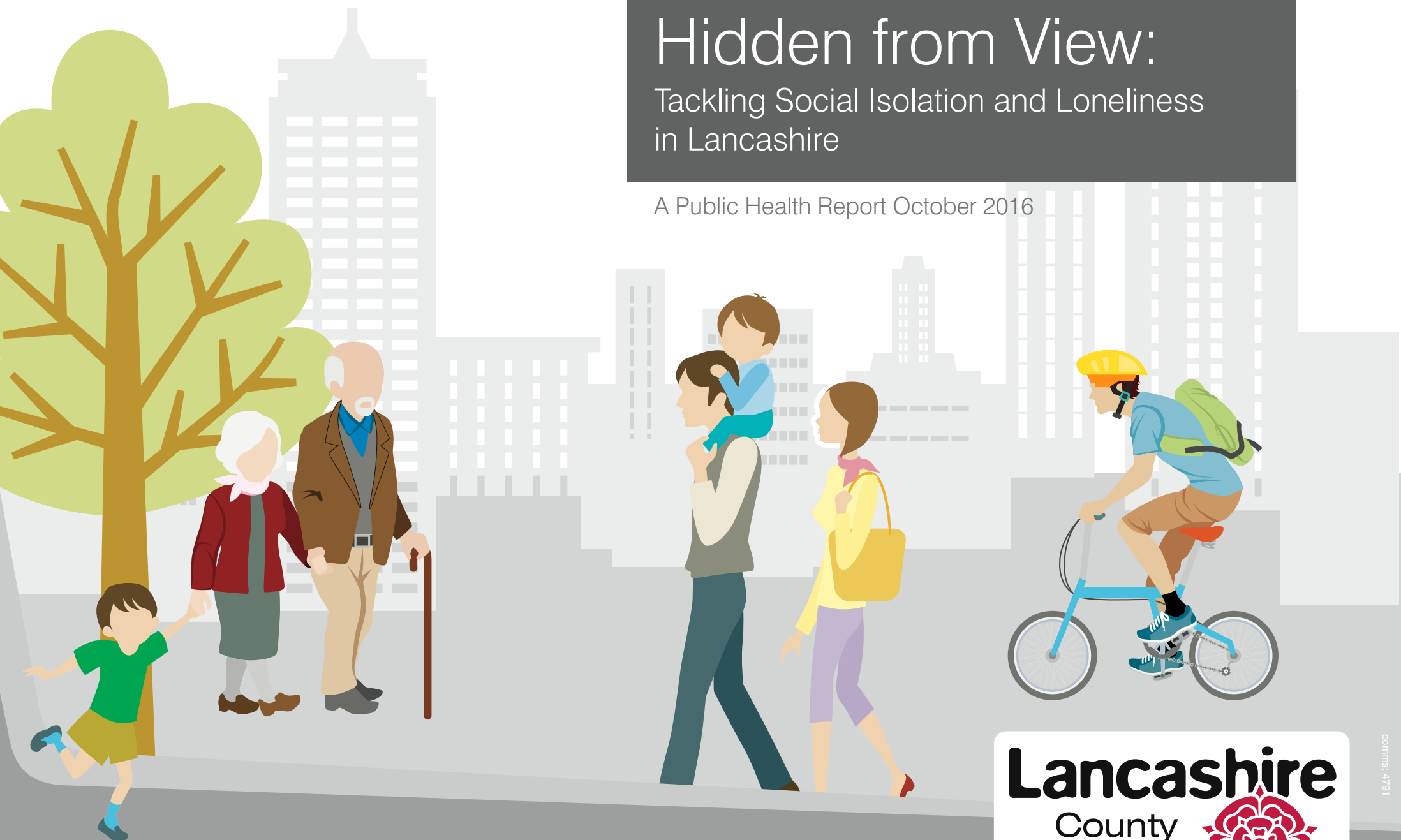


Hidden from View:

Tackling Social Isolation and Loneliness in Lancashire

A Public Health Report October 2016



www.lancashire.gov.uk

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This report is dedicated with fondness to the memory of Max Neill, who worked as a Community Connector at Lancashire County Council. Max's approach based on Person-Centred Thinking and Planning - for which he was known both locally and internationally - was instrumental in guiding our work, particularly the stakeholder events and the thinking which emerged.

