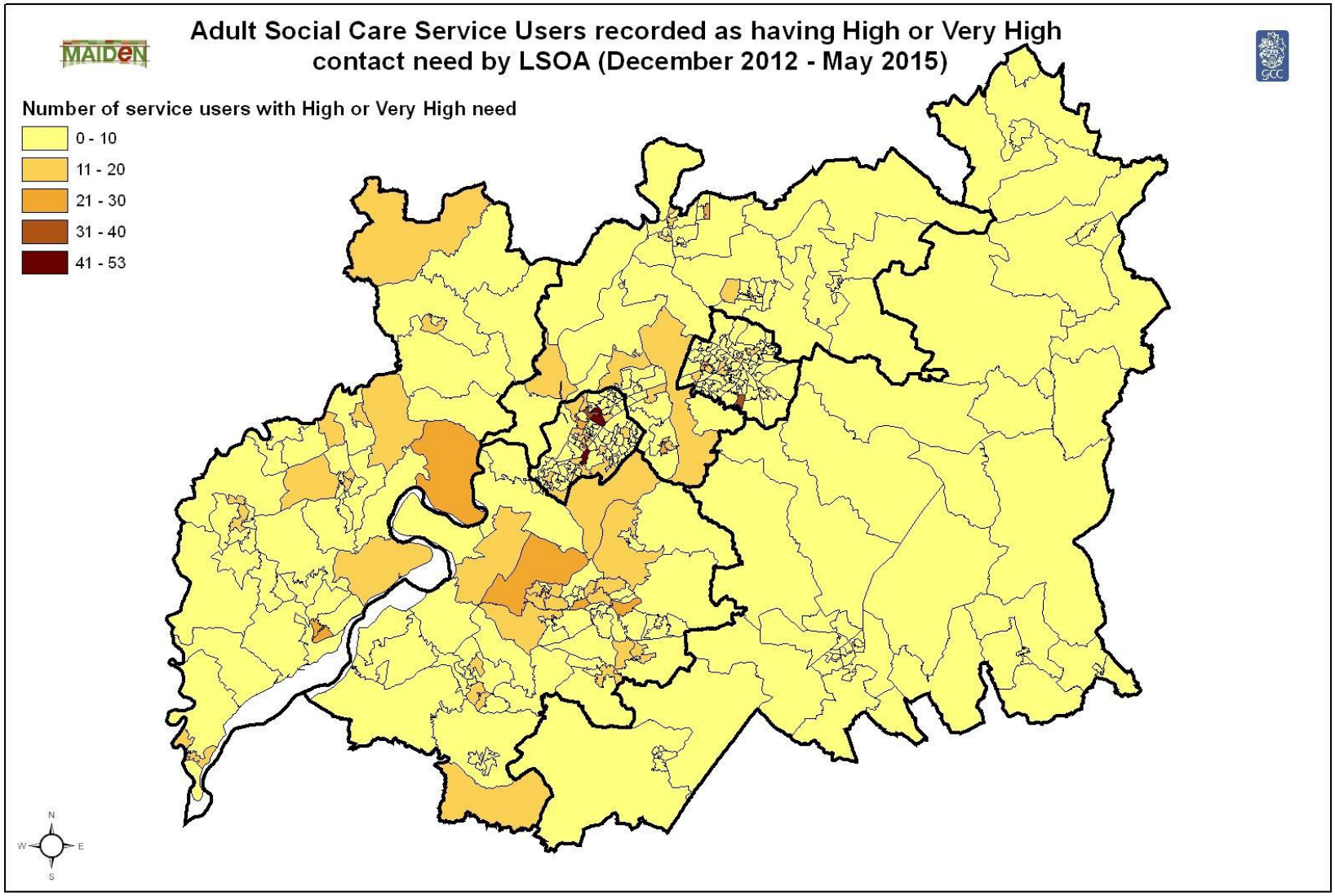
This isolation is perhaps compounded by the greater difficulties faced by these age groups when looking to get out and about in their local area. Among those aged 85+ over a third (34%) indicated they were unable to access all the services they would like to in their local area.

FACE social care assessments

When social workers carry out assessments of the needs of adult social care service users one of the needs they assess is that for social activities and relationships. By mapping the number of service users who are recorded with a level of need that is high or very high in local areas we can see where adult social care users with the highest level of actual loneliness are concentrated as shown in the following map.

It should be stressed that this dataset is not comprehensive – not all assessments in the period include such as rating. It should also be stressed that it does not show actual levels of need for social activity and relationships for the whole population with social care needs. The means testing element of the social care system will exclude many who do have high levels of need for social contact. This might explain why areas of the Cotswolds that the social isolation model described above suggests would be characterised by higher levels of loneliness do not show up in this map. However, it should highlight areas that contain concentrations of those with most loneliness and least financial resource

[31] Barnwood Trust, 2015, Wellbeing in Gloucestershire, Available here: http://barnwoodtrust.org/research/wellbeing_in_gloucestershire


