Loneliness and Social Isolation in Solihull

"Social isolation and loneliness is a major public health issue, associated with higher risks of mortality and morbidity. But people can 'recover' from loneliness, meaning that there is scope for interventions to improve social connections"[1] *(Public Health England)*

Introduction

The negative impact of social isolation and loneliness on health, wellbeing and subsequent demand for statutory services is increasingly being recognised; it has been estimated that lacking social connections is as damaging to health as smoking 15 cigarettes a day.[2]

The appreciation and understanding of social isolation and loneliness as a serious risk factor influencing health and wellbeing in all ages is in its relative infancy when compared to other risk factors such as obesity and smoking. Additionally, with the potential to affect all ages, tackling the issue of social isolation and loneliness can present challenges. However, there is increasing evidence that interventions can be beneficial and that loneliness can be 'cured'- there are large potential health and financial gains if levels of social isolation and loneliness are reduced and campaigns for local authorities and other organisations to tackle the issue are rapidly gathering momentum.

What are Social Isolation and Loneliness

Although they can coexist, social isolation and loneliness are different concepts:

Social Isolation

The inadequate quality and quantity of social relations with other people at the different levels where human interaction takes place (individual, group, community and the larger social environment).[3]

Loneliness

An emotional perception that can be experienced by individuals regardless of the breadth of their social networks.[3]

(Public Health England (PHE))

It is important to be aware that loneliness can occur without objective social isolation and that being socially isolated does not necessarily lead to loneliness. However, it is acknowledged that the distinction between the two with regards to the impact on health and relative effectiveness of interventions is still lacking (PHE) and it is important to address both.[3]

For some, particularly social isolation may be a personal preference for solitude that should be respected.

National and Local Recognition

There has been increased recognition nationally and locally, including by government and voluntary organisations of the importance of addressing social isolation and loneliness:

Nationally:

- The Care Act 2014[4]

- National Institute for Health and Care Excellence (NICE)[5-7]
- The Marmot Review[8]
- The Campaign to End Loneliness[9]
- Jo Cox Commission on Loneliness[10]

Locally:

- Health and Wellbeing Strategy (2016-2019)- Priority 3, Ageing well[11]
- Solihull Public Health Three Year Strategy- Ageing Well[12]

WHO IS AT RISK?

Loneliness and isolation can affect anyone at any age and impacts upon all socio-demographic groups. However, certain factors are known to increase the risk of isolation and loneliness[3,13-15]. These include:

- Living alone
- Increased deprivation
- Having caring responsibilities
- Being from an ethnic minority community
- Being gay or lesbian
- Poor physical and mental health, including disabilities and sensory impairment
- Being aged over 75
- Experiencing bullying
- Homelessness
- Being a refugee or migrant

Specific life events including bereavement, separation, the birth of a child, retirement and moving away from home can act as a trigger for a loss of social connections.[3]

WHAT ARE THE IMPACTS?

Health and Wellbeing

Social isolation and loneliness:

- Are associated with an increased risk of early mortality- *'lacking social connections is as damaging to health as smoking 15 cigarettes a day.'*[2]
- Have been shown to increase the risk of a range of conditions including coronary heart disease, stroke, dementia, depression and anxiety.[16-23]
- Can negatively impact an individual's quality of life and wellbeing.[24]

Evidence suggests that the costs to society of social Isolation and loneliness are significant:

It has been estimated that older people who are lonely are[19]:

- 1.8 times more likely to visit their GP
- 1.6 times more likely to visit A&E
- 1.3 times more likely to have emergency admissions
- 3.5 times more likely to enter local authority-funded residential care

How to Measure Social Isolation and Loneliness

A number of general wellbeing measurement tools include some assessment of social connectedness or loneliness, for example the Warwick-Edinburgh Mental Well-being scale and Outcomes Star.[25,26] However, the reliability of such 'single item questions' as an assessment of specifically isolation or loneliness has not been determined.[27] Measurement utilising a validated measurement tool is therefore important to assess prevalence in the borough and monitor the impact of services on levels of social isolation and loneliness as part of the performance monitoring and evaluation process.

The difference between social isolation and loneliness mean separate measurement tools are required.

Loneliness

Measurement tools tested for validity and reliability in adults include[27]:

- **The De Jong Gierveld Loneliness Scale**
- **The UCLA Loneliness Scale**

Social Isolation

Specific tools and questions include:

- **The Lubben Social Network Scale – 6 (LSNS-6)**
- Questions assessing levels of social interaction can be used, for example frequency of contact with others or support available if help was required.

Prevalence

Due to the subjective nature of social isolation and particularly loneliness, assessing the prevalence both nationally and locally can be challenging and intelligence, particularly at a local level is relatively limited.

The main nationally available indicator for social isolation and loneliness are two indicators from the Public Health England Outcome Framework[29]:

Indicator	Solihull (15/16)	England (15/16)
% of adult social care users who have as much social contact as they would like according to the Adult Social Care Users Survey	46.3%	45.4%
The percentage of adult carers who have as much social contact at they would like according to the Personal Social Services Carers survey	36.8%	38.5%

Applying national statistics to Solihull, in the over 65 population, an estimated[31]:

- 9,000 people are mildly lonely
- 4,000 people are intensely lonely
- 4,000 people say they feel cut off from society
- 5000 people feel trapped in their own home

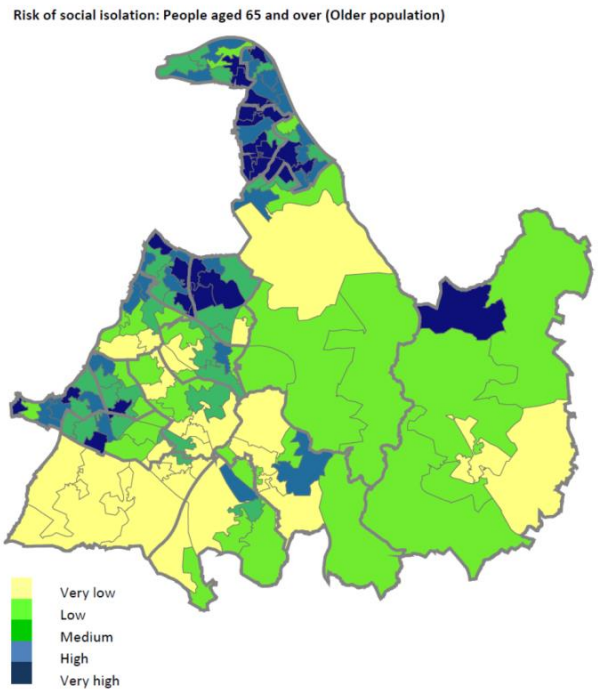
In the adult population (aged 16-64) an estimated[24]:

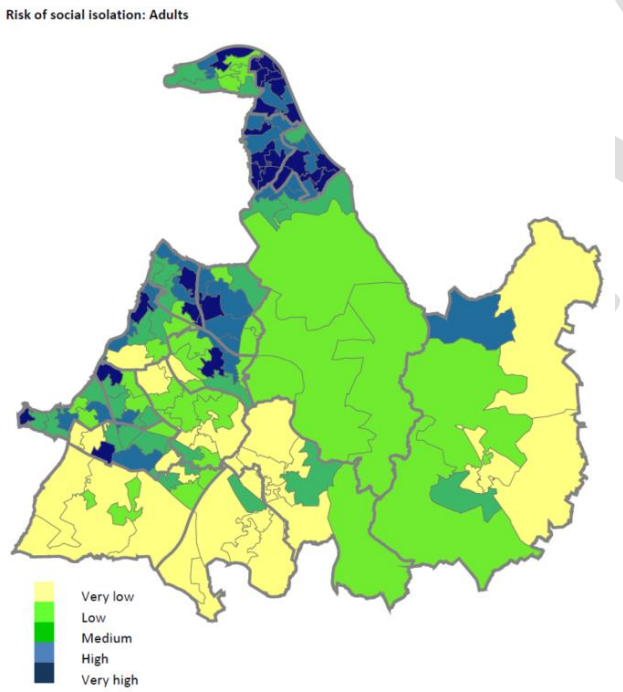
- 18,748 people are experiencing high levels of loneliness

In those aged 16-24, an estimated 32% report feeling 'always' or 'often' lonely, equating to 6594 people in Solihull in this age group[33].

To support the identification of high risk areas for social isolation and loneliness in the borough, two maps have been created showing composite scores for social isolation constructed from readily available data sources. One index applies to people aged 65 and over and the other is for adults. The indicators used for each were

selected to measure several risk factors for social isolation.





Although the prevalence of social isolation and loneliness can be difficult to assess, particularly at a local level, the data collected nationally and the, albeit more limited data available locally indicate that a significant proportion of the population of Solihull at any one time may be experiencing loneliness or be socially isolated. Additionally, it may disproportionally affect the most vulnerable members of society, including the elderly, people with disabilities and the most deprived groups.

WHAT IS EFFECTIVE?

As acknowledged by Public Health England, people are able to 'recover' from loneliness and isolation can be reduced.[1] However, due to the subjective nature and multifactorial causes of isolation and loneliness, the type of support required is likely to vary greatly based on socio demographic factors, individual preference and circumstances.

Much focus is placed on the role of group and one-to-one interventions when looking to address isolation and loneliness and although still relatively limited, evidence does suggest that a range of group and one-to-one activities can be effective and bring good returns on investment.[1,3,19,34-37]

- **Group Interventions**- this encompasses a wide range of activities, including support groups, physical activity and arts and crafts.[7] The primary purpose of the group need not be to alleviate loneliness or isolation; those targeted at specific population groups, with a focus on a shared interest or educational purpose and organised by members of the community themselves, may be particularly effective at tackling loneliness.[34,39]

- **One-to-one Interventions**- the provision of a range of support to individuals

experiencing isolation and loneliness, often to access activities or make/maintain social connections.[35] This includes for example befriending..

There may be specific physical or psychological barriers that make it more difficult to make or maintain social connections. This includes for example a lack of appropriate transportation, levels of safety in the area, caring responsibilities, a physical disability or a psychological condition.[3,34] Therefore, whilst the provision of a range of group activities in an area is important and a number of individual's will require the additional support offered by a one-to-one intervention, social isolation and loneliness are multifaceted and cannot be resolved by one organisation or intervention alone; partnership working between the public, community, voluntary and private sectors is required.

Community

The important role of the community in exacerbating or being protective against loneliness and isolation is acknowledged; the more informal social connections in a community are very important. For some, simply being introduced to a neighbour and developing this relationship may be the preferred option over attending a specific group activity. A place based approach to tackling loneliness and isolation that harnesses the 'hidden wealth of communities' including the informal social networks and community assets is advocated, including efforts to strengthen and engage communities to 'galvanise and direct existing capacity'.[34,39,40] Volunteering is acknowledged as "both an enabler of effective loneliness interventions and a way of directly preventing and alleviating loneliness" and involving members of the community from the beginning, in the development, delivery and management of activities is important, particularly to promote sustainability.[3,34] Community events and activities are important and support should be provided to 'build up the community's confidence and capacity' and form or strengthen existing important social connections in communities that can then be maintained beyond external support.[39]

Reaching, Understanding and Supporting

Social isolation and particularly loneliness can be deeply personal experiences and those who are most affected are likely by the very nature of the condition and stigma attached to be potentially difficult to reach. However, one of the most important aspects of addressing social isolation and loneliness is ensuring those at risk are identified and supported appropriately.[34]

A range of methods are required to reach people who are potentially lonely or isolated and more simple measures such as knocking on people's doors have been shown to be effective.[39] 'Targeted pathways' including partnerships with GPs, social care and 'active outreach programmes to liaise with those already engaged with lonely individuals' for example housing associations can be effective; specific programmes can also be used, however these come at a cost.[19] Taking the time to understand the needs of those who are lonely and isolated is important, along with ensuring an appropriate level of support is offered; more intensive support provided by a specific service may be required by some individuals.[34]

WHAT NEXT IN SOLIHULL?

There is already a range of work aimed at reducing levels of loneliness and social isolation occurring in Solihull across Council directorates and other organisations. This includes the commissioning of specific services for example local area coordinators and social prescribing and a number of different community events and activities.

However, the appreciation and understanding of social isolation and loneliness as a serious risk factor influencing health and wellbeing in all ages is in its relative infancy when compared to other risk factors such as obesity and smoking. Although the overall aim is to reduce levels of social isolation and loneliness in all age groups across Solihull, a number of the more basic elements involved in addressing risk factors for health and wellbeing are in a relatively early stage in Solihull and other local authorities. This includes obtaining adequate intelligence (particularly prevalence data), awareness raising, training and monitoring, that form the foundation of managing and influencing risk factors.

Based on the available evidence and consultation with a range of stakeholders, a number of recommendations are made that provide some initial actions to begin tackling the issue of social isolation and loneliness in the borough. However, the issue is multifaceted and cannot be resolved by one organisation or intervention alone. Social isolation and loneliness form only one aspect of wellbeing and are recognized by PHE as a health inequality issue, with a link to social disadvantage and associated factors such as unemployment, the causes of which are complex.[3] Specific areas of focus identified include the development of stronger communities and promotion of volunteering opportunities. However, future work is likely to require multi-agency working through a focused steering group and as part of wider work streams, aiming to tackle a number of different elements of health, wellbeing and deprivation that will encompass social isolation and loneliness, through effective partnership working between the voluntary, public and private sectors.

"A strategic approach to preventing and reducing social isolation is required, which includes all local public services (social services, police, fire, health, education, welfare, transport and housing sectors) and local society (individuals, community and voluntary organisations, local businesses and enterprises). Practitioners from all these sectors can examine together how to effectively contribute to reduce and prevent social isolation."(PHE)[3]

The initial recommendations, including raising awareness of the issue, engagement with other Council directorates and the additional planned qualitative work, aim to contribute towards and lay the foundations for subsequent work to reduce social isolation and loneliness across Solihull.

KEY INITIAL RECOMMENDATIONS

- Raising **awareness** of the issue across the borough, including amongst Council employees and frontline staff.
- Increased **intelligence**, including prevalence data and qualitative work with members of the community, particularly those 'high risk' groups for isolation and loneliness.
- **Reaching** more people who are potentially lonely or social isolated through specific services and the development of training, both face-to-face and e-learning.
- Ensure that current and future **interventions** to tackle loneliness and social isolation are easy to access, assess levels using a validated measurement tool and are targeted appropriately to address gaps in provision and high risk groups.
- **Enable** more people to make and maintain social connections by addressing potential physical or psychological barriers.
- Recognize that loneliness and social isolation may be affecting a proportion of Solihull Council employees either in the workplace, their personal lives or both and ensure this is addressed appropriately as part of the overall **Council workplace wellbeing offer.**

Social Isolation and Loneliness in Solihull Full Report

Amy Phillips, Public Health Registrar

Contents

Introduction

The negative impact of social isolation and loneliness on health and wellbeing is increasingly being recognised; it has been estimated that lacking social connections is as damaging to health as smoking 15 cigarettes a day.[2] Along side this there has been increasing evidence of the potential resource use and costs to society associated; those who are lonely are more likely to visit their GP, attend Accident and Emergency and enter residential care.[19] This recognition at a national and local level has been reflected in the development of a number of national campaigns to reduce levels of loneliness and social isolation, including the Campaign to End Loneliness and the Jo Cox Commission on Loneliness, along with the inclusion of measures of social isolation in the Adult Social Care and Public Health Outcomes Frameworks.[8,9,29,30] The proportion of Health and Wellbeing strategies in local authorities that include isolation and loneliness has also increased; Solihull's Health and Wellbeing and Public Health strategies both include addressing social isolation and loneliness, particularly in the older population.

However, the appreciation and understanding of social isolation and loneliness as a serious risk factor influencing health and wellbeing in all ages is still in its relative infancy when compared to other risk factors such as obesity and smoking. Additionally, with the potential to affect all ages, tackling the issue of social isolation and loneliness can present challenges. However, there is increasing evidence that interventions can be beneficial and that people can 'recover' from loneliness and isolation- there are large potential health and financial gains if levels of social isolation and loneliness are reduced and campaigns for local authorities and other organisations to tackle the issue are rapidly gathering momentum.

This report aims to provide an overview of social isolation and loneliness in Solihull, including the prevalence, measurement, current interventions along with potential gaps and a set of initial recommendations for future actions.

Social Isolation and Loneliness

Despite often being combined together, social isolation and loneliness are different concepts. Social isolation is more of an objective state, defined by the number of social connections and contacts a person has, whereas loneliness is more subjective and is a perceived lack of relationships- it can be a deeply personal experience.