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Foreword



(by Dr Sakthi Karunanithi, Director of Public Health, Lancashire County Council)

Social isolation and loneliness are pressing and difficult public health issues increasingly affecting us both individually and as communities. With tens of thousands of households throughout Lancashire estimated to be directly affected by social isolation

and loneliness, causing poor health and wellbeing and shortened lives, at potentially up to hundreds of £million cost annually to Lancashire health and social care, we can no longer afford to ignore this issue or adopt a fragmented approach.

By better understanding and tackling social isolation and loneliness systematically at a local level, partner organisations and people working across Lancashire can enable people to live longer, healthier and more fulfilling lives, while reducing pressure on our already overstretched health and social care systems.

This report, 'Hidden from View: Tackling Social Isolation and Loneliness in Lancashire', and its linked toolkit, provides a mass of useful and relevant information about social isolation and loneliness in Lancashire - gathered by Lancashire County Council with partners including statutory and voluntary organisations and the public. From

this information the authors develop and outline a set of evidence-based principles for success in tackling social isolation and loneliness at a local level, currently being trialled in projects in Lancashire.

I commend this report to organisations, staff and volunteers who would like to better understand the issues both for Lancashire as a whole and in their local areas. It will help to clarify the part you can potentially play in helping to tackle social isolation and loneliness, bringing this hidden issue into the open so that fewer people suffer through being or feeling alone.

Preface

With changing family and community structures and an ageing population, increasing numbers of people, especially older adults, are becoming socially isolated or lonely. Chronic social isolation can reduce life expectancy by an equivalent amount to smoking, with chronic loneliness increasingly recognised as having far reaching consequences for the health and wellbeing of both individuals and wider communities.

Social isolation and loneliness impact significantly on health and social care systems, both directly and through leading to long-term conditions. This is estimated to cost health and social services in Lancashire at least £40 million annually, and possibly £100s of millions. Whilst tackling social isolation and loneliness has been on the adult social care agenda for some time, the wider public health issues are increasingly recognised, providing a practical opportunity to integrate health and social care around this topic. There is therefore a strong imperative to tackle social isolation and loneliness, and it is

prioritised in a number of policies and strategies for partner organisations in Lancashire. The latest Director of Public Health Annual Report for Lancashire prioritises improving support for older people affected by social isolation and loneliness through a joined up, whole systems approach.

About this report

There is growing awareness about the extent of social isolation and loneliness and its impacts on health and wellbeing, with increasing recognition that something needs to be done to address this. The purpose of this report is to share learning and provide a practical resource for partner organisations on tackling social isolation and loneliness in Lancashire, based on a needs assessment carried out by Lancashire County Council to inform service planning. It became clear from working with partners that they wanted to tackle this issue as a priority, but needed guidance on how best to do this. This report and linked toolkit includes

details of our social isolation and loneliness needs assessment, linking to a broad range of resources - both third-party documents and Lancashire County Council's own work in Lancashire. It will help partner organisations and others in Lancashire to understand the issues around social isolation and loneliness in their localities and provide a framework for action. It summarises work carried out by Lancashire County Council with partner organisations, to:

- Better understand how many people in Lancashire experience social isolation and loneliness and where;
- Understand what can work to tackle the issue;
- Provide recommendations on how best to work at a local level.

Who is it for?

This report and toolkit aims to provide practical information and advice on understanding and addressing social isolation and loneliness for local partner organisations and their employees in Lancashire. It is aimed at a range of people including professionals, and those working and volunteering in public and third sector organisations, who work with the population of Lancashire.

A Note on the Use of 'We', 'Us', 'Our', 'You' and 'Your' in this Report

This report has been produced by a project group within Lancashire County Council, with help from many partners across Lancashire - especially through inputting to stakeholder events in summer 2015 to inform the needs assessment.

To clarify for the reader, "We", "Us" and "Our" is used in this report to refer to different things:

- Lancashire County Council or, more specifically, the project group who have written this report – for example, "We estimated how many Lancashire households are affected by social isolation";

- Partners living and working in Lancashire, including those who are working on the topic of social isolation and loneliness, and/or have contributed to the stakeholder events;
- More generically (possibly including the reader) – for example, when describing the general state of knowledge on this topic ("We know from the evidence...")

Similarly, "You" and "Your" is used to refer to:

- The reader, as a partner in Lancashire with interest in the topic of social isolation and loneliness;
- The reader, as someone (or an organisation) who has specifically contributed to this report through participating in the stakeholder events – for example, "You told us..."

While the language has been chosen to make the report more personable and easier to read, the context should make it clear who is referred to in each case.