Adult Social Care Service Users recorded as having High or Very High contact need by LSOA (December 2012 - May 2015)
MAIDeN
GCC
Number of service users with High or Very High need
0 - 10
11 - 20
21 - 30
31 - 40
41 - 53
N
W
E
S
Strategic Needs Analysis Team - GB: 12/06/2015
0 2 4 8 12 16 20 Miles
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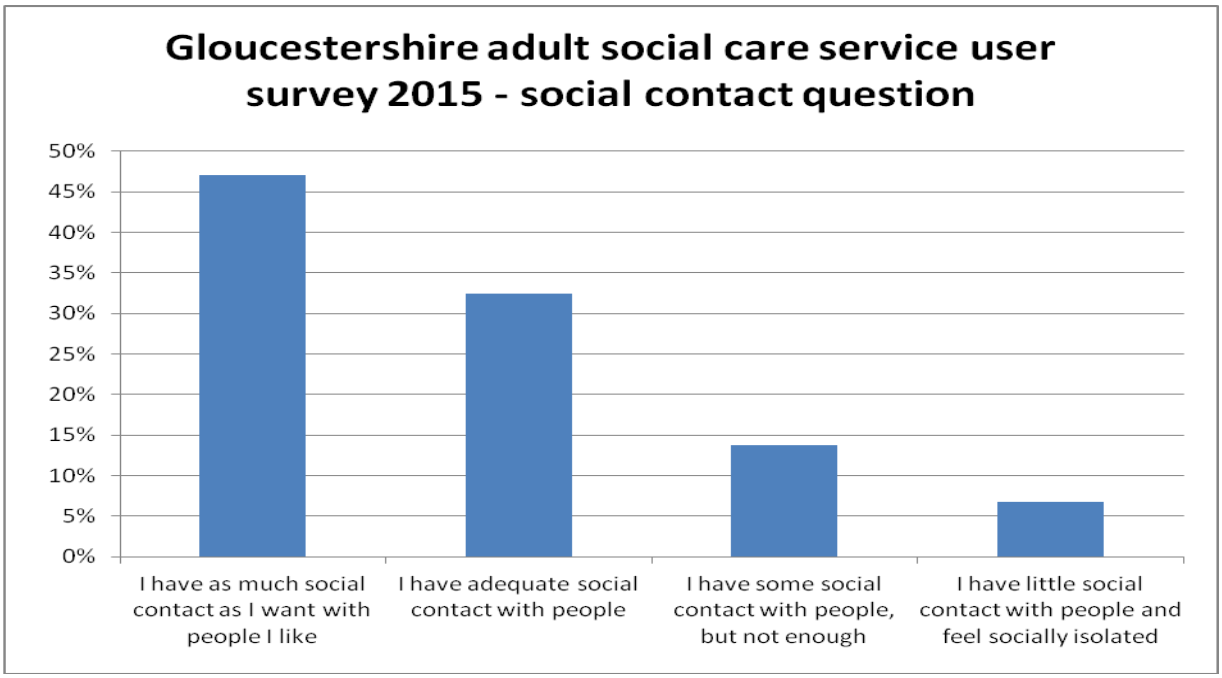
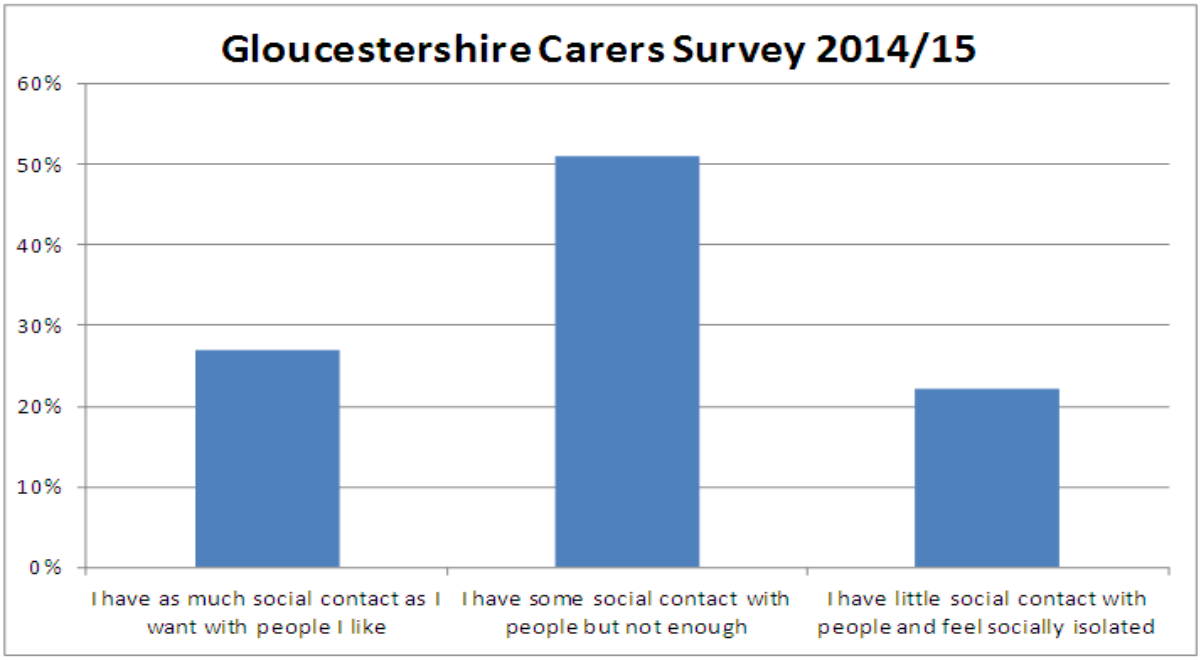
Gloucestershire adult social care service user and carer surveys