Definitions provided by Public Health England (PHE) include:

Social isolation

The inadequate quality and quantity of social relations with other people at the different levels where human interaction takes place (individual, group, community and the larger social environment).[3]

Loneliness

An emotional perception that can be experienced by individuals regardless of the breadth of their social networks.[3]

Source: PHE Reducing Social Isolation Across the Lifecourse[3]

It is important to acknowledge that loneliness can occur without objective social isolation and that being socially isolated does not necessarily lead to loneliness. However, they can often coexist and as acknowledged by PHE the distinction between the two with regards to the impact on health and relative effectiveness of interventions is still lacking.[3] Additionally, reducing an individual's level of social isolation may lead to a reduction in loneliness.[38] It is therefore advised that they should both be recognized and addressed.[3] It should be acknowledged particularly when focusing on social isolation that having fewer social connections and seeking solitude may for some be personal preference and it is important not to make assumptions that everyone who is isolated must be lonely and requires support.
In view of the lack of available evidence separating the causes and interventions for social isolation and loneliness they will largely be grouped together within this report. The exception is when measuring prevalence or monitoring outcomes of services, as the validated measurement tools used for social isolation and loneliness are different.

Impacts of Social Isolation and Loneliness

Health and Wellbeing

Studies demonstrating the negative impact of both social isolation and loneliness on the population's health and wellbeing have increased in recent years. Evidence suggests that social isolation and loneliness are associated with an increased risk of early mortality; it has been estimated that the impact on mortality is equivalent to other known risk factors, for example smoking.[2,35,42] The Marmot Review described the impact- "individuals who are socially isolated are between two and five times more likely than those who have strong social ties to die prematurely."[8]

Links with specific diseases have also been made; social isolation and loneliness have been shown to increase the risk of coronary heart disease, stroke, high blood pressure and dementia.[16-19]

The impacts on mental health have been shown to be significant, including increased levels of depression and anxiety associated with being socially isolated and lonely.[19-23] A report by Nesta in which some of the impacts of loneliness were estimated found that those older people who are lonely are 3.4 times more likely to suffer from depression compared to those older people who are never lonely.[19]

As acknowledged by the social care institute for excellence (SCIE), social isolation and loneliness can also have a negative impact on quality of life and wellbeing.[35] A survey by the Office for National Statistics (ONS) found those who reported being lonely were more likely to report low life satisfaction and levels of happiness.[24]

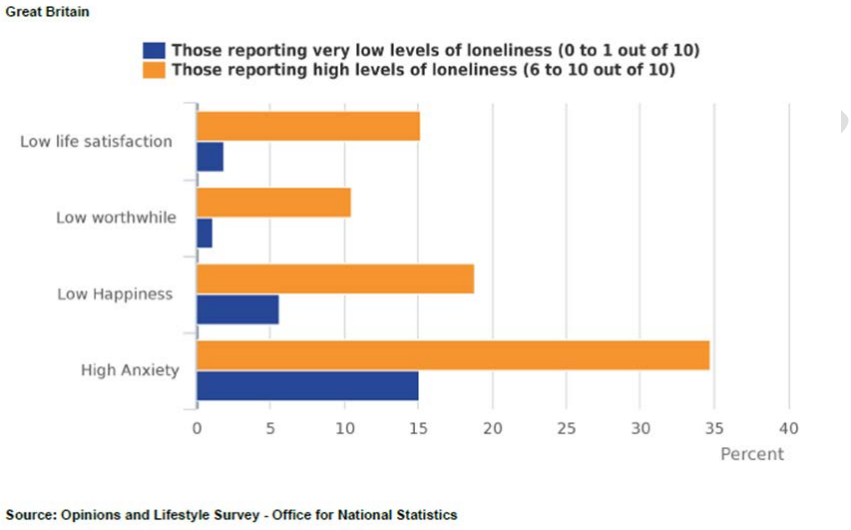


Figure 1: Source:Office for National Statistics[24]. Office for National Statistics Personal Well-being by Loneliness, all adults aged 16 and over, 2014-2015.

PHE have suggested four possible pathways through which social connections and relationships can influence and improve an individual's health[3]:

- providing individuals with a sense of belonging and identity
- providing material support or increasing knowledge about how to access material needs and services
- influencing the behaviour of individuals, for example through support or influence from family or friends to quit smoking, reduce alcohol intake, or to access health care when needed
- providing social support that enables individuals to cope with stressors such as pressures at school or work, redundancy, retirement or the death of a close relative

Source: PHE Reducing Social Isolation Across the Lifecourse[3]

Society

Isolation and loneliness can result in higher social and health care use and evidence suggests those who are isolated or lonely are at increased risk of early residential care admission.[35] A report published by Nesta estimated that older people who are lonely compared to those who are never lonely are:

- 1.8 times more likely to visit their GP
- 1.6 times more likely to visit A&E
- 1.3 times more likely to have emergency admissions
- 3.5 times more likely to enter local authority-funded residential care

Source: Investing to Tackle Loneliness, A Discussion Paper[19]

This report also estimated that 'chronic loneliness may cost commissioners £12,000 per person, of which approximately 40% occurs within five years (GP visits, A&E visits, hospital admissions, residential care, some costs associated with depression and diabetes)'.[19]
There is evidence that reducing levels of social isolation and loneliness can increase an individual's level of independence and lead to a reduced demand for statutory services, including GP's, A &E and residential care, particularly in the older population resulting in considerable savings by reducing the use of more intensive services.[19,35,43]
Reducing levels of social isolation and loneliness can not only have a positive impact on the individual and reduce demand for statutory services, but actions to reduce loneliness and isolation can also result in a potential 'harnessing' of contribution to society, by for example an increase in volunteering and social engagement.[35]

National and Local Recognition

Nationally

There has been increased recognition nationally, including by government and voluntary organisations of the importance of addressing social isolation and loneliness. In 2010, the Marmot Review (Fair Society, Healthy Lives) included as a priority objective to "reduce social isolation across the social gradient."[8] The Care Act 2014 included a reduction in social isolation and loneliness as part of primary prevention and promotion of wellbeing in order to reduce the need for care and support in the future.[4] Similarly, the Better Care Fund aims to join up social and health care and to promote self care and independence in the community – a report by The Kings Fund on 'Making Best Use of the Better Care Fund'

includes “preventing social isolation and loneliness to help to maintain independence” as part of primary prevention.[44,45]

Acknowledging the relevance of social isolation and loneliness and impact on health and wellbeing, a measure is now included as an indicator in the Public Health Outcomes Framework and Adult Social Care Outcomes Framework to assess levels of social isolation in users of social care and carers.[29,30]

This increased recognition and evidence of the health risks associated with social isolation and loneliness has also been reflected in the development of a number of national campaigns to reduce levels, including the Campaign to End Loneliness and the Jo Cox Commission on Loneliness.[8,9] A number of private companies and voluntary organisations have also become involved; the Co-operative are working with the Red Cross to research the issue and fund new services.[46]

In 2013, at the National Children and Adults Services (NCAS) conference, the health secretary Jeremy Hunt gave a speech to delegates in which he discussed some of the work by the Campaign to End Loneliness and “flagged loneliness as a critical issue affecting older people”, calling for action.[47]

An increasing number of Health and Wellbeing boards around the country are including social isolation and loneliness in their strategies. A study undertaken by the Campaign to End Loneliness over 2013 reviewing the inclusion of this area in different strategies in the UK, found that over half of strategies mentioned social isolation and loneliness as a serious issue, and the proportion of strategies not recognizing it had fallen throughout 2013.[48]

The importance of addressing social isolation and loneliness specifically in the older population, is included in a range of recent guidance by the National Institute for Health and Care Excellence (NICE).[5-7] This includes guidance on people coming into contact with potentially lonely or isolated individuals and the provision of appropriate interventions.

Locally

In line with the changes nationally, two key strategies from Solihull Council include social isolation and loneliness, particularly in the older population:

The health and wellbeing strategy (2016-2019) – Reducing social isolation is included Under Priority 3 (Ageing well – healthy older life); *“Through working together with local communities, we seek to create environments where people are not isolated or lonely, and have appropriate tools and support to enhance their emotional wellbeing.”*[11]

Solihull Public Health Three Year Strategy - Under the priority 'People will live longer and have healthier lives' social isolation and loneliness are recognized as a risk factor for premature mortality. In the Ageing Well section, '*reducing social isolation and loneliness through asset based approaches to community development and volunteering'* is a strategic priority and to '*Develop volunteering to support older people and reduce social isolation'* is a commissioning intention for 2017/18.[12]

Prevalence

Much of the research in this area is focused on the older population and public perception often associates loneliness and isolation to older age. However, although increasing age is a risk factor, both can affect all age-groups, including children.[33,49]

Due to the subjective nature of social isolation and particularly loneliness, assessing the prevalence both nationally and locally can be challenging. The majority of national data currently comes from a range of different surveys conducted across the country from the general population and specific population groups, providing an indication of the likely prevalence and potential levels of need in particular groups. The Campaign to End Loneliness advise using a range of different sources and methods to gain insight into the local loneliness prevalence, including the prevalence of risk factors, applying national estimates and utilising locally conducted surveys.[40]

Evidence suggests a potentially high level of stigma attached to feeling lonely or socially isolated.[33,49] As particularly loneliness is a deeply personal experience, this stigma can create further issues with assessing prevalence. It may also make it more difficult for the subject to be raised for example by front line staff coming into contact with those people who are isolated and lonely, potentially resulting in fewer people getting the support they require.

Risk Factors

The prevalence of some risk factors can be utilized to assess potential need and the location of 'high risk' groups in the borough. The prevalence of risk factors has been utilised by a number of areas and by AgeUK in mapping exercises.

Increasing age is a risk factor for loneliness and social isolation.[38] The Campaign to End Loneliness have identified a group of risk factors in the older population for loneliness and social isolation. Although these risk factors were compiled for those over 75 years, the

majority including poor health, sensory impairment, having caring responsibilities, living alone and bereavement can apply to all age-groups.

Personal circumstances:

- Living alone
- Being single, divorced, never married
- Living on a low income
- Living in residential care

Transitions:

- Bereavement
- Becoming a carer or giving up caring
- Retirement

Personal characteristics:

- Aged 75 plus
- From an ethnic minority community
- Being gay or lesbian

Health and disability:

- Poor health
- Immobility
- Cognitive impairment
- Sensory impairment
- Dual sensory impairment

Geography i.e. living in an area:

- With high levels of material deprivation
- In which crime is an issue

Source: Campaign to End Loneliness Risk Factors [13]

Other key 'high risk' groups for all ages identified include refugees, migrants and people who are homeless.[14,15]

A survey by the ONS of the over 16 UK population found a number of key risk factors in the adult population (figure 2).[24] One in five people renting from the local authority or housing association and one in three people in 'very bad or bad health' reported high levels of loneliness.[24]

Great Britain			Percentages
			Those reporting
	Very low levels of loneliness	Low to medium levels of loneliness	High levels of loneliness
Daily risk factors			
Tenure			
Owns outright	59.4	25.3	15.3
Owns mortgage	61.7	26.6	11.7
Rents LA/HA	44.7	33.5	21.8
Rents privately	50.5	32.6	16.9
Living alone			
Living alone	31.9	37.3	30.8
Not living alone	60.7	26.7	12.6
Marital status			
Married, remarried or in a legal partnership	67.4	23.0	9.6
Single	40.3	37.9	21.8
Separated or divorced	36.4	36.6	27.0
Widowed	30.8	34.5	34.7
Self reported health			
Very good or good health	59.9	27.1	13.0
Fair health	44.7	34.1	21.1
Very bad or bad health	34.4	30.8	34.7
Total	56.2	28.4	15.4

Source: Opinions and Lifestyle Survey (OPN) - Office for National Statistics

Notes:

1. LA - local authority; HA – housing association

Figure 2: Source:Office for National Statistics[24] Proportion of people who report feeling lonely in their daily life by risk factors, all adults aged 16 and over, 2014-2015

A recent key document by PHE focusing on reducing social isolation takes a 'life course approach' when reviewing the risk factors and potential interventions.[3] It is acknowledged that social isolation and loneliness are influenced by a range of different factors, operating at an individual, community and societal level.[3] There are a number of key events throughout the life course that can increase an individual's risk of isolation and loneliness, including ill health, the birth of a child, the death of a loved one or caring responsibilities.[3]

Loneliness and isolation in one stage of life, for example in childhood can increase the risk of both in subsequent life stages and the effects can be cumulative.[3] Therefore tackling isolation and loneliness in children and young people is important. Key risk factors identified for this age group include being a young carer, not being in education or employment, being bullied or adverse childhood experiences for example abuse.[3]

Key risk factors throughout the life course include:

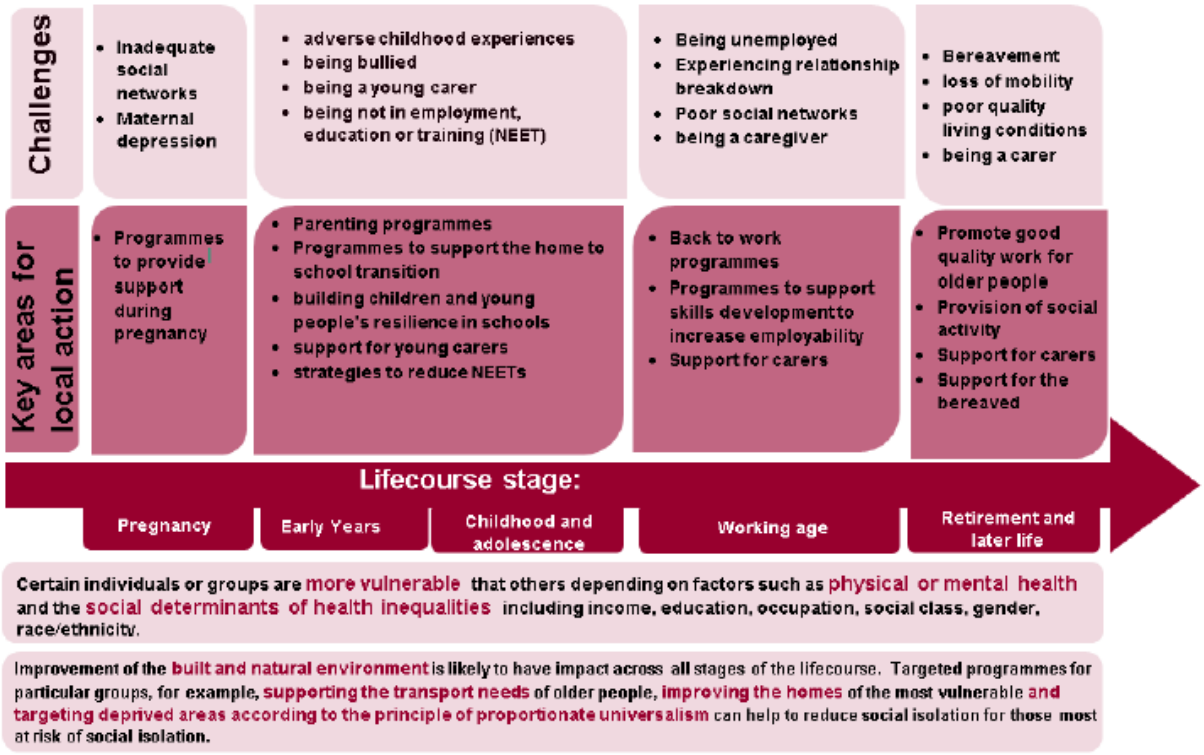


Figure 3: Source: PHE, Reducing social isolation across the Lifecourse[3]. Impact of social isolation across the lifecourse

As described in figure 3, alongside individual factors including personal resilience and health, community factors are also important; the built and natural environment and transport have a potentially important impact on an individual's level of social isolation and loneliness. This includes having adequate access to facilities such as community centres, convenient transport links for example a reliable bus service and a safe environment that encourages people to leave their houses including well-lit streets and open spaces.[3] Societal factors also have a role to play, including welfare reform, pension changes and the influence of the media.[3]

PHE identify a link between social isolation and health inequalities; there is a link between the risk factors for social isolation and social disadvantage.

> *"Social disadvantage is linked to many of the life experiences that increase risk of social isolation, including poor maternal health, teenage pregnancy, unemployment, and illness in later life. In addition, deprived areas often lack adequate provision of good quality green and public spaces, creating barriers to social engagement."*[3]

Safeguarding

As acknowledged by the Social Care Institute for Excellence (SCIE), particularly social isolation can be both a potential indicator of abuse, including domestic abuse and a form of psychological and emotional abuse if the isolation is enforced.[50] An appreciation of this potential association with various forms of abuse is important when looking to address the issue through raising awareness, training and the offer of support.