Executive Summary

What is social isolation and loneliness and why is it an important public health issue?

With changing family and community structures and an ageing population, increasing numbers of people, especially older adults, are becoming socially isolated or lonely. Social isolation has been shown to reduce life expectancy, and loneliness to impact more on health and wellbeing, for example, leading to greater risk of developing depression, dementia or physical conditions such as high blood pressure.

Whilst there is much overlap between social isolation and loneliness, they are different and may be experienced differently, have different impacts on health and wellbeing and may require different responses.

Social isolation is about lacking sufficient relationship quantity and quality, whilst loneliness is a subjective feeling which may or may not relate to observable isolation. People can be socially isolated

without necessarily feeling lonely, and vice versa, although the two often go together.

While none of us are immune from the risk of becoming chronically socially isolated or lonely, some people are at much greater risk. The risk relates to both individual characteristics and circumstances, especially triggers of events involving loss - for example of health, of a partner or friends, or of work. Such events tend to become more frequent with advancing age, and living in more deprived circumstances also tends to increase the risk.

This also needs to be seen in the context of wider society, since there are many factors that can impact on social isolation and loneliness, most of them outside our individual control. These include aspects of the places and communities we live in, and wider socio-economic factors, as well as our own personal characteristics and circumstances.

Whilst social isolation and loneliness has been on the adult social care agenda for some time, the wider public health issues are being increasingly recognised and there is a practical opportunity to integrate health and social care around this topic. Social isolation and loneliness impact significantly on health and social care systems, both directly and through leading to long-term conditions. [This is estimated to cost health and social services in Lancashire at least £40 million annually, and possibly £100s of millions.](#)



There is therefore a strong imperative to tackle social isolation and loneliness, and it is prioritised in a number of policies and strategies for partner organisations in Lancashire. The Lancashire Fairness Commission report and the Lancashire Health and Wellbeing Strategy consider tackling social isolation and loneliness as a priority issue. The latest Director of Public Health Annual Report for Lancashire prioritises improving support for older people affected by social isolation and loneliness through a joined up, whole systems approach.

How much of an issue is social isolation and loneliness for Lancashire?

Because social isolation and loneliness is essentially a hidden issue, it is hard to know exactly who or how many people are affected and where they are, and how much this costs.

Although we may not know individually who is affected by social isolation and loneliness, we have developed a good understanding, through 'modelling', of characteristics of those people most likely to be affected. We have been able to translate this into estimating how many households are affected in the various areas of Lancashire, and also who is most likely to be affected (in general).

Social isolation and loneliness is likely to affect 10s of thousands of people in Lancashire. We estimate that, across Lancashire, [at least 22,000 households or 35,000 people](#) contain one or more household members who are chronically socially isolated. Most, though not all, affected households are older adults aged over 70. We can add to this figure those who are lonely without being isolated - [other sources](#) estimate about 35,000 chronically lonely older adults aged 65 and over in Lancashire.

Different groups of people and different places have differing levels of need. As a general rule, likelihood of being socially isolated or lonely tends to rise both with age and deprived circumstances. The coastal and rural areas of North Lancashire are likely to have the highest levels of social isolation and loneliness in Lancashire, with 7% of all Fylde households estimated to be socially isolated, including 9% of all households in Lytham and St Anne's. Other districts including Wyre, Preston, and the East Lancashire districts, also have high proportions of socially isolated households at sub-district level.

Due to their generally older populations, areas with high levels of social isolation are not necessarily areas of high deprivation. However, as with area-based deprivation, there are pockets of social isolation and loneliness in most parts of Lancashire, often in urban centres. Overall, the numbers of households estimated to be socially isolated are spread fairly evenly between the three Lancashire County Council 'localities' of North, East and Central Lancashire.

What is the current picture and what is already happening?

Partner organisations and the public taking part in five [stakeholder events held across Lancashire in summer 2015](#) agreed that, in general, there are many relevant existing activities at a local level within Lancashire to help people who are isolated. The difficulties are mainly that activities are insufficiently coordinated or joined up and that many people who could benefit miss out through being hidden from view.

What works to help people experiencing social isolation and loneliness?

To help people already experiencing social isolation and/or loneliness, or who are at high risk of this, we need to consider a complete pathway. This starts with reaching people, through finding and successfully engaging with them; then understanding their particular circumstances, abilities and needs;

and finally supporting them in suitable and effective activities (preferably community-based). This all needs to be done in a way which is sustainable for the local system.