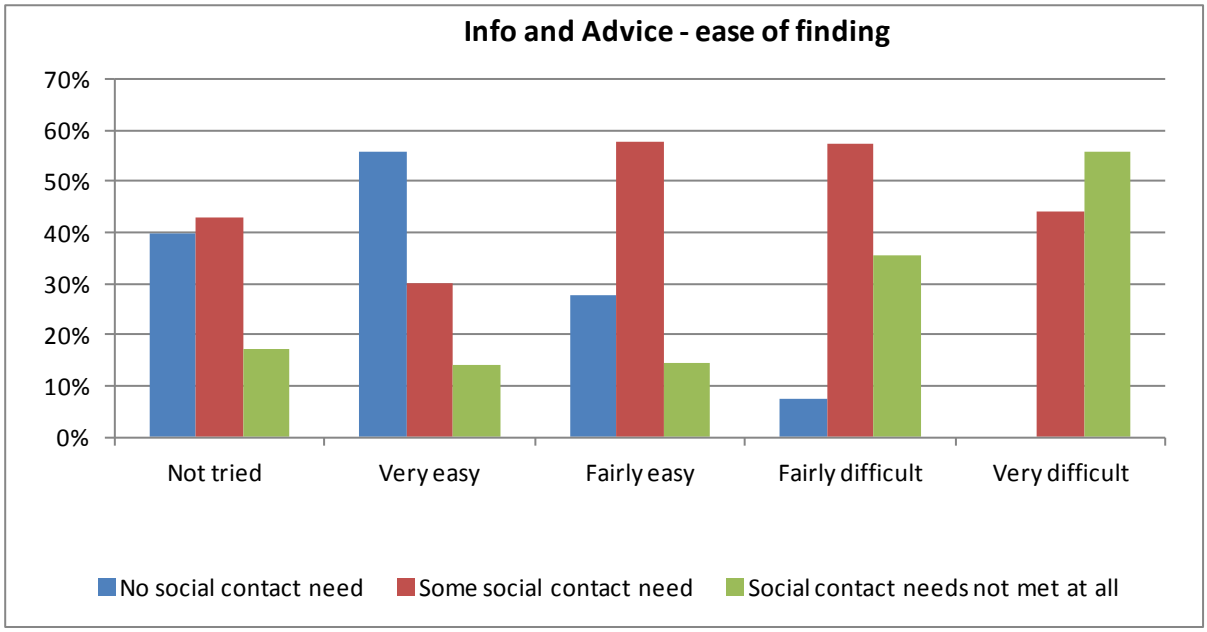
Every year the County Council carries out a survey of a sample of adults receiving adult social care services. One of the questions asks whether service users have as much social contact as they would like. In 2015 the responses were as shown in the following graph. As can be seen, one in five service users do not feel they have enough social contact.

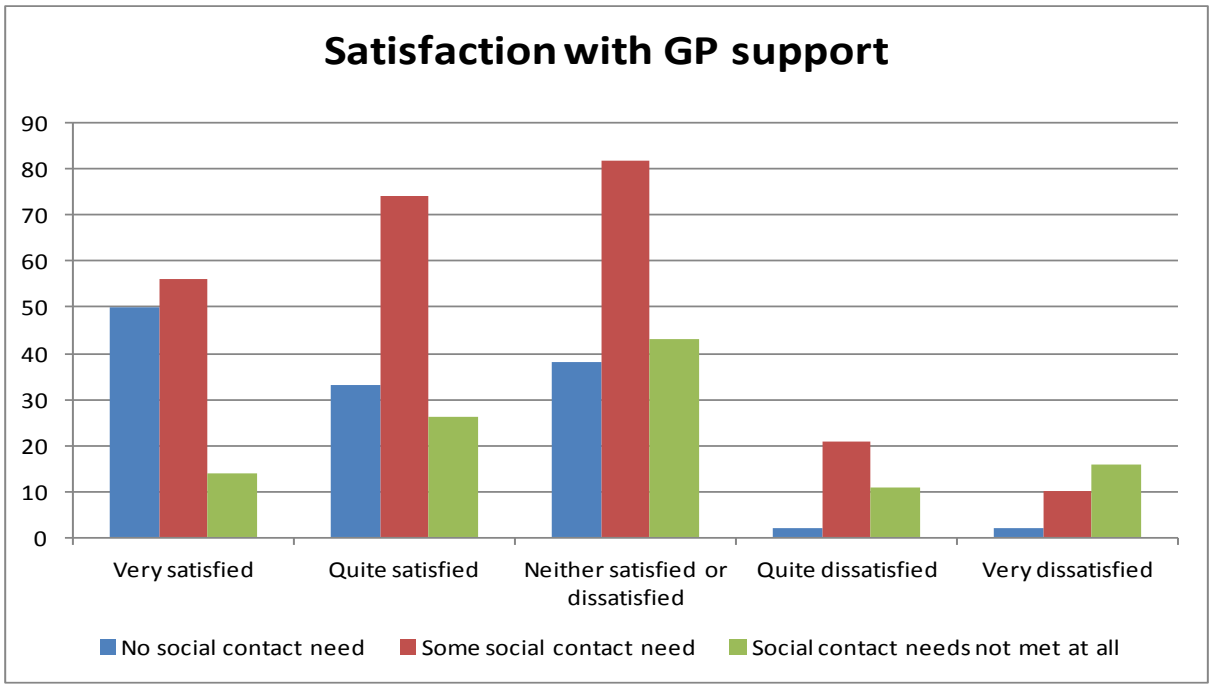


Carers whose needs have been assessed by the county council are surveyed every two years. Again, one of the questions asks whether they have as much social contact as they would like. The questions asked are slightly different but you can see in the following graph showing the responses to the latest 2014 survey that carers are experiencing more social isolation than service users with 73% of respondents feeling they do not have enough social contact.



Further analysis showed that those carers who have most need for social contact find it most difficult to access information and advice and are least satisfied with GP support.