Solihull Population

Loneliness and social isolation can affect all ages and socio demographic groups and is therefore an important issue to tackle in all local authorities. However, in view of these specific risk factors, there are a number of features of Solihull that make tackling isolation and loneliness a particular priority:

- The population of Solihull is generally older than England overall; 21% of the Solihull population are 65 and over and 3.1% are aged 85 and over, compared to 18% and 2.4% respectively in England.[51] Additionally, the population of Solihull is continuing to age relatively rapidly, by 2036 it is estimated that 6% of the population will be aged 85 and over.[51] Long term conditions (such as heart disease, chest disease, cancer, mental health, dementia) are more common in older age and an ageing population will increase the demand on health and care services and is likely to lead to an increased number of people living alone in the borough. It is projected that there will almost 14,000 people aged 75 and over living alone in Solihull over the 10 years.[51] There is predicted to be an increase in the number of single person households in the borough in general, by a projected 25% (6412 households) by 2039.[52]

- There are currently an estimated 24,000 carers in Solihull, a figure that is expected to increase between 2011 and 2021 by approximately 17%.[51]

- The population of Solihull is become increasingly diverse, almost 11% of the population now belong to Black, Asian and Minority Ethnic (BAME) groups.[51]

- Although Solihull overall is relatively less deprived compared to other Local Authorities, it is a 'relatively polarised borough; compared with other Local Authorities in England a relatively high proportion of LSOAs are in the most deprived 10% in the country' and 'one in six children are living in relative poverty'.[51,52] Health inequalities also exist in Solihull and the so called 'gap in life expectancy' between the least and most deprived groups is larger in Solihull compared to England overall.

As acknowledged by PHE, social disadvantage is linked to many of the risk factors for social isolation and loneliness.[3]

National Prevalence

PHE and the Office for National Statistics (ONS) have relatively recently attempted to assess the national prevalence of social isolation and loneliness.

The ONS survey utilized the findings of the Opinions and Lifestyle Survey and Wellbeing Survey in 2015 to assess the potential prevalence of loneliness in the UK and its impact on wellbeing.[24] Almost 3 out of 10 people aged over 80 and almost 1 in 6 people of working age reported high levels of loneliness.[24]

Proportion of people who report feeling lonely in their daily life by age group, 2014 to 2015 (Great Britain)

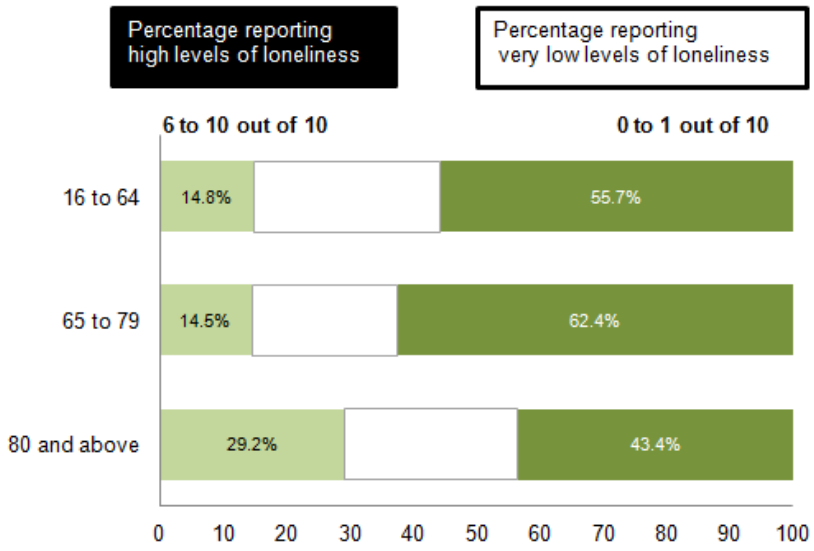


Figure 4: Source: Opinions and Lifestyle Survey - Office for National Statistics.[24] Proportion of people who report feeling lonely in their daily life by age group,2014-2015 (Great Britain)

There are now two indicators of social isolation in the Public Health England Outcome framework available, that are based on responses from one question in the Adult Social Care Survey and one from the Personal Social Services Survey of Adult Carers on satisfaction with the level of social contact.[29] Although these measures are based on two specific population groups (carers and social care users) they do provide an indicator in two potentially 'at risk' groups and enable benchmarking against other areas.

PHE Outcome Measure	England 14/15 (%)
1.18i - Social Isolation: percentage of adult social care users who have as much social contact as they would like (15/16)	**45.4**
1.18ii - Social Isolation: percentage of adult carers who have as much social contact as they would like (14/15)	**38.5**

Figure 5: Public Health England Outcomes Framework measures of Social Isolation[29]

As indicated by figure 5, in England, over half of adult social care users and adult carers are not satisfied with their levels of social contact.[29]

The Cooperative and Red Cross partnership researching social isolation and loneliness undertook a representative general adult public survey; almost one in five people (18%) of those questioned reported feeling lonely 'always' or 'often' and around half reported feeling lonely 'sometimes' or more often.[33] Interestingly, this survey found that certain population groups had a higher percentage of people reporting feeling lonely 'always' or 'often' including "those who were recently divorced or separated (33%); with a long-term physical / mental health condition (32%); people with mobility issues (30%); people with limited access to transport (29%); people experiencing bereavement in the last two years (19%); and parents of young children (32%)."[33]

Surveys

The prevalence of loneliness and social isolation in specific population groups, including carers and the older population has also been estimated, predominantly through the use of surveys. The Campaign to End Loneliness have compiled the findings of a number of surveys to provide estimates for the prevalence of loneliness within the UK amongst the older population:[31]

- **20 per cent** of the older population is mildly lonely and another **8–10 per cent** is intensely lonely.
- **17 per cent** of older people are in contact with family, friends and neighbours less than once a week, and 11 per cent are in contact less than once a month.
- **12 per cent** of older people feel trapped in their own home.
- **6 per cent** of older people leave their house once a week or less.
- **Nearly 200,000** older people in the UK don't get help to get out of their house or flat.
- **9 per cent** of older people say they feel cut off from society.

Source: Campaign to End Loneliness[31]

A survey by Carers UK in 2017, that found 8 in 10 (81%) carers admitted feeling lonely or socially isolated as a result of their caring responsibilities, rising to almost 9 in 10 (89%) for young carers under 24 years old.[53] A survey by Action for Children found that of the 17-25 year olds who used their services, 43 per cent had experienced issues with loneliness.[10]

The charity Sense found almost one quarter (23%) of those people with a range of disabilities surveyed reported feeling 'quite or very lonely on a typical day'.[54(35)] A more recent report by Sense produced on behalf of the Jo Cox Commission on loneliness provides a number of estimates for loneliness and isolation in specific population groups based predominantly on a range of different surveys [55]:

- It is estimated that 'up 79 per cent of autistic people and 70 per cent of their families feel socially isolated'.[55]
- 30 per cent of people with mobility issues reported either always or often being lonely.[55]
- Over one third of people with dementia reported feeling lonely.[55]
- It is estimated that 22 per cent of those people with cancer are lonely.[55]
- 'A third of people living with HIV aged 50 and over are socially isolated, and 82 per cent of over 50s living with HIV experience moderate to high levels of loneliness'.[55]
- 18 per cent of those people aged 18-35 with a learning disability surveyed reported feeling 'alone and cut off from other people'. [55]
- 14 per cent of adults with a vision impairment reported that they 'never or rarely have as much social contact as they would like, and say they feel very or completely cut off from the people and things around them'.[55]

Although certain groups are at an increased risk of feeling lonely or isolated, evidence suggests that loneliness and isolation affects the majority of people at some point in their lives. A survey of adults carried out by the Mental Health Foundation found that only 22% of those people surveyed reported never feeling lonely.[49]

Local Prevalence

Social isolation and loneliness can be difficult to assess at a local level and obtaining ward level data can be particularly challenging. The main indicator that is reported regularly by all local authorities is the Public Health Outcomes Framework described.

PHE Outcome Measure

In Solihull 36.8% of adult carers and 46.3% of adult social care users report having as much social contact as they would like.[29] This indicator allows benchmarking against other areas in England and allows trends to be assessed. As indicated by figure 6 and 7, Solihull has the lowest percentage of adult carers who have as much social contact as they would like when compared to England overall and Solihull's statistical neighbours. However, the percentage of adult social care users who have as much social contact as they would like in Solihull is slightly higher than both England and a number of the statistical neighbours; as indicated by figure 8, the proportion of social care users having the social contact they would like has increased since 2010/11, from 38.9% to 46.3% in 2015/16.

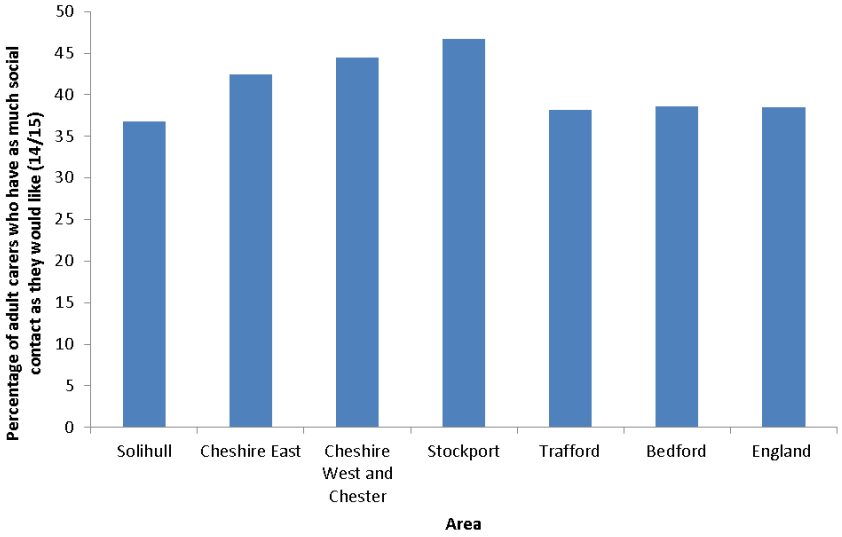


Figure 6: Percentage of adult carers who have as much social contact as they would like (14/15)

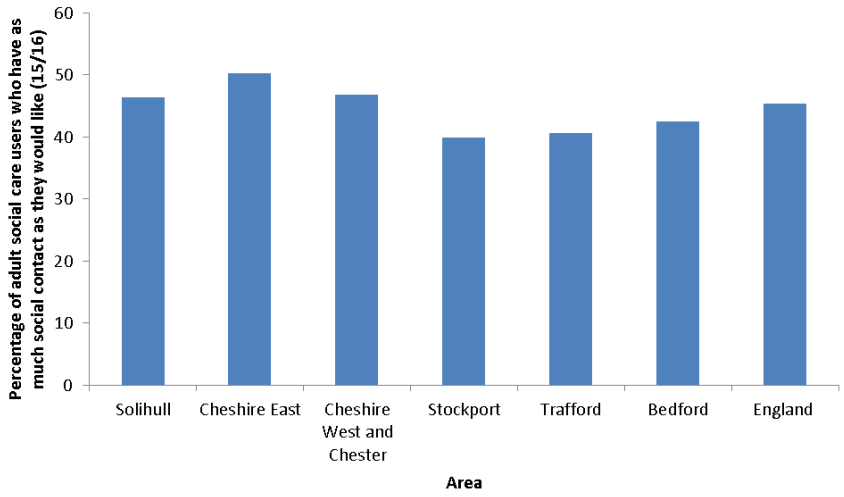


Figure 7: Percentage of adult social care users who have as much social contact as they would like (15/16)

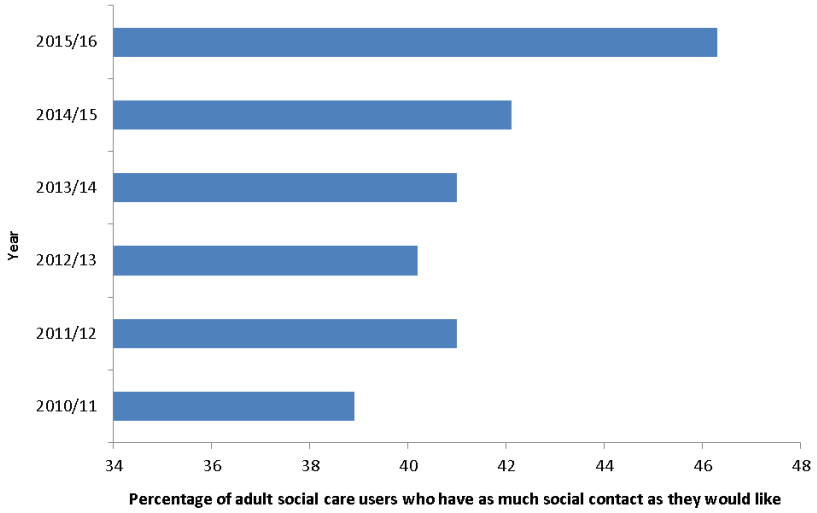


Figure 8: Percentage of adult social dare users who have as much social contact as they would like (2010-2016)

Local Surveys

The main assessment of loneliness and social isolation in Solihull has been through the Place Survey conducted in 2016, which assessed social isolation more than loneliness. Although the survey sample was relatively small (710 respondents), it does include all adults and demonstrates some geographical variations across the borough, particularly between the North and South; almost one in ten respondents in the North of the borough meet socially with friends, relatives or work colleagues less than once a month. In rural Solihull 1% know no people on their street by name, compared to 8% of respondents in the North.

	How often do you meet socially with friends, relatives, or work colleagues?			
	Several times a month	Once or twice a month	Less than once a month	Never
North Solihull	61%	25%	9%	4%
Urban West	71%	18%	7%	4%
Rural	66%	28%	4%	3%
Solihull	67%	22%	7%	4%

Figure 9: Solihull Place Survey, How often do you meet socially with friends, relatives or work colleagues?

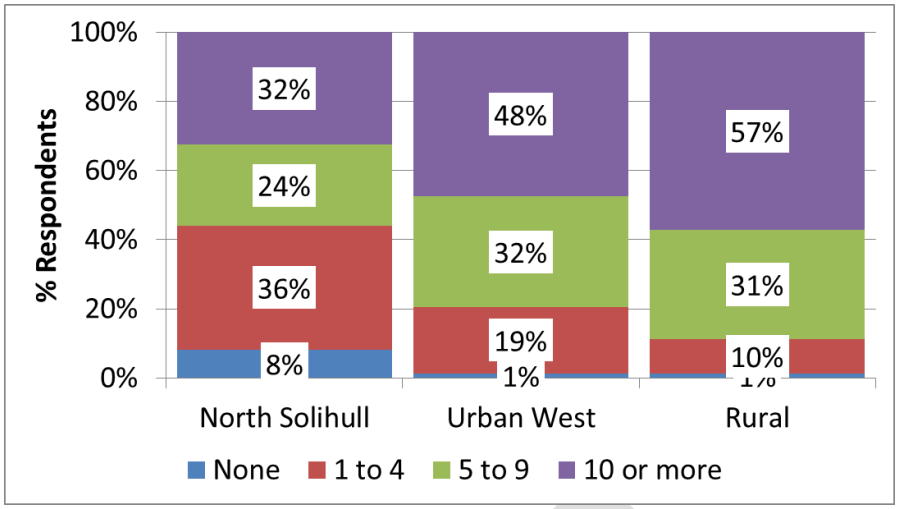


Figure 10: Solihull Place Survey, How many people on your street (or in your immediate neighbourhood) would you say you know by name?

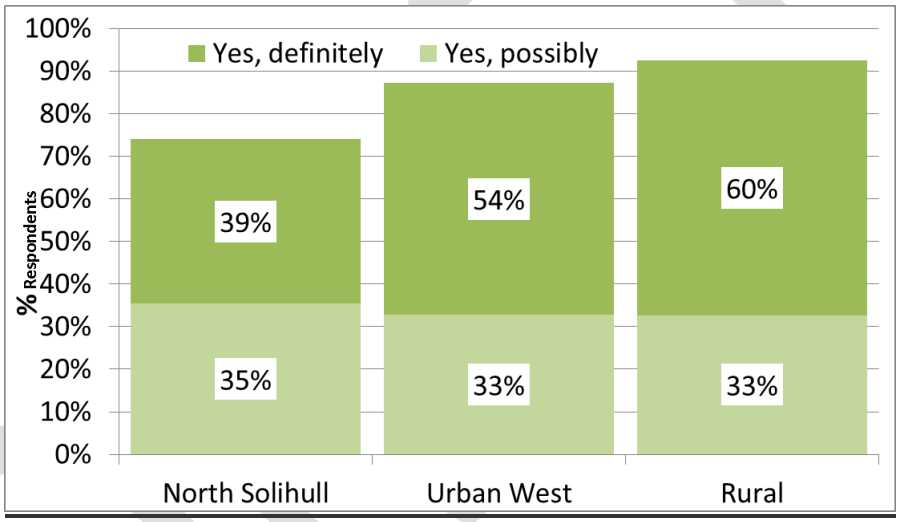


Figure 11: Solihull Place Survey, A Neighbour Would Provide Practical Help if you Fell Ill

Much of the additional information available in the borough on the likely prevalence is based on the use of potential risk factors for social isolation and loneliness.