People who are socially isolated [can be helped through](#) engaging with social group activities, where appropriate, face-to-face on a one-to-one basis (for example, through befriending), or through using technology to connect with others. The psychological aspects of loneliness must be addressed to effectively help people who are chronically lonely, as well as addressing any social isolation which they may also experience.

There are many aspects of how activities can be set up and organised to make them more effective; for example, including educational, arts or social support elements in group activities, targeting them at specific groups of older people, and actively including participants in the design of activities. While the evidence base is growing,

the evidence on what works is not particularly strong, and this increases the need to build in good monitoring and evaluation, to better understand what works and why, especially in a local context.

It appears that interventions to tackle social isolation and loneliness can be cost-effective and, in some cases, cost-saving also. However, despite our understanding of the high economic impacts of social isolation and loneliness, the evidence base is again weak around costs and benefits of particular interventions.

To help identify people who are socially isolated or lonely, a 'making every contact count' (MECC) approach can be taken. This makes use of frontline professionals, who may come into contact with those in need - either in their homes or elsewhere in the community - to reach people and refer them to a next stage of help, should they wish. Other ways to identify people in need include a technical data-driven approach

– for example, using results from modelling or lists of vulnerable people held by partner organisations; and a public awareness-raising approach, to actively engage the community in tackling the issue.

At a population level, strategies to promote positive ageing should be considered.

Putting it all together to tackle social isolation and loneliness at a local level

We can use the information gathered here to help reduce social isolation and loneliness at a local level, to help create and deliver a sustainable whole systems approach to reach, understand and support people. This involves statutory and third sector organisations working together with each other and communities, including potentially businesses.

The [proposed approach](#) developed here for finding and helping individuals

experiencing social isolation and loneliness is based on the new [Lancashire Wellbeing Service](#) acting as a hub for referral of individuals. It will holistically assess people's needs, and provide initial support. Strong partnership working at local level is essential to complement this and make it work effectively. This includes making full use of, and supporting, community groups and activities, with good information sharing including the via the new Live Well directory; as well as innovative approaches to find and engage with people who are socially isolated or lonely.

Bringing social isolation and loneliness into focus

We have identified that places across Lancashire have local populations, among whom some people will be socially isolated or lonely and mainly hidden from view. We now need to bring into focus efforts to tackle this determinant of health and wellbeing across Lancashire.

Tackling loneliness and social isolation are part of everybody's business, and we all have a role to play - whether as a good neighbour looking out for those affected in our own communities, or as service providers and policy makers. Interventions will be most effective if they are part of a strategic, whole systems approach. There is an opportunity to bring this into focus as part of the NHS Five-Year Forward View and associated Sustainability Transformation Plans for Lancashire; and to link in with New Models of Care, Vanguard sites and Healthy New Towns.

We provide resources and examples of where approaches are already being developed and are working across Lancashire, [such as the Transformation Challenge Award \(TCA\) work](#) in Rossendale and Chorley. This aims to reduce the demand for more expensive social and health care services through providing an integrated wellbeing and resilience system.

We describe how partners can mobilise the outlined approach to [reaching](#), [understanding and supporting](#) individuals experiencing or at risk of social isolation or loneliness through building on and making use of existing resources. This includes the new [Lancashire Wellbeing Service](#), for which 35% of current referrals relate to social isolation or loneliness.

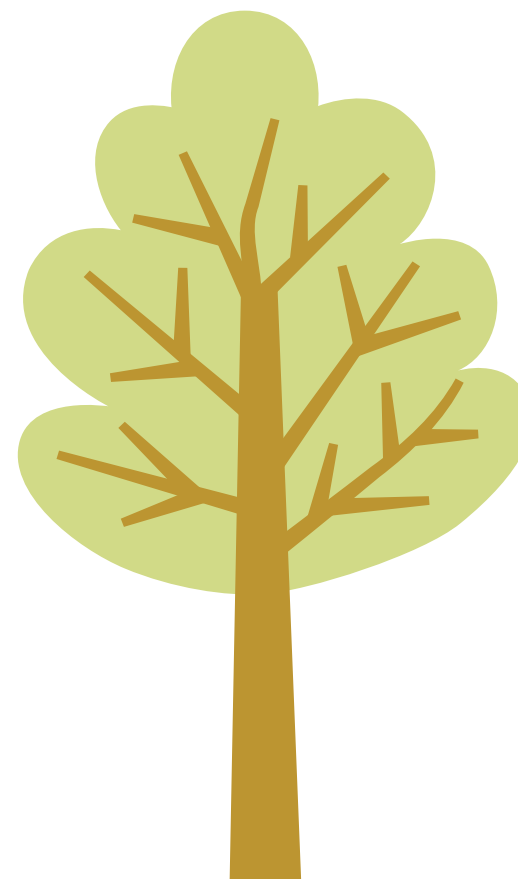
Partners can mobilise through coming together around the issue of social isolation and loneliness in appropriate localities and sub-localities (considering who is best placed to take a lead). This may involve an initial stocktake of relevant local needs and assets; as well as thinking and acting innovatively in considering social isolation and loneliness across local policies, strategies, plans and activities. Local partners may share information and expertise (including making use of the new Live Well directory), and identify gaps and possible duplication. Through such work, local pathways can be established for people who are socially