Postcard survey

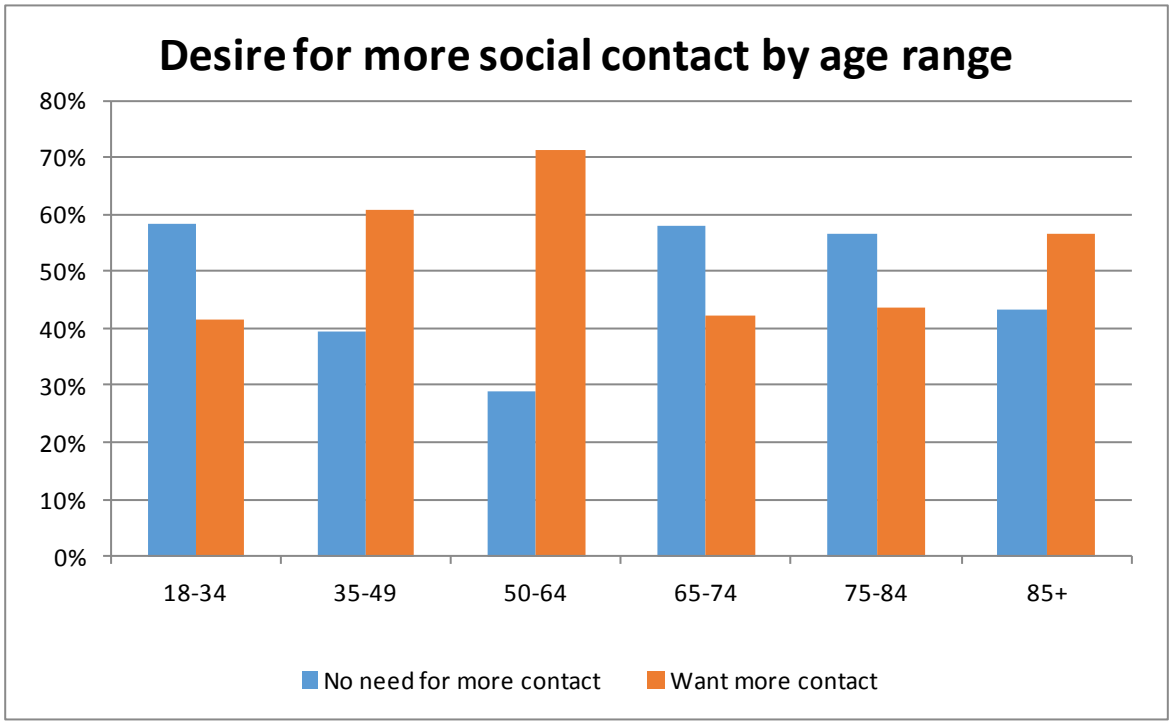
The Gloucestershire Rural Community Council (GRCC) was commissioned by the County Council to conduct a Loneliness and Isolation survey in Gloucestershire. The purpose of the survey was to gain a general picture of loneliness and isolation amongst people in the county.

The survey was open to people of any age group but was principally targeted at those aged 50+. The questionnaire was in the form of an A5 postcard containing 15 short questions and

ran from summer 2014 to spring 2015. Questionnaires were delivered to a wide range of venues across the six districts of Gloucestershire, including older people's groups, libraries and events, as well as through the village and community agents.

There were 390 responses in total – not enough to draw confident conclusions but some messages came across:

- Half of respondents wanted more contact with people
- Just over half the respondents had suggestions as to what would make a difference to them. 14% of all respondents said that more contact with people would make difference and 13% improved transport
- 4% had no contact with friends or family each week
- 13% had no access to transport – of these 69% of them want more social contact
- 71% of 50-64 year olds want more contact as shown in the following graph. This reflects the higher levels of loneliness identified for this age group in national research.



Further evidence from around the county

Social prescribing

Gloucestershire Clinical Commissioning Group, in partnership with local district councils and third sector organisations, in the last year and a half set up and supported several pilots of social prescription services across the county. Social referrals were defined here as 'a clear, coherent and collaborative process in which healthcare practitioners work with patients and service users to select and make referrals to community-based services'[32].

As the following table shows, social isolation was the commonest reason for social referrals accounting for 54% of all reasons for referral.

Locality	Most Commonly Included Reason for Referral	Total No. of Referrals including this reason	% of Referrals including this reason
Forest of Dean (n=84)	Social Isolation	55	64%
	Mental Health & Wellbeing	51	60%
	Benefits Advice	31	36%
South Cotswolds (n=87)	Mental Health & Wellbeing	43	48%
	Social Isolation	38	43%
	General Health & Fitness	26	29%
Stroud & Berkeley Vale (n=21)	Social Isolation	12	55%
	Mental Health & Wellbeing	10	45%
	Benefits Advice	3	14%
	General Health & Fitness	3	14%
Total (n=192)	Social Isolation	105	54%
	Mental Health & Wellbeing	104	53%
	General Health & Fitness	59	30%
	Benefits Advice	56	27%

Change in wellbeing following social prescription was measured in a small number of cases with an improvement in 100% of cases in Cotswold and 72% in the Forest of Dean. In the Forest of Dean 67.6% of patients saw a reduction in their total number of primary care appointments in the 6 months after referral. In South Cotswolds 44% of patients saw a reduction.

Feedback from social prescribing hub co-ordinators generally favoured patients meeting face to face in GP surgeries. Whilst signposting gave greater flexibility and scope for creativity, where there was no formal referral there was a much lower take-up rate. Patients often need support beyond simple signposting to ensure they take advantage of the opportunities provided. Some patients fed back that it was vital, particularly in rural areas, for help with transport issues to be available.