Heat Map

Age UK have produced a 'heat map' that estimates the relative risk of loneliness in the over 65 population in different parts of England, including Solihull. This estimate is based on a number of risk factors for loneliness including age, household size, self-reported health status and marital status and uses data from the English Longitudinal Study of Ageing (ELSA).[56]

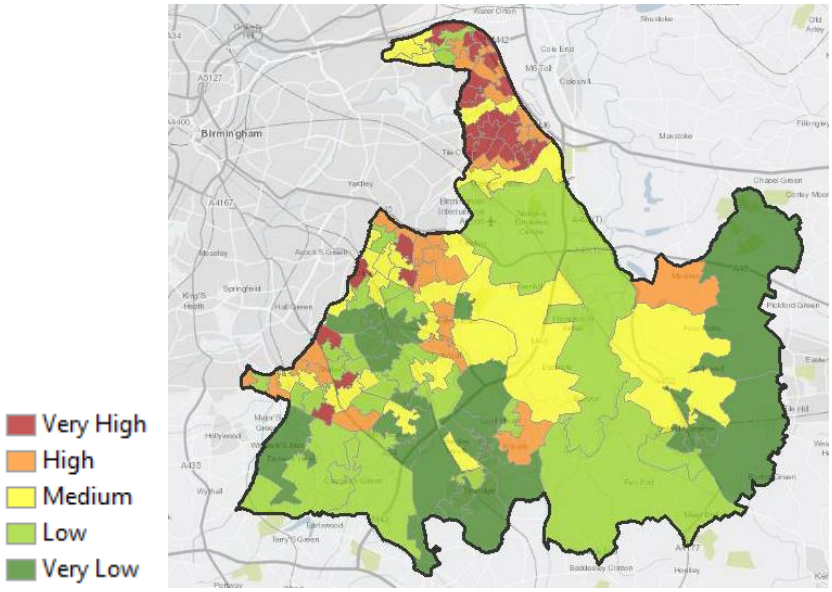


Figure 12: Age UK Heat Map, Risk of Loneliness in Solihull (65+)

A number of local authorities have used a similar approach to map potential prevalence, by utilising various risk factors to identify high risk areas, some through the use of specific software packages such as Mosaic; a similar approach has been taken in Solihull to map high risk areas across the borough.

Social Isolation Indices for Older People and Adults in Solihull

The following maps show composite scores for social isolation constructed from readily available data sources. One index applies to people aged 65 and over and the other is for adults in Solihull. The indicators used for each were selected to measure several risk factors for social isolation and loneliness.

Older people's index includes:-

- 65 in single households
- Assisted bin collection*
- Limiting long term illness
- Widowed or separated
- Index of deprivation affecting older people**
- > 65 who are carers

- Single > 65 with no access to car or van

The Adult index includes:-

- Living alone
- Widowed/separated
- Limiting long term illness
- Income deprivation**
- From an ethnic minority group
- Care provider
- No access to a car or van
- Lone parent

Most of the data was extracted from the 2011 census.[69] The exceptions were *SMBC local data and ** IMD 2015.[57]

For each data item the data was sorted lowest to highest and then split into local quintiles. As Solihull has 134 Lower Super Output Areas (LSOAs) each quintile included 27 LSOAs. Quintiles were then labelled and scored depending on perceived risk i.e. very low (score = 1) low (score =2) medium (score = 3) high (score = 4) and very high (score =5). Scores for each LSOA across all indicators were then totaled and again placed into quintiles and mapped (figures 13-19). It should be noted that this method has limitations and the maps produced are based on the available evidence and current data availability.

Risk of social isolation: People aged 65 and over (Older population)

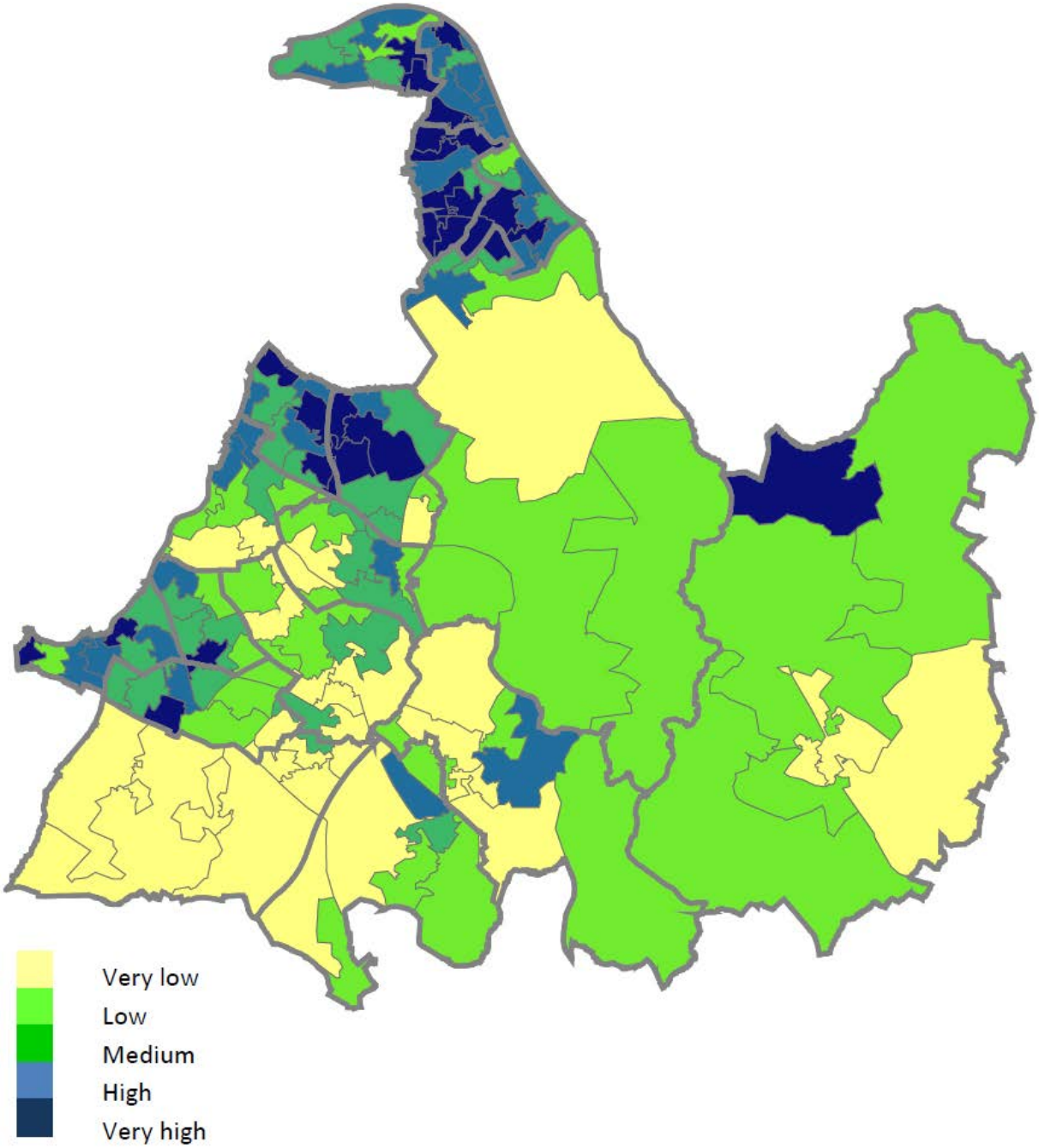


Figure 13

Risk of social isolation: People aged 65 and over (Older population)
North of the borough (expanded to show LSOA names)

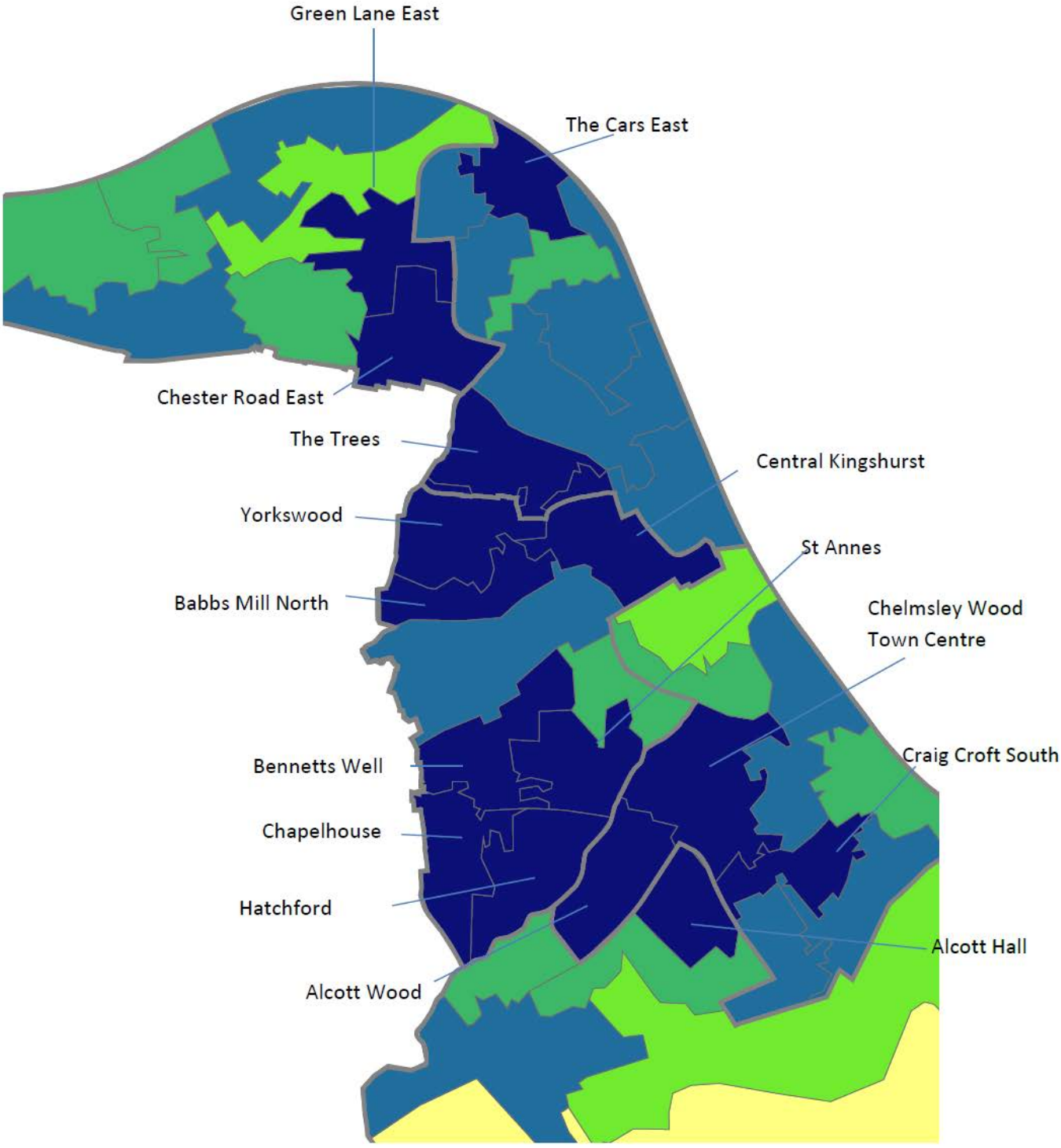


Figure 14

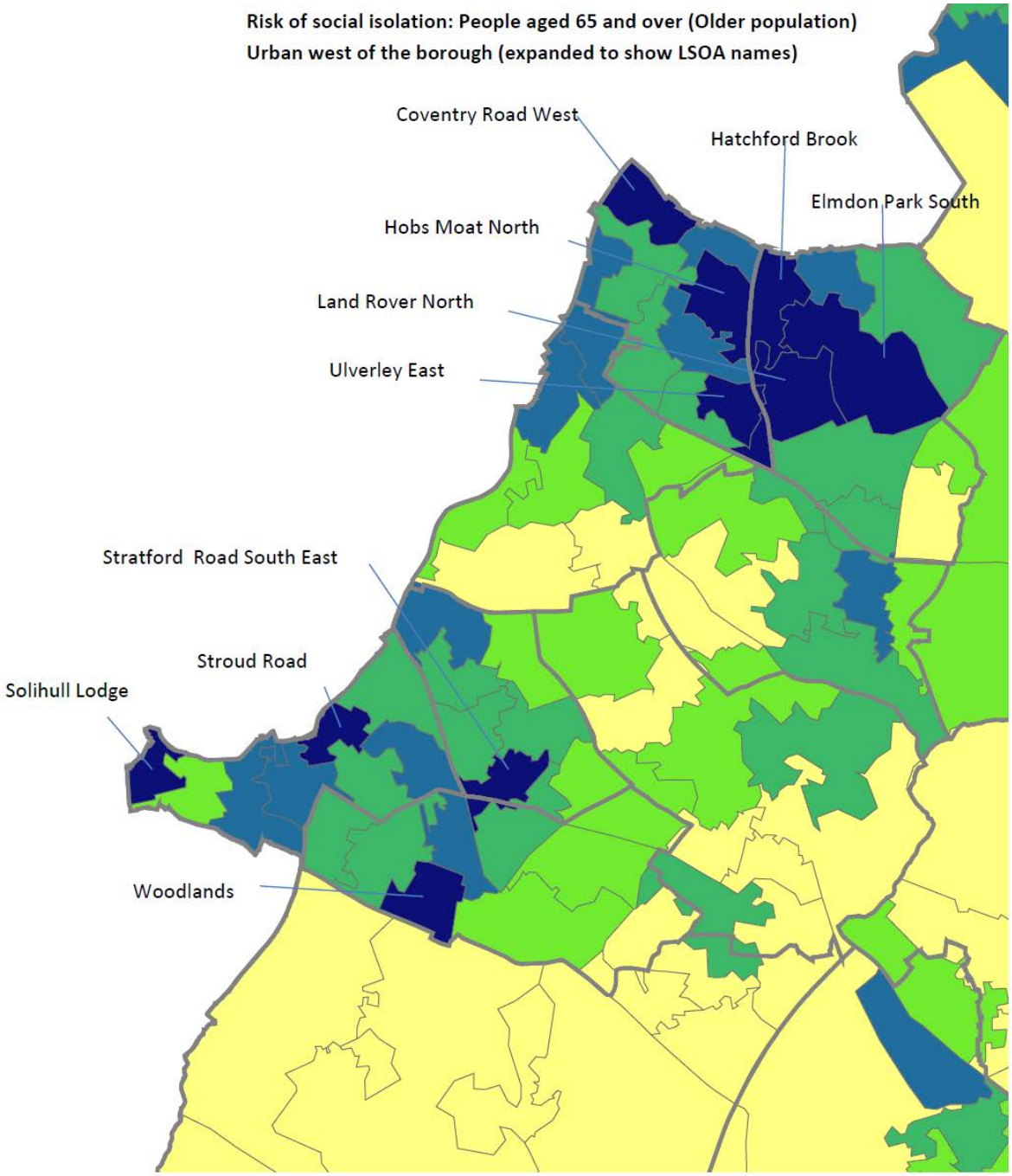

Risk of social isolation: People aged 65 and over (Older population)
Urban west of the borough (expanded to show LSOA names)
Coventry Road West
Hatchford Brook
Elmdon Park South
Hobs Moat North
Land Rover North
Ulverley East
Stratford Road South East
Stroud Road
Solihull Lodge
Woodlands

Figure 15

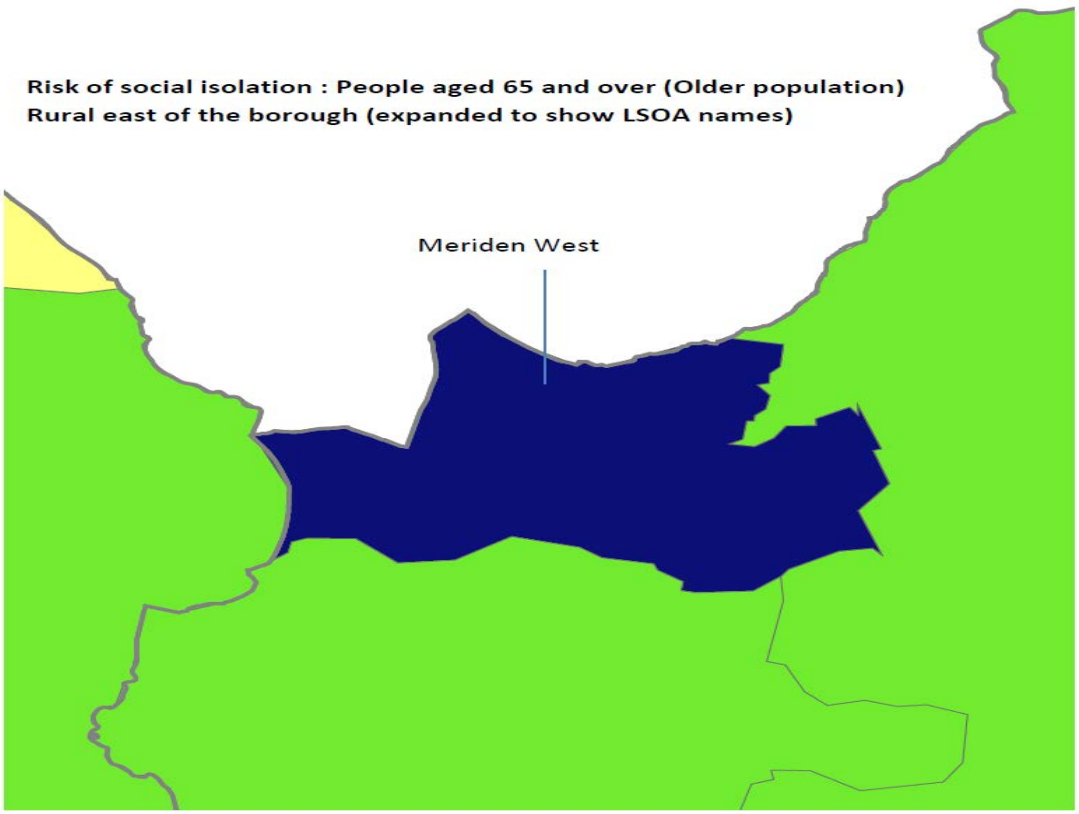


Figure 16

Risk of social isolation: Adults

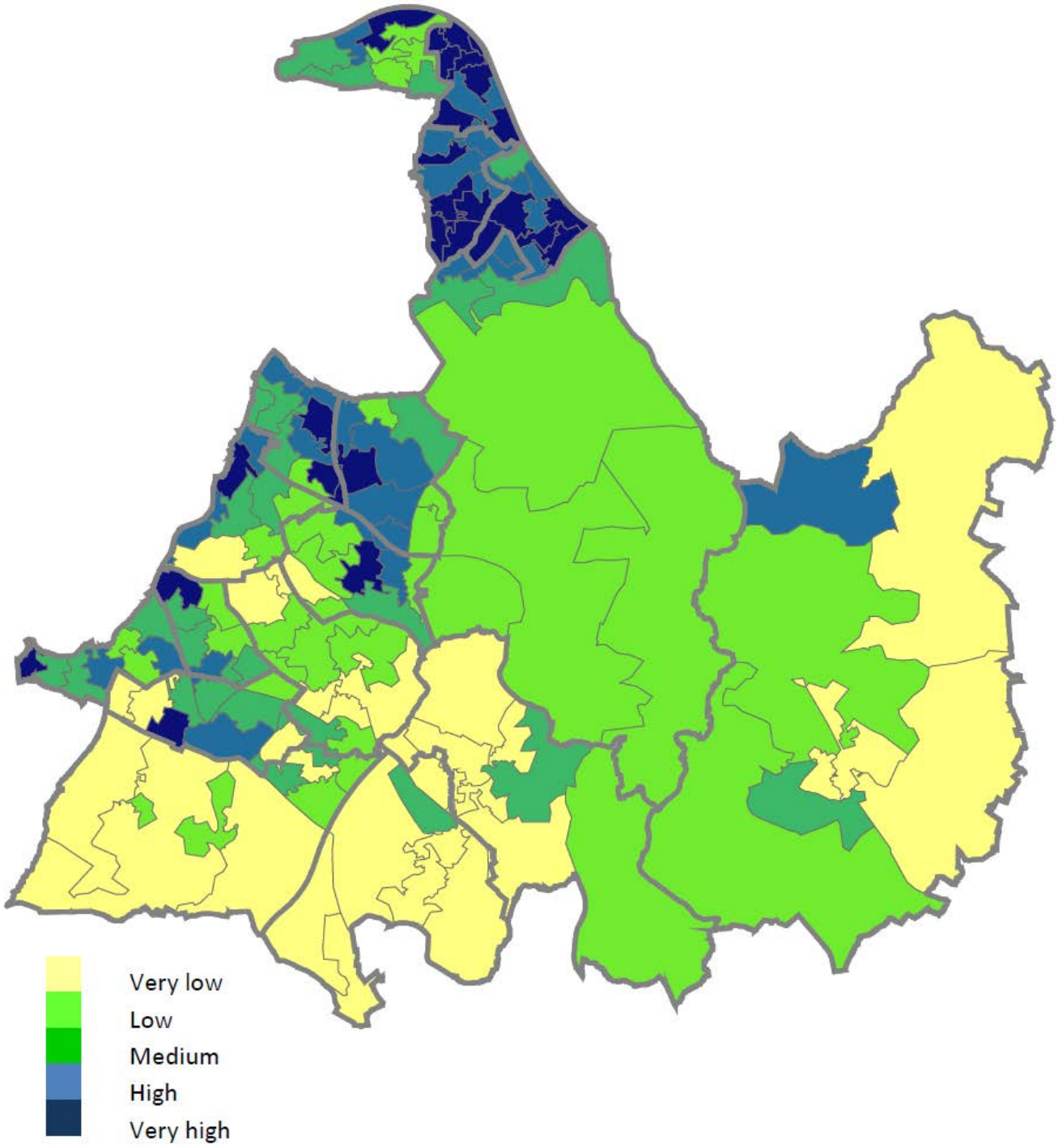


Figure 17

Risk of social isolation: Adults
North of the borough (expanded to show LSOA names)

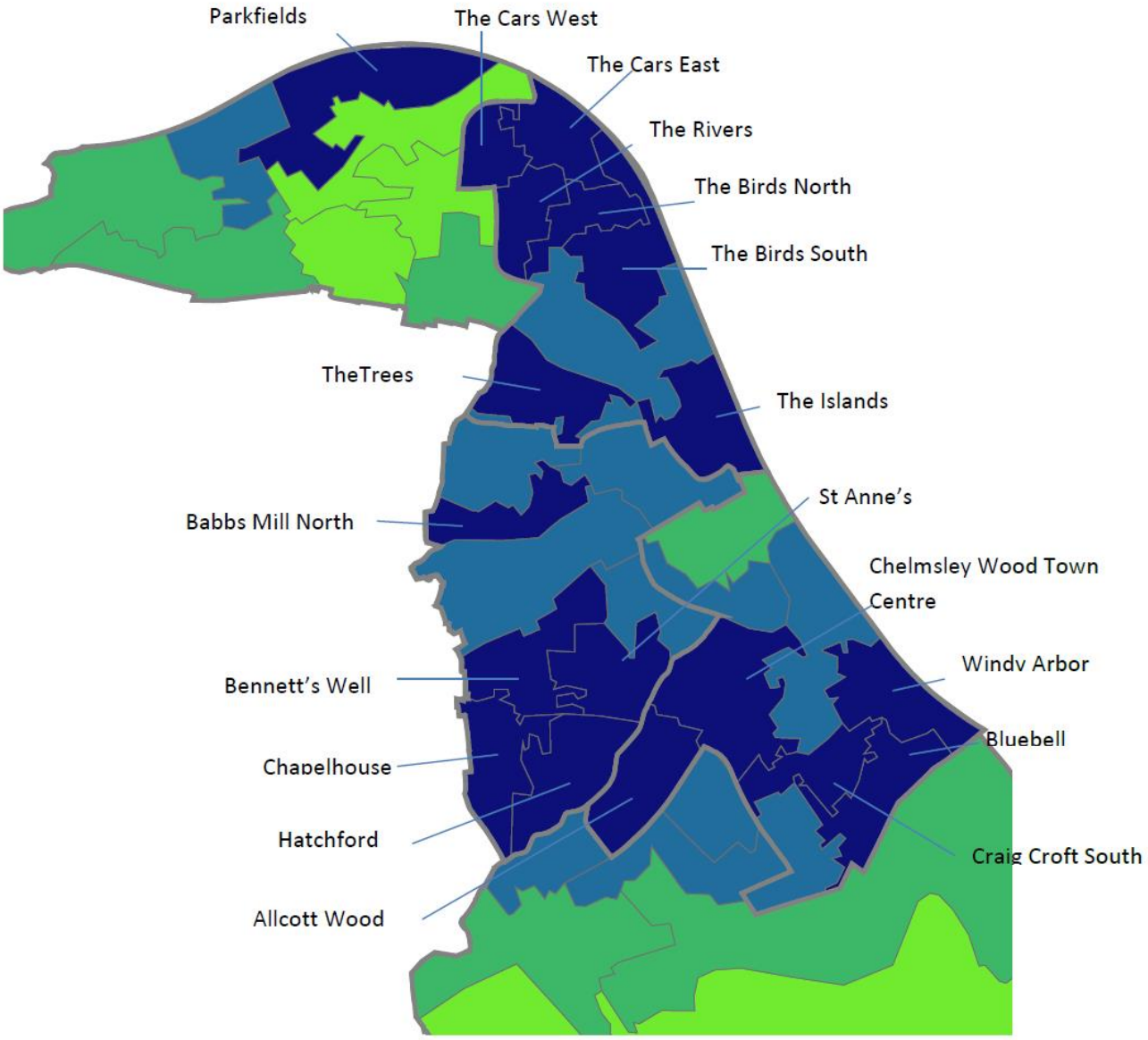


Figure 18

Risk of social isolation : Adults

Urban west of the borough (expanded to show LSOA names)

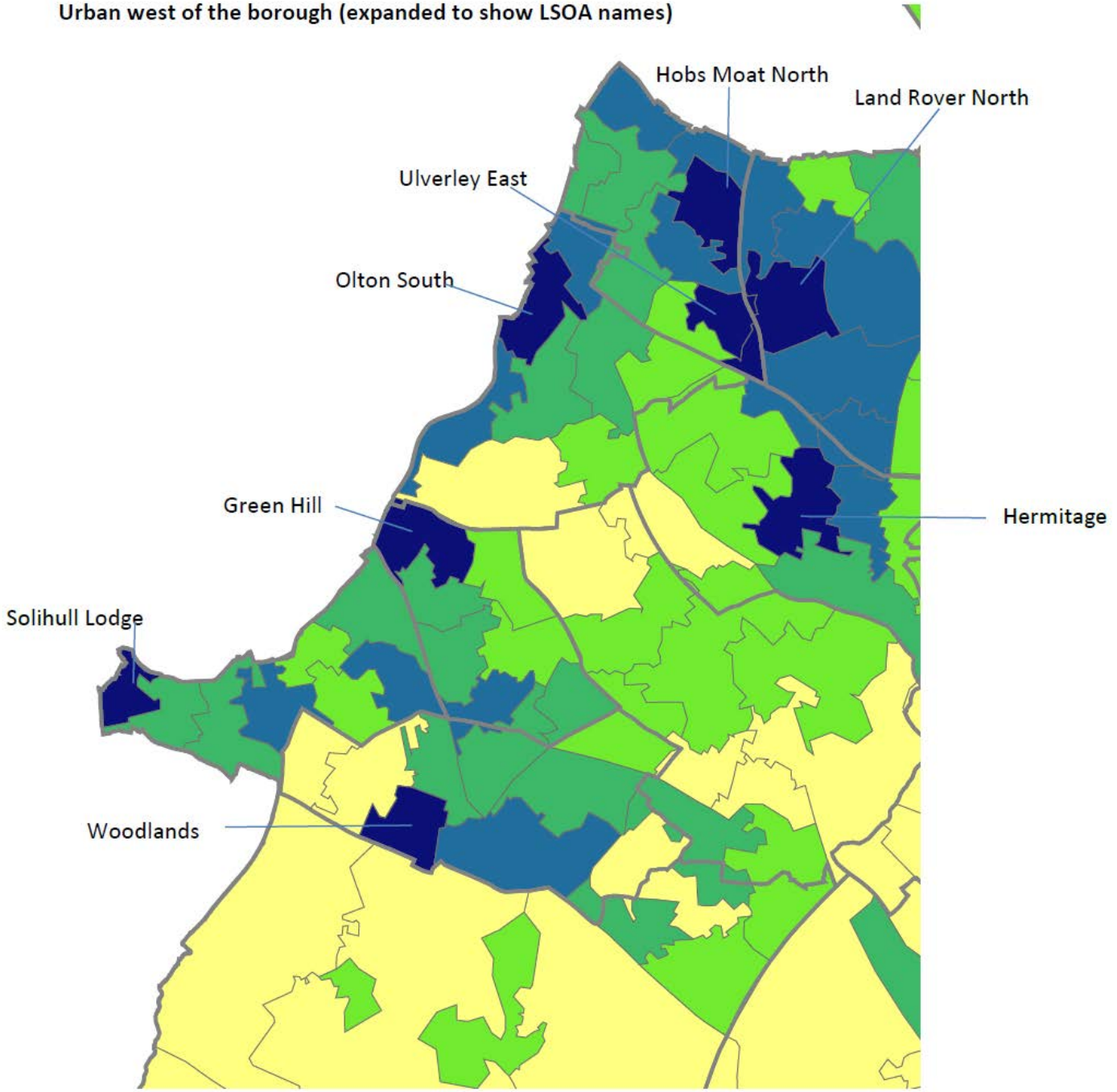


Figure 19

National Statistics

Applying national statistics described previously to the population of Solihull provides an estimate of the likely prevalence in the borough[31]:

National (aged 65+)	Solihull (aged 65+)
20% mildly lonely 8–10% intensely lonely 9% say they feel cut off from society 12% feel trapped in their own home	9,000 people are mildly lonely 4,000 people are intensely lonely 4,000 people say they feel cut off from society 5000 people feel trapped in their own home

In the adult population (aged 16-64), a survey by the ONS found that 14.8% of people in this age group reported high levels of loneliness, equating to 18,748 people in the Solihull population (based on 2016 mid-year population estimates).[24] A nationally representative survey of adults aged 16 and over by the Co-operative and Red Cross found that 18% of respondents reported feeling lonely 'always' or 'often', equating to approximately 30,806 people in Solihull.[33] Interestingly, this survey found that those in the 16-24 age group were more likely to report feeling 'always' or 'often' lonely, at 32% equating to approximately 6594 people in this age group in Solihull.[33]

Alongside the use of risk factors and surveys to assess and map loneliness, the Campaign advise using a number of tools to try and identify more people who may be lonely or socially isolated and identify areas of need. This includes for example training those people who may come into contact with people at risk of loneliness, including health professionals to identify those at risk and be aware of the appropriate referral processes to available services and support. By reaching more people who are potentially lonely or isolated and ensuring the appropriate support or services are made available, this will also contribute to increasing the intelligence surrounding the prevalence and potential at risk groups.

Service Data

Data from services that potentially come into contact with people who are lonely or isolated provides an additional method of obtaining some insight into the possible prevalence of loneliness or social isolation in the borough, particularly in specific population groups.

- **Care Navigator Service**– Basic performance data obtained indicates almost a third (31%) of those referred to the service by GP's between 01.01.17-31.07.17 self

identified as being lonely/socially isolation (178 people). Interestingly some of the qualitative data obtained from this group indicates the main reasons identified for this loneliness/isolation included death of a spouse, caring responsibilities or health problems.

- **Carers Centre**- The Carers Centre carry out Carers Assessments to identify specific needs and support options available for those with caring responsibilities in the borough. Elements of social isolation and loneliness are assessed as part of this to identify specific outcomes in order to address needs. A significant proportion of assessments identified needs relating to isolation or loneliness. Out of 279 assessments undertaken in 16/17, 187 identified 'Developing and maintaining family or other significant personal relationships' as a need, 201 identified 'Making use of necessary facilities or services in the local community' and 227 identified 'Engaging in recreational activities'.
- **Local Area Co-ordination**- Of the 43 people who have accessed longer term support during the first six months of the service, the majority live alone and over half (24 people) are looking to 'build personal network/community connections/hobbies/tackle isolation'.

Summary

Although the prevalence of social isolation and loneliness can be difficult to assess, particularly at a local level, the data collected nationally and the, albeit more limited data available locally indicate that a significant proportion of the population of Solihull at any one time may be experiencing loneliness or be socially isolated. Additionally, it may disproportionally affect the most vulnerable members of society, including the elderly, people with disabilities and the most deprived groups. The isolation index maps highlight potential areas of the borough that could be prioritised for the collection of intelligence, interventions and the allocation of resources.

Measuring Social Isolation and Loneliness

There are a number of validated tools for measuring social isolation and loneliness available that can be used in surveys or in the monitoring of individual services. This measurement is important not only to contribute to intelligence relating to the likely prevalence and high risk areas in the borough, but to also monitor the outcome of interventions on levels of social isolation and loneliness forming part of the overall performance assessment and

supporting the evaluation process.[27] Determining an appropriate measurement tool is considered by Nesta to be a critical element of designing a programme to address isolation and loneliness.[19] However, it is important to ensure that the baseline and follow up assessment of isolation and loneliness does not excessively increase workload or become too arduous or intrusive for service users and the population of Solihull. A balance is therefore required between an adequate assessment and the additional time and resources required to complete this. The Nesta report describes three important elements for commissioners to consider when selecting an appropriate measurement tool, including:

- the reliability and validity
- ease of administration
- potential for benchmarking the results against nationwide data.[19(71)]

Utilising a measurement tool can also assist in ensuring services are being targeted appropriately to those most in need; by setting a minimum initial loneliness or isolation 'score' for those entering the service, those people with high levels of loneliness or social isolation can be prioritised.[19]

It should be noted that the differences between social isolation and loneliness mean there are separate measurement tools for each.