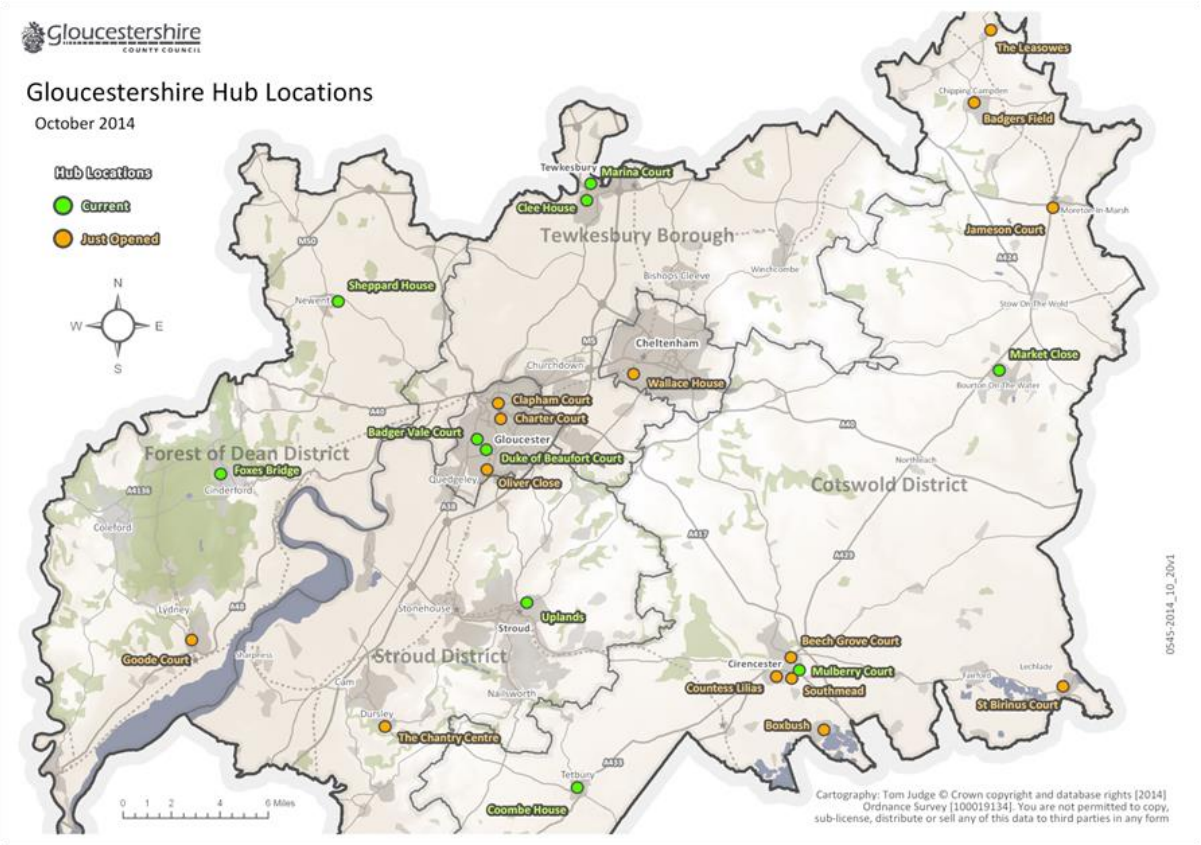
Community Hubs for older people

There are 19 Community Hubs for Older People operating countywide in Gloucestershire[33]. The Hubs are purpose built within ExtraCare Housing Schemes, or are situated within

[32] Gloucestershire's Social Prescribing Pilots: Interim Evaluation, Gloucestershire County Council, March 2015

[33] Gloucestershire County Council, 2014, Community Hub Development in Gloucestershire: Year One Countywide Evaluation,

traditional Sheltered Housing Schemes, Village Halls and Day Centres. The age range for participants is 55 upwards or lower if the health and care need is applicable. Hubs have been in existence for a period ranging from 1 year to 7 years and are offering daytime drop-in, half and whole day opportunities.



Amongst the activities they offer are: coffee mornings and afternoon teas, race nights, excursions and lunch clubs.

Between April and July 2014 almost 300 people participated in an evaluation of the hubs. One question asked how they rated their level of social contact on a scale of 1 to 10 before and after attending the hub. The average at start was 5.1 and after attendance at the hub 7.05 - a **19.5%** improvement**.**

Although some hub attendees commented that they had large families and maintained interests outside the hub, many were very appreciative of the opportunity for social interaction, thus alleviating loneliness and isolation. Every type of activity including one-to-one and group afforded the prospect of social contact. It was obvious that social contact was the catalyst for recruitment and participation in structured group activity. Social contact was also proving invaluable as part of the grieving process.

Forest of Dean

In the last year and a half a variety of qualitative and quantitative data in relation to the Forest of Dean District was gathered and considered. What emerged was a complex picture that does not lend itself to ‘top down’ views of loneliness and social isolation in the District. Whilst some places could be highlighted as areas with high risk and levels of social isolation

a systematic picture was impossible to build up because of the complexity of the relationship between individual-level factors such as living alone and caring for others and the community context.

There are people living alone, caring for others or experiencing dementia dispersed across the District. More concentrated are those who spend the most hours caring, live alone in an area of high social deprivation and adult social care service users who have high levels of need for social contact. For instance, Cinderford West and Lydney East were highlighted as such areas.

Conversations were held with a variety of people including staff from the District Council community engagement team, Citizens Advice Bureau, Forest of Dean Integrated Community Team as well as lunch club volunteers, carers and other members of the community. The following issues were highlighted in the course of these conversations. This does not pretend to be a comprehensive or representative summary of all relevant issues but they may reward consideration when attempting to address social isolation in the county.

- A raft of solutions is required to address social isolation and loneliness as there are lots of contributory factors and different people need different solutions and for some people it changes over time
- The people and organisations and people who can identify and route the socially isolated need to be identified and understood
- People prefer information and advice from a familiar face
- There is a need for better marketing that doesn't just create demand but effectively matches volunteers to need
- Commissioners need to listen to local voices to fully understand local need
- Early diagnosis of dementia accompanied by appropriate support is crucial if social isolation of both the carer and the person with dementia is to be minimised
- The community can be more inclusive for people with dementia and their carers if it is sufficiently informed and educated and volunteers empowered through appropriate support
- Important to reduce the stigma and negativity attached to dementia
- We need to look at older people as someone who has something to offer their community rather than people who need services.
- Carers, stroke and Parkinsons disease patients all have particular need for help in reducing social isolation and loneliness
- Lunch clubs and similar initiatives have important role in combating social isolation
- There is a need for more volunteer befrienders and buddy systems – if volunteers are socially isolated themselves this can be doubly effective
- Some feel that befriending creates dependency but to be effective it needs to be a preventative, non-health intervention delivered by volunteers with funding to coordinate and ensure safeguarding not an issue
- More volunteer drivers are needed to improve accessibility of social isolation solutions
- People often know about local social groups and services but don't access them - a friendly face going with them the first time would make it much easier for them to get involved .