Measurement Tools

General Wellbeing Measurement Tools

A number of general wellbeing measurement tools include some assessment of social connectedness or loneliness. However, this is often only one question that forms part of the overall assessment of wellbeing. In order to monitor levels of loneliness as an outcome, a slightly more detailed separate assessment may be required. Similar 'single item questions' to assess loneliness are discussed within a report reviewing loneliness measures by the Campaign to End Loneliness- such short measures as an assessment have not been extensively researched to assess their reliability.[27]

- The widely used **Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)** includes in the full version the statements: 'I've been feeling close to other people' and 'I've been feeling interested in other people'.[25]
- The validated **LEAF-7** tool for monitoring quality of life includes a question on social networks: 'How satisfied are you with your social life nowadays?'.[32]
- The **Outcomes Star** is a holistic tool for measuring a range of outcomes, including wellbeing and social networks/relationships.[26]

Loneliness Measures

The Campaign to End Loneliness have reviewed a number of the most common tools for measuring loneliness.[27] Although reviewed for the purpose of assessing loneliness in the older population, the tools are suitable for all adults.

Two of the most relevant measurement tools in the report, both of which have been tested for reliability and validity include[27]:

- **The De Jong Gierveld Loneliness Scale –'**In this 6-item scale, 3 statements are made about 'emotional loneliness' and 3 about 'social loneliness'.[27]

Advantages of this measure include that it assesses for different types of loneliness and is widely used across Europe; it is 'very well-tested and evaluated for use in a number of languages and countries.'[27]

- **The UCLA 3-Item Loneliness Scale –** 'This scale comprises 3 questions that measure three dimensions of loneliness: relational connectedness, social connectedness and self-perceived isolation.'[27]

Advantages of this measure include its wide usage, for example in the English Longitudinal Study of Ageing (ELSA). The English Longitudinal Study of Ageing (ELSA) use a revised version of this scale as indicated in figure 20.

Lead-in and questions are read to respondent.

Lead-in: The next questions are about how you feel about different aspects of your life. For each one, tell me how often you feel that way.

Question	Hardly Ever	Some of the time	Often
First, how often do you feel that you lack companionship?	1	2	3
How often do you feel left out?	1	2	3
How often do you feel isolated from others?	1	2	3
How often do you feel in tune with the people around you?	3	2	1

Note: The score is the sum of all items.

Figure 20: Revised UCLA. Source: Investing to Tackle Loneliness, A Discussion Paper[19]

Social Isolation and Social Connectedness Measures

Social isolation and connectedness are in part assessed by the measures described for loneliness. However, there are a number of specific questions that can be used to assess potential levels of social isolation, these can include for example levels of contact with

friends/family and whether individual's feel they have someone to turn to for help. Specific tools and questions include:

- **The Lubben Social Network Scale – 6 (LSNS-6)** – this is a six item self reported scale to assess social isolation. It is particularly focused on older adults and asks questions about the individual's relationships with family and friends.[28]
- In the report by **'What Works Wellbeing'** presenting a new Local Wellbeing Indicator set for local authorities and those in public health, as part of an overall assessment of wellbeing to assess social relationships the following questions/measures were described as being the 'ideal' set of indicators.[58] These questions could be adapted to be used as part of the assessment of social isolation for service users.
    - Close support, i.e. having support when needed- the percentage of people who agree with statement "If I needed help, there are people who would be there for me".[58]
    - Personal relationships, i.e. an assessment of social networks – the percentage of people who meet socially with friends, relatives or work colleagues at least once a week.[58]
- The indicator in the **Public Health Outcomes Framework** assesses levels of social isolation by asking the question:[29]
    - "Thinking about how much contact you have had with people you like, which of the following best describes your social situation?"
- When assessing social participation specifically in older people**, NICE** suggest using the 'proportion of older people and their carers who use services and report that they have as much social contact as they would like' as an outcome.[7]

There are a wide range of questions and tools that can be utilised to assess an individual's level of social isolation, including the use of diagrams to help visually 'map' an individual's social relationships. It may also be possible to develop a set of questions specifically for use in Solihull, similar to those used in the Place Survey conducted in 2016.

In addition to measuring a reduction in levels of loneliness or isolation, the Nesta report advocated measuring the impact on health and social care usage, this includes GP and A&E visits, readmission to hospital and entry to residential care.[19]

Interventions

"Social isolation and loneliness is a major public health issue, associated with higher risks of mortality and morbidity. But people can 'recover' from loneliness, meaning that there is scope for interventions to improve social connections" (Public Health England)[38]

The input required to reduce social isolation or loneliness may be different, for example those experiencing isolation may require more 'practical support' such as transport provision, whereas those who are lonely may benefit more from activities or psychological support.[59] However, as acknowledged by PHE, although social isolation and loneliness are different, more research is required to distinguish between their 'complex relationship' to determine their individual impacts and what interventions are effective for each, equally they can often co-exist and both issues need to be addressed to improve health and wellbeing.[3]

Despite the increase in interventions designed to tackle loneliness and social isolation, there remains a 'lack of high quality evidence' and issues with 'weak methodologies' in some evaluations.[34,35] However, more recently a number of reviews of the available evidence have been published. These have been undertaken by some key organisations including Age UK, PHE and the Social Care Institute for Excellence and supported by consultation with experts.[1,3,134,35] People can 'recover' from loneliness and isolation and certain interventions can be beneficial; as noted in a report by Nesta, 'conservative estimate from specific studies suggests that 6% of individuals became 'non-lonely' following an effective intervention'.[19]

Much of the current evidence relating to interventions focus specifically on alleviating loneliness and isolation in later life, possibly reflecting the general public opinion that it is a condition affecting the older population.[33] However, these nonetheless contribute valuable insights into addressing loneliness and isolation in all age groups.

What Works?

Whilst there are some interventions that are designed to tackle social isolation and loneliness specifically, due to the subjective nature of the condition and multifactorial causes, the most appropriate service or intervention is likely to vary greatly based on socio demographic factors and individual preference; there will be no universal service or activity that will work for everyone and the primary focus of a service does not need to be reducing isolation to be effective. For some, becoming more connected will not require any specific service and may be as simple as being introduced to a neighbour. Equally, as discussed previously there will be a proportion of people who are socially isolated who do not wish to access support and are content with their solitude. Although there is not a 'one size fits all'

approach to tackling the problem, with the development of campaigns such as the Campaign to End Loneliness and work by PHE the evidence for what may contribute to a reduction is increasing.

Reaching, Understanding and Supporting

The Campaign to End Loneliness have produced a toolkit based on the best available evidence to assist local authorities and health and wellbeing boards in producing a strategy to tackle loneliness in their local areas.[20] This toolkit bases much of it's guidance on a review and consultation conducted by Age UK on interventions to tackle the issue.[34] Although this toolkit is primarily focused on tackling loneliness rather than social isolation and is targeted specifically on older people, it provides a useful tool for all age groups and supports a systematic approach to addressing the issue, ensuring all elements have been adequately considered.

According to a review by Age UK and the toolkit, 'one of the biggest challenges, and the greatest innovations, takes place in broader areas of operation'.[34] The three areas frequently noted as being the most important were those addressing the challenges identified in figure 21.

Challenge	Suggested Actions
1. Reaching lonely interventions "The very nature of loneliness, and its links to lack of regular contact with others, means creative solutions are needed to identify those who would benefit most from loneliness initiatives."[39]	1) Loneliness Data – to identify and 'map' the location of those at risk of loneliness. 2) First Contact Schemes (eyes and feet on the ground)- train individuals or have specifically employed 'agents' who lonely individuals are most likely to come into contact with on engaging people experiencing loneliness and make appropriate referrals.[60(52)] 3) Using links to the health service – establish processes for health professionals to identify and refer at risk individuals onto services and support. E.g. social prescribing 4) Mass media and mailouts – targeting those at risk of loneliness through leaflets via supermarkets, GP surgeries etc. 5) Business as usual methods - employ identification strategies that complement existing activities/relationships in a local community e.g. distributing a loneliness questionnaire through local pharmacies to increase referrals to a local charity service. Simple measures for example knocking on doors can also be effective.[39]
2. Understanding the nature of an individual's loneliness and developing a personalised response	1) Guided conversation- A relatively unstructured engagement with a person exploring their circumstances, needs and wishes, leading to a discussion about available services to improve their wellbeing. These in-depth discussions are vital in ensuring someone's needs are recognised and responded to. 2) Stigma- The stigma attached to loneliness can be a barrier to an individual asking and accepting help. Services and commissioners therefore have a choice to make about whether to mention the 'L' word when addressing an individual. 3) Understanding Accessibility- Disabilities and sensory loss are major risk factors for loneliness, therefore determining and ensuring that individual's are able to access services is important.
3. Supporting lonely individuals to access appropriate services	Loneliness can have a damaging effect on a person's confidence- once an individual has been reached they may need support to reconnect with their community/existing services to facilitates access to direct interventions. Usually time-limited and goal-orientated, this allows a greater throughput for the same resource as a basic befriending service.

Source of text: Promising approaches to reducing loneliness in later life. [34]

The actions described may precede and lead onto the services more commonly associated with reducing loneliness including the group or one-to-one activities- they are 'vital first steps' and form the foundation of subsequent work to address the issue.[34] The importance of raising awareness and reducing any stigma attached for example through campaigns and training is acknowledged; 'central to success in tackling loneliness, are efforts to improve awareness of the issue'.[39] This includes awareness in the community and among professionals, particularly frontline staff who may come into contact with individuals who are lonely or isolated.[39]

The importance of those people in contact with individuals who may be potentially lonely or isolated, including healthcare, social care and public health practitioners having the awareness and skills to provide advice about local support or activities in the area to potentially alleviate isolation is acknowledged in NICE guidance.[5-7] This includes the importance of creating partnerships between different organisations when delivering care and support in older people's own homes to ensure people at risk of loneliness or isolation are identified and referred to appropriate partners; "people who have cognitive impairment, communication difficulties or sensory loss may feel an increased sense of social isolation if care workers do not have time to help them make connections with other sources of support in their local community.'[6]

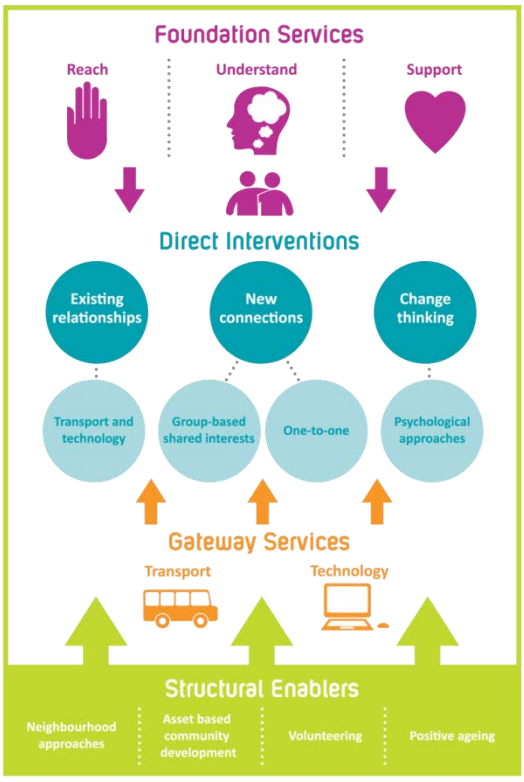


Figure 21: Campaign to End Loneliness, Loneliness Framework[20]

Direct Interventions

The majority of the current research on interventions for social isolation and loneliness is based on the so-called 'direct' interventions. An evidence review by AgeUK group these interventions into those that "improve social skills; enhance social support; increase opportunities for social interaction; or address maladaptive social cognition (defined as behaviour that is counter-productive or interferes with everyday living)".[38] As acknowledged by this review, the majority of the research and studies are based around those interventions that 'increase opportunities for social interaction'.[38] These interventions are often grouped into so-called 'group' and 'one-to-one' interventions. Recent guidance from NICE on mental wellbeing and independence for older people includes as a quality statement that 'Older people most at risk of a decline in their independence and mental wellbeing are offered a range of activities to build or maintain social participation.'[7] Group activities described by NICE include for example singing programmes or arts and crafts. The one-to-one activities described include befriending and the provision of information on local services offering support or advice.[7]

The returns on investment for such interventions can be difficult to calculate. However, although still relatively limited, the evidence of cost-effectiveness is increasing. Nesta estimated that the likely value of a successful programme for targeting loneliness 'could be in the range of £770–£2,040 over the life of an individual'.[19]

One-to-One Interventions

Many of the one-to-one interventions described in literature to alleviate social isolation and loneliness are similar in supporting and enabling individual's to become more connected and access services in their community, albeit in different ways. This includes befriending, local area coordinators, care navigators and social prescribing.[39]

Intervention	Description
Befriending	*"An intervention that introduces the client to one or more individuals, whose main aim is to provide the client with additional social support through the development of an affirming, emotion-focused relationship over time."*[35] The exact nature of the intervention differs between services, but usually involves either paid workers or volunteers making contact with individuals either in their own residence or on the telephone, to provide company and support that individual in accessing services for a time limited period.[35]
Care Navigators	*"The Care Navigator Service will support and enable older people primarily, but not exclusively, and find solutions to the problems/issues they face and will help them to navigate and access relevant services that can meet their needs."*[61] Care Navigators are linked to GP practices who can refer to the service, along with District Nurses or Social Workers. The support offered is not exclusively around making social connections and includes advice on benefits, falls and housing.
Community Navigators	"*Usually volunteers who provide 'hard-to-reach' or vulnerable people with emotional, practical and social support, acting as an interface between the community and public services and helping individuals to find appropriate interventions."*[35] Similar to the befriending service, the service varies between areas and can involve face-to-face or telephone contact.
Local Area Co-ordinators	*"Local Area Coordinators support people facing issues around health, disability or ageing to stay strong through family, friends and community*."[62] They can support people (aged 18 and over) to get information, get connected to others in the community and access activities, and also build capacity and resilience in the wider community.[62]
Social Prescribing	"*Sometimes called community referral, this is a generic model that enables individuals presenting through primary health care to be signposted and connected to local organisations, groups and activities….Staff with knowledge of the resources available in the local community match individuals to opportunities and support them to engage in activities."*[1]

Evidence of effectiveness and positive returns on investment has been increasing for the interventions described in figure 24. Evaluation of the local area coordinator service in Thurrock and Derby Council included a social return on investment analysis (SROI).[63] Significant benefits were indicated, including reduced social isolation, an increased sense of belonging to the community and a forecasted return on investment of £4 for every £1

invested.[63] A research briefing by the Social Care Institute for Excellence found there to be 'good evidence' that befriending and community navigator interventions are effective at reducing levels of loneliness and improving wellbeing.[35] Research by Knapp et al assessing the potential economic impacts of befriending and community navigators, found the schemes to deliver a 'net economic benefit'; a befriending type scheme delivered in Bristol found an early social return on investment of £1.20 for every £1 invested and this was deemed to likely be an underestimate due to initial development costs.[3,64]

As acknowledged by The Kings Fund, determining and demonstrating the effectiveness and cost-effectiveness of social prescribing is considered to be relatively difficult.[65] However, a number of studies evaluating current schemes around England indicate improvements in health and wellbeing and evidence of a reduced use of statutory services following the use of social prescribing, including a reduced level of A&E admissions and GP appointments.[65] Much of the published literature currently available on care navigation programmes comes from North America, where positive outcomes have been evidenced, including improved quality of life and reduced hospital admissions.[66] However, as stated in the Care Navigation Competency Framework by Health Education England there is 'emerging evidence' of similar such positive outcomes for UK programmes.[66]

Group Interventions

Evidence suggests that a range of group interventions can be effective at reducing levels of loneliness and isolation in participants.[35,37] A number of the group interventions described in the literature however do not have social contact as the 'primary offer' and reducing social isolation and loneliness may be only a secondary outcome, if it is an identified outcome at all.[41]

'Many community based interventions intended to reduce social isolation will not be identified as such within the community they serve. Instead, they will be focused on activities that can be shared; bringing people together naturally in a way that is appropriate to their particular needs.' (PHE)[3]

As such, a large number of activities commissioned by local authorities, run by the private sector, voluntary organisations, faith groups and more informal groups in the community could potentially be a group intervention that may reduce loneliness and social isolation. NICE guidance for mental wellbeing and independence in older people acknowledge specifically that group physical activity programmes for older people can be effective at reducing the risk of social isolation and loneliness.[7]

Some specific features of groups have been shown to be particularly effective. For example SCIE concluded that for social group interventions, 'cultural' and 'health related interventions' can be beneficial.[35] Three features of interventions for loneliness identified in the literature as being the most effective, including within a systematic review of interventions in older people, were those that are:

- 'group-based, and targeted at a specific group'
- 'focused on a shared interest, or with an educational focus'
- 'set up to involve older people in running the group'[38,39,41]

An example of such activity includes the 'Men's Sheds' scheme which brings predominantly men over the age of 55 years together, with the common interest of 'shed based' activities such as wood work or bike repair.[67]

Psychological Approaches

Social isolation and particularly loneliness can be personal, subjective experiences and the perception of isolation and loneliness are influenced by an individual's mental health and resilience.[37] Increasing the opportunities for making social connections can help to tackle social isolation or loneliness, but it may have relatively little impact if an individual's mental health and 'maladaptive social cognition' is contributing; "coping, self-esteem, and psychosocial health are significant moderating factors for perceived isolation and feelings of loneliness."[19,37,68] Additionally, loneliness and isolation can coexist with other mental health conditions, including depression; evidence suggests that loneliness and isolation can be both a cause and affect of mental health conditions such as depression.[51] Psychological approaches as a potential intervention for those people who are isolated or lonely has been identified as an area with particular potential for growth- a recent meta-analysis found those interventions addressing 'maladaptive social cognition' had the greatest impact on loneliness.[19,37,41,68] Although there are a range of potential psychological interventions, including cognitive behavioural therapy (CBT), mindfulness and group activities to develop communication skills, as acknowledged in the review by AgeUK and Campaign to End Loneliness, the use of such interventions for loneliness or isolation is not yet widespread.[41]

Technology

The Campaign to End Loneliness describe access to technology as a so-called 'gateway service' that plays a 'critical role in directly enabling existing relationships and a vital supporting role in those interventions designed to support new social connection'.[41] However, it is also acknowledged that the role technology plays in tackling social isolation

and loneliness is widely disputed.[41] The evidence for the impact of technology, including social media on levels of social isolation and loneliness and as a potential intervention to tackle the issue is still relatively limited, with some concerns raised regarding the use of social media increasing loneliness and isolation particularly in young people.[47] However, there is some, albeit limited evidence to suggest the use of technology in certain instances may be an effective method for addressing isolation and loneliness, for example internet training schemes for those aged over 50 in their own homes and a telephone befriending service (Call in Time).[41]

Community

Tackling the issue of social isolation and loneliness extends beyond the commissioning of specific services or interventions. Social isolation and loneliness form only one aspect of wellbeing and are recognized by PHE as a health inequality issue, with a link to social disadvantage and associated factors such as unemployment, the causes of which are complex.[3] Therefore the issue cannot be tackled by a single organisation and requires the development of partnerships between the public, community, voluntary and private sectors.[40] Guidance from the Local Government Association and Campaign to End Loneliness suggested (specifically for older people in this document) that 'initiatives to combat loneliness will be most effective if they are built into an overarching strategy for promoting older people's wellbeing'; the benefits of working for example to strengthen communities and increase community engagement will extend beyond reducing loneliness and isolation.[39]

The important role of communities in protecting or exacerbating loneliness and isolation is acknowledged.[41] NICE have produced guidance on how community engagement can reduce health inequalities and support health and wellbeing initiatives and PHE discuss the importance of so-called 'community centred approaches' to address health and wellbeing, which encompasses social isolation and loneliness.[1,69] PHE group 'community centred' approaches into four 'strands':

- **strengthening communities** – where approaches involve building on community capacities to take action together on health and the social determinants of health
- **volunteer and peer roles** – where approaches focus on enhancing individuals' capabilities to provide advice, information and support or organise activities around health and wellbeing in their or other communities
- **collaborations and partnerships** – where approaches involve communities and local services working together at any stage of planning cycle, from identifying needs through to implementation and evaluation
- **access to community resources** – where approaches connect people to community resources, practical help, group activities and volunteering opportunities to meet health needs and increase social participation

Source: PHE community centred approaches[1]

A place based approach that harnesses the 'hidden wealth of communities' including the informal social networks and community assets, is advocated, including efforts to strengthen and engage communities to 'galvanise and direct existing capacity'.[39-41] Developing community capacity and increasing resilience to loneliness is important, particularly to increase the sustainability of interventions with fluctuations in funding.[39] The Marmot Review acknowledges increasing social capital in communities through increased community empowerment as one pathway for reducing social isolation.[8] The important role the more informal connections and relationships built within communities have on preventing and alleviating loneliness cannot be underestimated. Community events and activities are important and support should be provided to 'build up the community's confidence and capacity' and form or strengthen existing important social connections in communities that can then be maintained beyond external support, for example the 'Casserole Club' volunteer scheme.[39,70]

There is an appreciation of the importance of how services are developed and the role of community engagement in the development, delivery and management of activities and services, including when determining any 'gaps' in service provision- 'often the vital step of asking what people want is missed out when designing services'.[3,71,72] The Joseph Rowntree Foundation advocate a participatory community development approach to reduce loneliness and the Campaign to End Loneliness discuss the importance of services being developed and delivered at a neighbourhood level, with community engagement and the use of volunteers.[71,72] Volunteering is very important as "both an enabler of effective loneliness interventions and a way of directly preventing and alleviating loneliness".[41] NICE guidance on mental wellbeing and independence for older people acknowledges the importance of volunteering; "Older people should also be made aware of the value and benefits of volunteering. It provides the opportunity to socialise, have an enjoyable experience and help others to benefit from their experience, knowledge and skills."[7]

The built and natural environment in communities is also important to consider when addressing the issue. The physical environment can influence an individual's ability and motivation to interact socially. This includes factors influencing levels of safety or perceived safety, for example street lighting and safe pavements and access to public spaces for example parks and community centres.[3] Access to adequate and appropriately priced transport can support people to initiate and maintain social connections; transport links need to be both accessible and affordable.[3] Although this can be a particular issue for the older population and those with disability, it can affect all ages; it is estimated that almost half of students (aged 16-18 years) have 'experienced difficulty' with funding their transportation.[3]

Local Activity

When compared to other risk factors, the widespread appreciation of the serious detrimental effects of social isolation and loneliness on health and wellbeing is a relatively recent development. However, there is already a lot of promising work in a number of the key areas occurring in Solihull:

Awareness and Intelligence- The inclusion of social isolation and loneliness in two key Council strategies (Health and Wellbeing and Public Health) demonstrates a commitment by the organisation to focus on addressing the issue. The 'five ways to wellbeing' is being promoted in the Council and more widely, which includes a reference to isolation and loneliness through 'get connected', helping to raise awareness of the importance of the issue in the borough. Additionally, a group of questions assessing social isolation were included in the 2016 Place Survey, providing an insight into potential prevalence and geographical differences across the borough.

Reaching- There is evidence that loneliness and social isolation are already being assessed by a number of providers and organisations, through both informal and more formal approaches. In some areas of work, for example tackling domestic abuse, assessing for social isolation is already a priority and there are a number of other areas where the issue is being raised. This includes for example financial inclusion officers making contact with local area coordinators, informal assessment through conversations in the Solihull Connect Centres and more formal assessments including Carers Assessments by the Carers Centre, 'Wellbeing Assessments' by Solihull Community Housing Wellbeing Service and the 'Safe and Well' Checks by West Midlands Fire Service.

Interventions

There are a number of services and activities in the community that are already likely to be supporting people who may be at risk of isolation or loneliness in Solihull. This includes some specifically targeted at potentially high risk groups, for example Infant Feeding Café's. A number of services currently commissioned by the Council have reducing levels of social isolation and loneliness as an outcome, demonstrating an appreciation that a wide range of services and interventions can contribute to supporting those who are isolated or lonely. Additionally, a number of services with more focus on tackling isolation and loneliness are commissioned.

Utilising the framework described in the Campaign to End Loneliness, some of the key interventions have been mapped against the different levels of intervention in figure 21. Due to the large number of activities in the community, including voluntary led organisations, faith and support groups, this is not a definitive list of what is currently

available or being offered across Solihull, particularly beyond Public Health. A number of attempts have been made to map the activities in the borough, including the creation of a range of directories available online that aim to make it easier for people to explore and access services and activities.

Services more specifically addressing social isolation and loneliness that are currently commissioned are predominantly one-to-one interventions and include local area coordinators, care navigators, befriending (Linking People Together) and social prescribing. Within Solihull there is currently a service redesign being undertaken of the 'Wellbeing Offer' for the borough. This is likely to involve the integration of a number of different services linked to wellbeing and lifestyle, including potentially those addressing isolation and loneliness, into a more streamlined, holistic service with potentially one referral and access point. There is also likely to be a community element to the offer, including for example measures to increase 'self-help' and volunteering, with an online portal for access to a directory of services and support. Social isolation and loneliness is an important aspect of wellbeing and these changes to the wellbeing offer for Solihull provide an opportunity to integrate the assessment and referral process for social isolation and loneliness into the pathway that is being developed. This offer is currently still in development and it will be important for social isolation and loneliness to be recognized and included early on in the process of redesign.

One-to-One Interventions

The local area coordinator service currently operates in five areas of Solihull (Smith's Wood, Kingshurst & Fordbridge, Olton, Lyndon, and Shirley East) and after starting in April 2017 it is still in the relatively early stages in the borough. However, a review of the first six months (April-September 2017) of the service indicates some positive findings. In the six month period, 211 people have contacted the service for local information and advice (with a target of 400 for the whole year) and a range of support has been provided. 43 people have accessed longer term support, with the majority of this group living alone and over half (24 people) looking to 'build personal network/community connections/hobbies/tackle isolation'. Follow up using the Warwickshire-Edinburgh Mental Well-being Scale (WEMWBS) questionnaire began in July- currently only a small number of follow up questionnaires have been completed, however wider use of this is planned and initial indications are that wellbeing and connectivity has been improved for those being supported by the local area coordinators. It is estimated that 22 people have been diverted from care or other services and the local area coordinators have worked with a range of community partners to promote community building, including supporting the set up of new Street Associations and other community initiatives. It is estimated that the number of people supported by the local area coordinators will steadily increase as the service progresses.

An evaluation of the care navigator service is being undertaken; anecdotal evidence suggests that it has been very positively received by GP's in the borough. Since April 2016, the social prescribing service in Solihull has had a total of 536 clients, with 148 demonstrating improved WEMWBS results. Ongoing evaluation of these one-to-one services will be very important in order to support future commissioning decisions and contribute to the national evidence base.

The IAPT (Improving Access to Psychological Therapy) service in Solihull is able to provide one-to-one and group support and therapy for those people who are negatively impacted by loneliness or isolation. People can self-refer and following an initial assessment the service are also in a position to refer onwards to alternative appropriate activities or support in the borough. Raising awareness of psychological interventions as a potential support option for social isolation and loneliness is important, along with ensuring this support is ongoing after contact with IAPT, potentially through the voluntary sector.

The redesign of the wellbeing and lifestyle services means the support offer for people who are socially isolated and lonely in Solihull is in a state of transition. However, this transition also provides an opportunity to improve the offer for those who are potentially isolated or lonely. It will be important to ensure throughout this transition that there remains enough specific evidence-based one-to-one support for the population of Solihull and that reducing social isolation and loneliness are acknowledged as a priority.

Level	Services
Foundation Services	- Local Area Co-ordination (available in selected areas of the borough) - Care Navigators - Age UK Linking people Together - Health Exchange Social Prescribing - West Midlands Fire Service Safe and Well - Community Advice Hubs - Carers Assessments by the Carers Centre Solihull - Wellbeing assessments by Solihull Community Housing Wellbeing Service
Direct Interventions	• **Current Directories or Mapping Exercises**- - Solihull Voluntary & Community Services Directory –this lists approximately 600 organisations, however estimates that over 750 exist in the borough. http://solihull-sustain.org.uk/2015/10/updated-voluntary-and-community-directory-published/ - Solihull Local Information Directory- this contains information about organisations and sports clubs in Solihull. http://eservices.solihull.gov.uk/LocalInformation/ - The Solihull Directory on Solihull My Life Portal- this provides information on a wide range of organisations in the borough, including housing, money, work and leisure. https://solihull.mylifeportal.co.uk/solihulldirectory - Health Exchange Social Prescribing- this provides a directory of predominantly social activities in the borough. http://socialprescribing.healthexchange.org.uk/ • **Council Commissioned Services and Community Activities (Specific Groups and One-to-One predominantly commissioned by Public Health)** - A number of the 'foundation services' described above can also provide 'one-to-one' support - Gro organic - Warwickshire Wildlife - Youplus - Three Trees Community Centre - Age UK- range of clubs and activities on offer - Eat Well Move More - Step Into Solihull - Wheels For All - Cancer and cardiac Rehab - Solihull Integrated Addiction Services (SIAS) - Man v Fat - Solihull Carers Centre – providing a range of support, including carers assessments and a befriending service to those with caring responsibilities in the borough. - Infant Feeding Cafes - Family Nurse Partnership (FNP) - Parenting Support including a number of parenting classes - Health visiting service - School nursing - Street Associations - The Cars, Big Local • **Psychological Support** - IAPT- Improving Access to Psychological Therapies (NHS)

	- Solihull Mind
Gateway Services (technology and transport)	• **Technology** - Social Prescribing Directory - Community Advice Hubs - My Life Portal • **Transport** - Not in Education, Employment or Training (NEET) Travel Training Team - WorkWise to support travel for those in new employment sand apprentices - English National Concessionary Pass- free bus and rail travel for people with disabilities. - Transport accessibility – range of products and facilities in place to support public transport use by people with disabilities. - Older person's pass- free bus and rail travel for those over pension age. - Children and students- reduced rates available.

Figure 22: Interventions for Loneliness and Social Isolation in Solihull

What Next in Solihull?

The appreciation and understanding of social isolation and loneliness as a serious risk factor influencing health and wellbeing in all ages is in its relative infancy when compared to other risk factors, such as obesity and smoking. Although the overall aim is to reduce levels of social isolation and loneliness in all age groups across Solihull, a number of the so-called 'foundation' elements involved in addressing risk factors for health and wellbeing are in a relatively early stage in Solihull and other local authorities. This includes obtaining adequate intelligence (particularly adequate prevalence data), awareness raising, training and monitoring that form the foundation of managing and influencing risk factors.

A review of the evidence in this area and one to one meetings with a range of different stakeholders in the Council and providers of services have contributed to the development of a number of recommendations, the majority of which address the important elements discussed and some of the current potential gaps.

Despite the relatively recent increased recognition of the issue, evidence of the negative impacts and what can alleviate isolation and loneliness is developing and campaigns for local authorities and other organisations to tackle the issue are rapidly gathering momentum. Additionally, despite being challenging, there is increasing evidence that interventions can be beneficial and that loneliness can be 'cured'- there are large potential health and financial benefits of reducing levels of social isolation and loneliness in the borough.

Challenges

The nature of loneliness and social isolation as a risk factor for early mortality present some specific challenges:

- Both can affect anyone at any age and time.
- The awareness, appreciation and understanding of the issue of social isolation and loneliness as a risk factor for early mortality and ill health is a relatively recent development compared to others such as smoking and obesity. Therefore intelligence surrounding the issue, including likely prevalence and levels of awareness and training is more limited.
- Particularly loneliness can be a deeply personal experience and those who are most affected are likely by the very nature of the condition to be potentially difficult to reach and engage.
- Isolation and the feelings of loneliness can be transient, lasting hours or days to chronic, lasting many years.
- It is potentially more difficult to assess and monitor levels of loneliness and social isolation than other risk factors such as smoking or weight.
- There is some stigma attached to being socially isolation and lonely, which may prevent people from seeking support[49]
- Appropriate interventions are very dependent on socio-demographic factors and individual preferences- therefore the range of potential activities and services that may reduce loneliness and social isolation are extensive.
- Similar to risk factors such as obesity, the wider environment can influence isolation and loneliness. This includes the location of housing, levels of safety including lighting and transport links; a multi-agency approach is required.

Recommendations

Five key initial priority areas have been identified:

1. **Awareness**

Objectives

- Loneliness and social isolation are recognized by the Council and other public, private and voluntary sector organisations as important risk factors that:
    - Cause early mortality, poor health and wellbeing, resulting in increased demand on statutory services.
    - Affect all ages and population groups and are not confided to the older population.
    - Require partnerships across the Council and with external organisations to ensure a whole systems approach is taken to addressing the issue.
    - Extends beyond the provision of services- the built and natural environment, including transport can have a large impact on the prevalence of social isolation and loneliness.
- The population of Solihull:
    - Are aware how to recognise social isolation or loneliness, particularly the early signs or potential risk factors in themselves and others and are aware of the potential negative impacts of social isolation and loneliness on health and wellbeing.
    - Feel comfortable discussing the issue of isolation and loneliness without the fear of stigma.
    - Are aware where to obtain information on the appropriate support and/or services available through a clear, easy to use pathway.