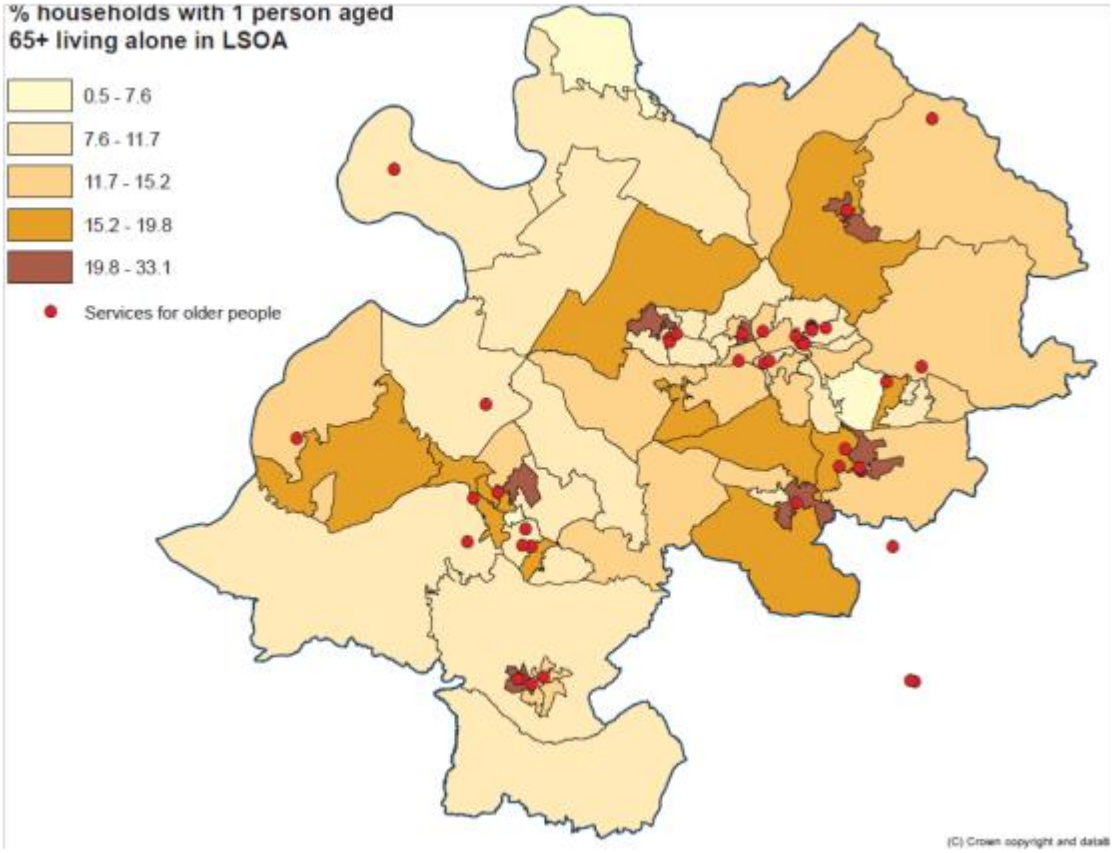
- Churches play an important role in the District. An audit in 2014 identified over 40 church-based activities such as befriending and community activities that address social isolation[34]
- Newent and Sedbury have particular issues because of their cross-border position

Stroud

Stroud District Council have produced a short report on tackling social isolation and loneliness in the District[35]. This report mapped services for older people against the map of modelled social isolation described previously.

Amongst the issues raised were:

- The lack of a 'physical' befriending service in Stroud
- Lack of evening services
- Services tend to cluster in towns – availability of transport is a key issue
- New technologies such as Skype can help



[34] Cinnamon Faith Action Audit, 2015, http://www.cinnamonnetwork.co.uk/cinnamon-faithaction-audits/

[35] Stroud District Council, 2015, Tackling Social Isolation and Loneliness in the Stroud District

Cotswold District

Cotswold District Council carried out research in 2013 and 2014 into the scale, extent and impact of loneliness and isolation amongst over 65's in the Cotswolds[36]. As in Stroud, the Gloucestershire social isolation risk index map was used to identify areas where loneliness was likeliest. Interviews and focus groups with older people in those areas were then used to find out about their experience of loneliness and isolation. The research confirmed the negative impact on their mental and physical health. Full details of the research findings can be found in the referenced report. Some key findings and recommendations were:

- Prevention/early intervention services help to alleviate loneliness and save money
- Loneliness affects carers as well as those who live alone
- Weekends and winter tended to be the loneliest times
- Village Agents (and other community navigators), befriending services and volunteer car services were valued by those who use them but many did not know about them.
- Better availability of community transport needed
- Scope for improving use of IT by older people
- Increased coverage/awareness of carer respite services
- Lunch clubs, social group and community events are sporadic and for a variety of reasons don't always meet the needs of those who would most benefit from them.

Following publication of this research a further community transport study was commissioned by the District Council[37]. The aim of the study was to "reduce loneliness and isolation by taking a collaborative approach to improving the community transport offer across the Cotswolds". Amongst the findings was the potential for both increasing the awareness of community transport services and for improved partnership work to improve its availability.

Cheltenham – Warden Hill

In 2013 Cheltenham Partnership agreed one of the priorities for its new action plan was to set up a task and finish group to undertake a mapping exercise to understand where older people might be living alone, and where the clubs and activities geared towards older people are. There was also a commitment to undertake some survey work to ascertain the views of older people on loneliness and isolation. Warden Hill ward was chosen for this work because of its high number of over 75's.

There were 54 survey respondents. 31% of the respondents said they get lonely sometimes or often. Advertisement of activities and improved health would help older people in Warden Hill to participate more in their community. Activities were preferred to be advertised through flyers through the door, in local shops or in a local community paper. The most wanted community activities were a social club and/or a book club. The three most popular interests were; gardening, knitting and listening. Most people got out at least once a week. However, non-drivers tended to go outside Warden Hill less than those who only used public transport.