Recommended Actions

- Effective communication to ensure awareness is raised and a partnership approach is taken to tackling the issue, with sharing and co-ordination of intelligence, activities and identification of potential gaps in provision.
- Awareness raising activities including linking with national campaigns and awareness days, for example the Jo Cox Loneliness Start a Conversation, which includes making a pledge to start a conversation with someone who may be potentially lonely and the open letter campaign for carers.[10]
- Ensure there is readily available information for Council employees, providers and external organisations, particularly frontline staff on the issue of loneliness, how to measure this using a validated tool, high risk areas in the borough and support options available, for example through the use of a locally produced isolation and loneliness 'toolkit' or information sheet.
- Ensure the issue of social isolation and loneliness are considered where appropriate in future policies, including the awareness and consideration of the impact of developments in the built and physical environment, including transport provision on social isolation and loneliness.
- Awareness raising and stigma reduction in the wider community, including campaigns for the general population and specific at risk groups including carers and the older population.

2. Intelligence

Objectives

- Intelligence on the issue is developed, including prevalence data and location of high risk groups. This will assist in more targeted approaches and provide baseline information to monitor interventions on social isolation and loneliness and assess trends.
- Gain a deeper understanding of different experiences of social isolation and loneliness in the borough, particularly within at risk groups, including what additional support can be offered.

Recommended Actions

- Explore additional methods for determining the prevalence of social isolation and loneliness in the borough, preferably at regular intervals to supplement the current Public Health Outcomes Framework indicators. For example, inclusion of a specific validated assessment of social isolation and loneliness in the Solihull Place Survey that takes place every two years.
- Ensure social isolation and loneliness are being measured utilising validated tools by services in order to contribute to the prevalence data across the borough.
- Include a regular section on social isolation and loneliness as part of the Joint Strategic Needs Assessment (JSNA).
- Undertake qualitative research, including focus groups and surveys to explore the issue of social isolation and loneliness, particularly within potentially at risk groups in Solihull to improve intelligence, identify potential gaps and barriers to accessing services and engage the community.

3. Reach

Objectives

- More people who are potentially isolated or lonely in the borough are reached and access the appropriate level of support; resources are targeted appropriately ensuring the 'right people at the right time' are engaged.[19]
- A range of methods are utilised to reach people who are potentially lonely or isolated, including specific one-to-one services and ensuring all people who may come into contact with isolated or lonely groups are not only aware of the risk factors but also feel confident in having conversations about the issue and are aware what support is available, in a 'Making Every Contact Count' approach.

Recommended Actions

- Develop an appropriate training package on social isolation and loneliness that will help raise awareness and aim to ensure more people at risk are reached. This training would include-
  - The impacts of social isolation and loneliness.
  - At risk groups and how to raise the issue of social isolation and loneliness.
  - Taking action, including for example directing the individual to services/support or making an appropriate referral themselves.
- Distribute the training package appropriately across Council employees and the borough, to include targeting specifically front line staff who have contact with the Solihull population either on the telephone (for example the Connect line) or face to face, including pharmacies, libraries and schools. This should also include those employees who go into people's homes, including for example financial inclusion officers and the home library service who may be one of the only forms of contact an individual may have. Ensuring the most appropriate method of delivery is important- for some groups this may be a paper briefing rather than an e-learning module or inclusion in existing training modules, for example safeguarding training.
- Engage with partners already assessing for isolation and loneliness as part of their everyday practice, including the sharing of information, and where appropriate promote the use of consistent validated measurement tools and referral pathways across organisations.
- An expectation that those people coming into contact with people at risk of loneliness and isolation, including health and social care practitioners have an awareness of activities and support available in the borough and how to access this.
- Ensure that there remains specific evidence based one-to-one services in place to reach those people who are socially isolated and lonely who potentially require more intensive support. This includes ensuring that those services currently commissioned are evaluated effectively to support future commissioning decisions and add to the evidence base nationally.
- Determine and provide guidance on appropriate courses of action to take for those identifying and engaging people who are isolated or lonely, with an appreciation that for some a specific activity or service is neither sought nor required and alternative approaches may be necessary.

4. Interventions

Objectives

- Ensure the population of Solihull are able to make and maintain social connections if they so choose through a variety of methods, including more informal community activities or one-to-one and group activities.

    - Appropriate evidence-based interventions, including one-to-one services are provided and targeted appropriately to those most at risk, ensuring any 'gaps' in service provision for different population groups are identified and addressed through more in depth work by appropriate partners, for example through ongoing 'mapping' exercises.

- Ensure interventions are sustainable, ideally with reduced reliance on external funding. This includes the promotion of volunteering and an asset based approach, involving the community from early on in the development of activities.
- Wider recognition of the range of services that may alleviate social isolation and loneliness, demonstrated by an increased proportion of interventions including reduced isolation and loneliness as an outcome.
- Consistent use of a validated tool to directly measure and monitor levels of isolation and loneliness in service users, linked to performance monitoring and evaluation.
- The development of a clear referral point for those people who are lonely and isolated and in need of additional support, along with an appropriate specified 'directory' of activities and support available.
- Co-ordinate activities with other relevant work streams and campaigns in the Council, including the 'wellbeing offer', 'five ways to wellbeing' and stronger communities.

Recommended Actions

- Ensure the continued commissioning of evidence based one-to-one and group based interventions for social isolation and loneliness, including appropriate evaluation and measurement of loneliness and isolation to support future commissioning decisions. This includes on the going development of volunteering opportunities and community activities, for example through local libraries.
- Increase the number of services that include a reduction in the levels of social isolation and loneliness as an outcome, this includes extending beyond those services directly tackling loneliness and social isolation, to ensure it is a focus for all those who come into contact with individuals potentially at risk.
- Determine a validated measurement tool for social isolation and loneliness to be used consistently across the Council and external organisations in existing assessments and services. For some services this may include a measurement at baseline and intervals throughout an intervention. Process measures may be used, for example a minimum percentage of service users having a complete assessment of their social isolation and loneliness conducted. Assessing levels of social isolation and loneliness in this way will also contribute to increasing the intelligence on the issue in the borough. Outcome-based contracts, paying only for specific reductions in loneliness or isolation, or Social Impact Bonds could be considered for certain services.[19]
- Clarify the most appropriate referral route for those people being identified as lonely and socially isolated in the borough, with a designated clear directory of services available. This may include for example the use of one of the existing directory or points of contact including the Community Hub. It would be important to ensure where appropriate specific support including one-to-one interventions or psychological support can be readily accessed.
- Explore in greater depth with relevant partners appropriate methods to measure and address the issue of social isolation and loneliness in children specifically.
- Continue to map current services, interventions and community assets in the borough, including further work to assess potential 'gaps' in provision and barriers to access, particularly in the at risk population groups and high risk areas identified.
- The inclusion of social isolation and loneliness in the assessment, referral and monitoring processes of the new 'Wellbeing Offer' service redesign.
- Ensure the issue of social isolation and loneliness is appropriately represented in current campaigns, including for example the 'five ways to wellbeing' and 'Support to Success'.

5. Enabling

Objectives

- Ensure the population of Solihull are not prevented making or maintaining social connections by any specific barriers, including issues with accessibility, levels of safety, transport, caring responsibilities, physical disability or psychological conditions.

Recommended Actions

- Ensure there is recognition and awareness, particularly by those who come into contact with people most at risk of loneliness and isolation that psychological support, including Cognitive Behavioural Therapy (CBT) is an available intervention. This also includes working with providers of such services to raise awareness and assess adequacy of current service provision and available referral pathways.
- Work with partners to ensure the impact of future developments on levels of social isolation and loneliness in Solihull are considered and that the provision of transport is adequate and affordable, particularly for those not in employment/training or with a physical disability.
- Work with partners to ensure appropriate support is being offered to population groups who may have specific barriers to maintaining social connections or leaving the house, including carers and individuals with physical disabilities.

6. Workplace Wellbeing

Objectives

- Recognize that loneliness and social isolation may be affecting a proportion of Solihull Council employees either in the workplace, their personal lives or both and ensure this is addressed appropriately as part of the overall Council wellbeing package.

Recommended Actions

- Ensure the issues of social isolation and loneliness are addressed on the staff wellbeing intranet page. This may involve supplementing existing pages on social connections.
- Ensure managers acknowledge the importance of social isolation and loneliness and feel comfortable in identifying those potentially at risk and in providing appropriate support.

The recommendations provide some initial actions to begin tackling the issue of social isolation and loneliness in the borough. However, the issue is multifaceted and cannot be resolved by one organisation or intervention alone. Social isolation and loneliness form only one aspect of wellbeing and are recognized by PHE as a health inequality issue, with a link to social disadvantage and associated factors such as unemployment, the causes of which are complex.[3] Specific areas of focus identified include the development of stronger communities and promotion of volunteering opportunities. However, future work is likely to require multi-agency working through a focused steering group and as part of wider work streams, aiming to tackle a number of different elements of health, wellbeing and deprivation that will encompass social isolation and loneliness, through effective partnership working between the voluntary, public and private sectors. The initial recommendations, including raising awareness of the issue, engagement with other Council directorates and the additional planned qualitative work, aim to contribute towards and lay the foundations for subsequent work to reduce social isolation and loneliness across Solihull.

References

1. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417515/A_guide_to_community-centred_approaches_for_health_and_wellbeing__full_report_.pdf
2. Holt-Lunstad, J, Smith TB, Layton JB. (2010) "Social Relationships and Mortality Risk: A Meta-Analytic Review" PLoS Med 7. 2010 Jul 27;7(7):
3. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/461120/3a_Social_isolation-Full-revised.pdf
4. https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance
5. https://www.nice.org.uk/guidance/ng22/resources/older-people-with-social-care-needs-and-multiple-longterm-conditions-1837328537797
6. https://www.nice.org.uk/guidance/ng21/chapter/Recommendations
7. https://www.nice.org.uk/guidance/qs137/chapter/Quality-statements
8. www.parliament.uk/documents/fair-society-healthy-lives-full-report.pdf
9. https://www.campaigntoendloneliness.org/
10. https://www.jocoxloneliness.org/
11. http://www.solihull.gov.uk/Portals/0/StrategiesPlansPolicies/PublicHealth/Health_and_Wellbeing_Strategy.pdf
12. http://eservices.solihull.gov.uk/mginternet/documents/s44304/Solihull%20Public%20Health%203%20year%20Strategy%202017-18%20Commissioning%20Intentions.pdf
13. https://campaigntoendloneliness.org/guidance/wp-content/.../Risk-factorsGFLA.pdf
14. http://migrantsorganise.org/wp-content/uploads/2014/09/Loneliness-report_The-Forum_UPDATED.pdf.
15. https://www.crisis.org.uk/about-us/media-centre/1-in-4-homeless-people-will-spend-this-christmas-alone/
16. http://heart.bmj.com/content/early/2016/03/15/heartjnl-2015-308790.full.pdf
17. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2841310/pdf/nihms163826.pdf
18. http://jnnp.bmj.com/content/early/2012/11/06/jnnp-2012-302755#
19. http://www.socialfinance.org.uk/wp-content/uploads/2015/06/Investing_to_Tackle_Loneliness.pdf
20. https://campaigntoendloneliness.org/guidance/

21. https://www.researchgate.net/profile/Louise_Hawkley/publication/7184615_Loneliness_as_a_Specific_Risk_Factor_for_Depressive_Symptoms_Cross-Sectional_and_Longitudinal_Analyses/links/09e4150ad296529ebf000000/Loneliness-as-a-Specific-Risk-Factor-for-Depressive-Symptoms-Cross-Sectional-and-Longitudinal-Analyses.pdf
22. https://www.gov.uk/government/publications/mental-health-services-cost-effective-commissioning
23. https://www.campaigntoendloneliness.org/threat-to-health/
24. https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/measuringnationalwellbeing/2015-10-01#loneliness-and-well-being
25. http://www2.warwick.ac.uk/fac/med/research/platform/wemwbs/
26. http://www.outcomesstar.org.uk/wp-content/uploads/Briefing-what-is-the-Outcomes-Star-june2017-web.pdf
27. https://www.campaigntoendloneliness.org/wp-content/uploads/Loneliness-Measurement-Guidance1.pdf.
28. http://www.bc.edu/schools/gssw/lubben/description_of_thelsns.htmlhttp://www.phoutcomes.info/search/social%20isolation
29. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/629812/ASCOF_handbook_definitions.pdf
30. http://campaigntoendloneliness.org/guidance/wp-content/uploads/2015/06/StatisticsGFLA.pdf
31. http://leafoutcomes.uk/index.html
32. http://www.redcross.org.uk/~/media/BritishRedCross/Documents/What%20we%20do/UK%20services/Co_Op_Trapped_in_a_bubble_report_AW.pdf (
33. https://www.campaigntoendloneliness.org/wp-content/plugins/download-monitor/download.php?id=252
34. https://www.scie.org.uk/publications/briefings/files/briefing39.pdf
35. http://evserver02.solihull.gov.uk/EnterpriseVault/ViewMessage.asp?VaultId=195D4FD683FB4264EB5F7411792B6765E1110000evsite&SavesetId=201704263250044~20170302121331000~Z~F115933495B9B76646C4366822A05741&AttachmentId=3
36. https://www.york.ac.uk/media/crd/Loneliness%20and%20social%20isolation.pdf
37. https://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/Age%20UK%20Evidence%20Review%20on%20Loneliness%20July%202014.pdf?dtrk=true.
38. https://campaigntoendloneliness.org/wp-content/uploads/downloads/2012/03/A-guide-for-local-authorities-combating-loneliness.pdf.
39. https://www.campaigntoendloneliness.org/wp-content/uploads/CEL-Missing-Millions-Guide_final.pdf.

40. https://www.campaigntoendloneliness.org/wp-content/uploads/Promising-approaches-to-reducing-loneliness-and-isolation-in-later-life.pdf.
41. http://www.ahsw.org.uk/userfiles/Research/Perspectives%20on%20Psychological%20Science-2015-Holt-Lunstad-227-37.pdf.
42. http://content.apa.org/record/1997-43758-003
43. https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/
44. http://www.kingsfund.org.uk/publications/making-best-use-better-care-fund
45. https://www.co-operative.coop/campaigning/loneliness-campaign
46. https://www.campaigntoendloneliness.org/wp-content/uploads/downloads/2013/10/FINAL-Jeremy-Hunt-Response-17.10.13.pdf.
47. http://www.campaigntoendloneliness.org/wp-content/uploads/downloads/2013/11/FINAL-Still-ignoring-the-health-risks-an-update-to-our-June-2013-review-of-HWBs4.pdf
48. https://www.mentalhealth.org.uk/sites/default/files/the_lonely_society_report.pdf
49. https://www.scie.org.uk/publications/ataglance/69-adults-safeguarding-types-and-indicators-of-abuse.asp
50. http://www.solihull.gov.uk/Portals/0/KeyStats/JSNA/JSNA_summary.pdf
51. www.solihull.gov.uk/portals/0/keystats/solihullpeopleandplace.pdf
52. http://www.carersuk.org/images/News__campaigns/The_world_Shrinks_Final.pdf
53. https://www.sense.org.uk/sites/default/files/11636-FriendshipReport-Sngl-MR.pdf
54. https://www.sense.org.uk/sites/default/files/loneliness_report_-_someone_cares_if_im_not_there.pdf
55. http://www.ageuk.org.uk/professional-resources-home/research/loneliness/loneliness-maps/
56. https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015
57. http://evserver02.solihull.gov.uk/EnterpriseVault/ViewMessage.asp?VaultId=195D4FD683FB4264EB5F7411792B6765E1110000evsite&SavesetId=201704263250044~20170302121331000 0~Z~F115933495B9B76646C4366822A05741&AttachmentId=3
58. http://www.ageuk.org.uk/documents/en-gb/for-professionals/evidence_review_loneliness_and_isolation.pdf?dtrk=true.
59. http://www.housingcare.org/downloads/kbase/3310.pdf
60. http://www.ageuk.org.uk/solihull/services-for-you/care-navigator-service/
61. https://solihull.mylifeportal.co.uk/localareacoordination/
62. http://www.thinklocalactpersonal.org.uk/_assets/BCC/Learning_Outcomes_for_Thurrock_and_Derby_March_2016.pdf.

63. eprints.lse.ac.uk/46440/1/Knapp_Building_community_capital.pdf

64. https://www.kingsfund.org.uk/publications/social-prescribing

65. https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_FINAL.pdf.

66. http://menssheds.org.uk/what-is-a-mens-shed/

67. A meta-analysis of interventions to reduce loneliness, C Masi Masi CM, Chen H-Y, Hawkley LC, Cacioppo JT. A meta-analysis of interventions to reduce loneliness. Personality and Social Psychology Review. 2011;15(3):219-66.

68. https://www.nice.org.uk/guidance/ng44.

69. https://www.local.gov.uk/sites/default/files/documents/casserole-club-pdf-2-page-653.pdf

70. https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/Loneliness_briefing_SUMMARY.pdf

71. https://www.campaigntoendloneliness.org/wp-content/uploads/downloads/2011/11/Safeguarding-the-convey.-A-call-to-action-from-the-Campaign-to-End-Loneliness.pdf.

72. https://campaigntoendloneliness.org/guidance/structural-enablers/