[36]Hennessy-Ford, Research into the scale, extent and impact of loneliness and isolation in the Cotswolds, http://www.cotswold.gov.uk/media/777430/Loneliness-Report.PDF
[37] STC Ltd, 2015, Cotswold Community Transport Study, available at http://www.cotswold.gov.uk/media/1344840/Cotswold-Community-Transport-Study.pdf

Gloucester

Gloucester City Council found that 75% of referrals in their Social Prescribing pilot (see above) were self-declared as isolated or lonely. They plotted these postcodes against the Gloucestershire social isolation risk map and there was a reasonable level of congruence between the two. It seems reasonable, then, to assume a level of correlation between being isolated and attendance at a GP.

Examples of evidence on what works in addressing loneliness

NICE guidance

The National Institute for Healthcare and Excellence (NICE) has recently published guidance on addressing social isolation for people with multiple long-term conditions[38]

Befriending

Although research evidence is scarce, befriending would appear to have a positive effect on the health of both voluntary befrienders and befriendees, and has the potential to be a cost-effective intervention which can be of benefit to the most isolated and lonely individuals in our society. More research is needed to substantiate these findings.[39]

At a Campaign to End Loneliness workshop on befriending held in December 2014[40] the following findings were shared:

- Befriending means different things to different people: it is not a one-size-fits-all service. The term does not always cover the breadth of activity and can be perceived as patronising
- Funding, managing volunteer responsibilities, and a lack of evidence and ability to measure impact, were the most frequently faced challenges by befriending schemes
- Technology, 'micro' volunteering, increased demand and offering a flexible and personalised service were most cited opportunities for befriending
- Fears for the future held by befriending schemes include supporting more fragmented families, a significant reduction in state support and loss of community and conversation
- Hopes for the future include improved life expectancy and health, more flexible volunteers and more communal living

Befriending schemes for older people have been found to reduce social isolation, loneliness and depression among older people and hence the need for treatment. Schemes that cost £80 per person per year to run produced savings of £300 per person per annum.[41]

[38] NICE (2015), Older people with social care needs and multiple long-term conditions, available at: https://www.nice.org.uk/guidance/ng22/resources/older-people-with-social-care-needs-and-multiple-longterm-conditions-1837328537797

[39] A Summary of recent research evidence about loneliness and social isolation, their health effects and the potential role of befriending, Mary Roberts, August 2014 http://www.befriending.co.uk/assets/downloads/publications/Befriending,%20loneliness%20and%20health-%20Research%20summary.pdf

[40] http://www.campaigntoendloneliness.org/wp-content/uploads/Befriending-Workshop-Report.pdf

Inclusive communities

Dr Brian Fisher examined the relationship between community empowerment and improved health[42]. Among the many findings in his review he shows that:

- Low levels of social integration and loneliness significantly increase mortality whilst people with stronger networks are healthier and happier.
- Social networks are consistently and positively associated with reduced illness and death rates
- The most significant difference between this group and people without mental ill health is social participation. Social relationships can also reduce the risk of depression.
- Areas with poor social capital experience higher rates of cardiovascular disease in general and recurrence of acute coronary syndrome, in particular among lower income individuals.
- Several studies have suggested that social networks and participation may act as a preventative agent.

A framework for building strong inclusive communities was commissioned by Think Local Act Personal and Public Health England. The following graphic from that framework shows what Camden residents thought such a community would look like.[43]

[41] Knapp M et al. (2011). Building Community Capacity: Making an Economic Case. Personal Social Services Research Unit, London
School of Economics and Political Science [Online]. Available from: www.thinklocalactpersonal.org.uk/_library/BCC/Making_an_economic_case_doc.pdf

[42] Fisher, B. et al (2011). Empowering Communities for Health: Business Case and Practice Framework. Health Empowerment
Leverage Project [Online]. Available from:
http://www.thinklocalactpersonal.org.uk/_library/BCC/HELP_cost_savings_report_report_Nov_2011.pdf

[43] PHE & TLAP, Developing the Power of Strong, Inclusive, Communities, 2014, Available at: http://www.thinklocalactpersonal.org.uk/_library/Resources/BCC/Report/TLAP_Developing_the_Power_Brochure_FINAL.pdf

Another study showed the role that churches can play in this context. Helping people to build relationships and have mutual support for each other was a strong focus of their work in supporting communities. Activities highlighted included providing a space for people to interact with each other, such as activity groups and lunch clubs. This gave people somewhere to socialise, build social relationships, and particularly in older adults, helped to reduce loneliness or social isolation.[44]

A recent report by the Kings Fund also stresses the ability of strong community social networks to have a significant impact on health. The report places particular emphasis on the important role that District Councils can play here[45].

Summaries of good practice in addressing loneliness and social isolation

Two resources provide guidance on factors that need to be taken into account in the UK by those attempting to reduce loneliness and social isolation.

The Campaign to End Loneliness has created an online resource that provides adult social care, clinical commissioning groups and public health teams guidance on planning how to address the loneliness experienced by older people in their local populations[4647]

A recent evidence review for Age UK[48]. contained a number of recommendations for effective initiatives. These are summarised here:

- they must involve older people at every stage, including planning, development, delivery and assessment
- Even where schemes use considerable resources to overcome physical isolation of potentially lonely hard-to-reach groups, participation is often very low.
- Befriending schemes have proved one of the more effective services for combating both isolation and loneliness, but they are best used in conjunction with other services.
- Group activities are particularly useful in helping older people out of loneliness and isolation.
- The title 'befriending' is unhelpful for a specific service, as it covers several types of intervention and means different things to different people.
- Schemes should be tailored to the needs of a group or area.
- Because loneliness has complex causes, schemes designed to address a group or individual's loneliness need to take their other circumstances into account.
- Interventions not specifically targeted at combating isolation and loneliness can still have a tangible positive effect on them.

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[44] Bickley, P. 2014. 'Good Neighbours: How Churches Help Communities Flourish' Available at: http://www.cuf.org.uk/sites/default/files/PDFs/Research/Good%20Neighbours%20Report-CUF-Theos-2014.pdf

[45] Buck D & Dunn P, 2015, The district council contribution to public health: a time of challenge and opportunity, The Kings Fund, available at http://www.kingsfund.org.uk/publications/articles/district-council-contribution-public-health

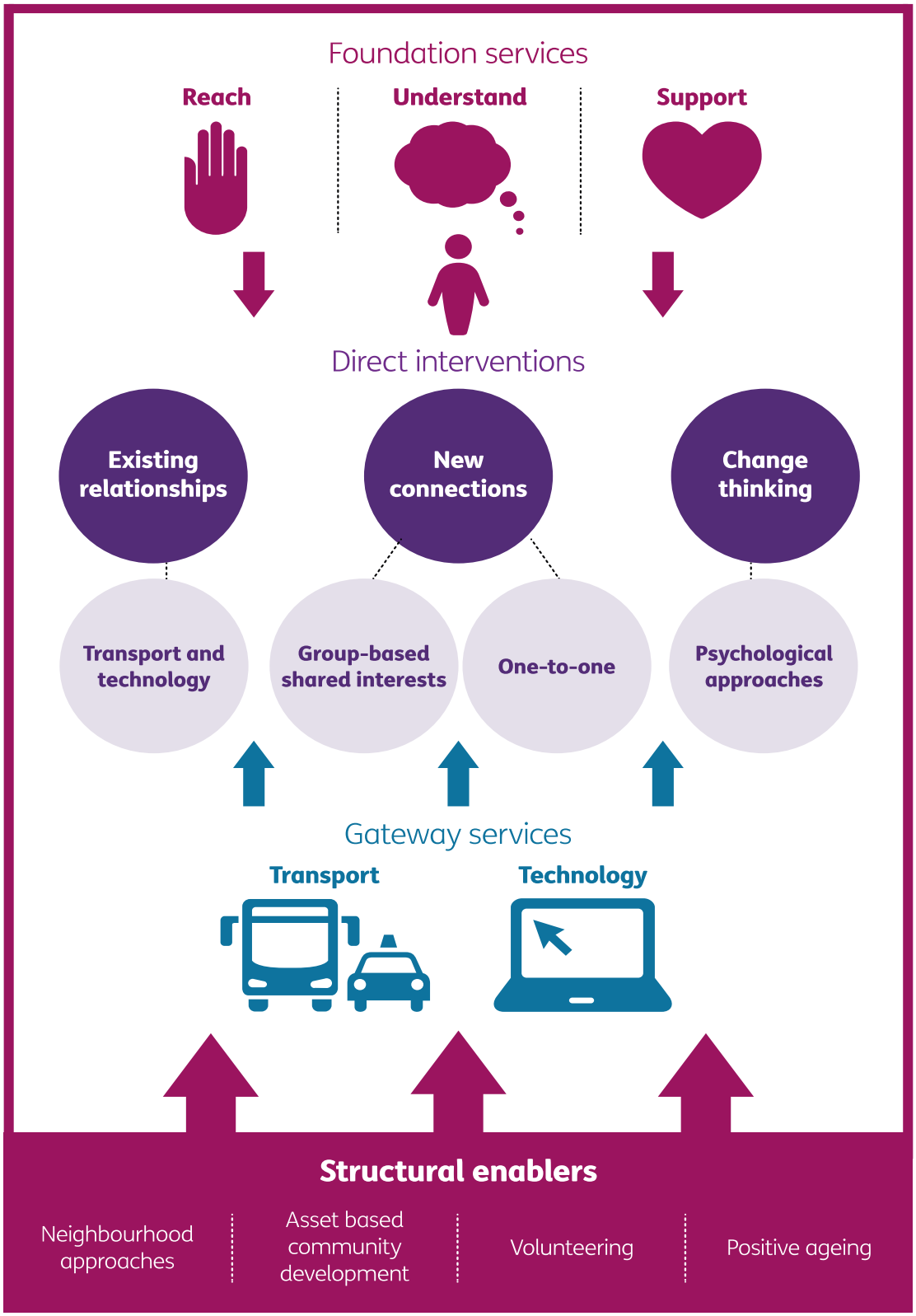
[46] http://campaigntoendloneliness.org/guidance/

[47] Jopling, K. 2015. Promising approaches to reducing loneliness and isolation in later life http://www.campaigntoendloneliness.org/wp-content/uploads/Promising-approaches-to-reducing-loneliness-and-isolation-in-later-life.pdf

[48] Age UK, 2010, Available at: http://www.ageuk.org.uk/documents/en-gb/for-professionals/evidence_review_loneliness_and_isolation.pdf?dtrk=true

- Intergenerational contact is probably more effective in combating loneliness than contact with one's own age group, although both have proven successful.
- Identifying people at risk of loneliness can be difficult, but targeting those disproportionately affected by loneliness – lower socio-economic groups, the widowed, the physically isolated, people who have recently stopped driving, those with sensory impairment and the very old – has proven most effective.
- People who have enjoyed friendship and companionship are more likely to be lonely than those who have never had close ties.
- The loss of a service which has had success at alleviating loneliness is worse than never having had the service at all. This also applies to patchy and unreliable services.
- Many schemes cannot yet be proven to be successful, even though it has been assumed that they have. Measurement of effectiveness should be built in to the design of any new project.
- Need for transport

Finally, the review includes the following graphic showing a framework for effective interventions to address loneliness and social isolation.


Foundation services
Reach
Understand
Support
Direct interventions
Existing relationships
New connections
Change thinking
Transport and technology
Group-based shared interests
One-to-one
Psychological approaches
Gateway services
Transport
Technology
Structural enablers
Neighbourhood approaches
Asset based community development
Volunteering
Positive ageing

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Gloucestershire Rural Community Council

Gloucestershire CCG

Gloucestershire Care Services

Carers Gloucestershire

Age UK