isolated or lonely, which are clear to partners and the public alike.

Resources

This report links with a large number of documents intended as a supporting toolkit. These include both third-party documents and additional resources from the work carried out by Lancashire County Council.

Full use can be made locally of these resources, such as modelling and [mapping](#), and the [evidence on what works](#), to combine with local intelligence on the ground. We would likewise encourage partners to share their learning more widely, to help others across Lancashire.



Chapter 1: About Social Isolation and Loneliness and why it is an important issue

What do we mean by social isolation and loneliness?

The terms social isolation and loneliness mean different things but are often used interchangeably.

When we talk about a person being socially isolated this is about the frequency of any social contact they might have and the quality of those contacts. Loneliness is much more subjective and is about how someone feels. So for example a person can have little or no social contact and yet not feel lonely, and another person may appear to have good social networks and yet still feel lonely. Of course, many people who are socially isolated may feel lonely as well.

Why is it an important Public Health issue?

Social isolation and loneliness is well evidenced as an important public health issue. Now there is growing recognition that loneliness is a serious problem, with far reaching consequences, not just for individuals, but also for wider communities.

With an ageing population, changing structure of families and communities, increasing numbers of older people are becoming socially isolated and / or lonely.

We know from the evidence that being socially isolated or lonely has significant impacts on people's physical and mental health. Research suggests that being socially isolated reduces life expectancy, through affecting health as strongly as smoking 10 to 15 cigarettes a day or alcoholism.

Loneliness leads to greater risk of developing depression, dementia, or physical conditions such as high blood pressure. People who are lonely are more likely to visit their GPs or accident and emergency departments and are more likely to have emergency admissions. In addition, estimates suggest that people who are socially isolated and lonely are three times more likely to enter local authority funded residential care.

As well as the damaging effects on individuals' health and wellbeing there are significant economic costs, which are explored in [Chapter 2](#).

All of which adds up to the fact that tackling social isolation and loneliness is a Public Health imperative.

“Individuals who are socially isolated are between two and five times more likely than those who have strong social ties to die prematurely.”

Michael Marmot (2010) – Fair society, healthy lives (The Marmot Review)

While it could be said that everybody is potentially at risk of becoming chronically socially isolated or lonely, it is also important to recognise that this risk is by no means equal for everyone⁷, with certain groups of people more at risk of being affected. Key life events often relating to loss, such as bereavement, retirement, loss of health or of a familiar environment, can act as triggers. In general, older people, especially aged 70+, are more likely to experience social isolation and loneliness due to these contributing factors. Similarly, living in more deprived circumstances tends to

increase the chance of being socially isolated and lonely.

Research over decades³⁸ has found a fairly constant proportion (10-13 per cent) of older people feeling lonely often or always. Over the same time period, there have been a growing percentage of older people who sometimes feel lonely. As we have an ageing population the scale of the problem is increasing. Recent estimates³⁸ suggest that over one million people in the UK aged over 65 are often or always lonely.

Essex County Council in 2013 published an approach⁸ to estimating population-level social isolation. They reviewed the evidence to identify 14 characteristics which increase an individual's risk of experiencing social isolation, and we have used these to help understand the likely scale of the impacts of social isolation and loneliness in Lancashire. This is explored in Chapter 2.

There are also factors such as living in rural communities or deprived urban communities which increase an individual's risk. Social isolation and

loneliness is complex, and by its very nature the scale of the suffering is often hidden until the impact manifests itself as medical problems which then require costly clinical interventions.

Characteristics which increase the risk of being affected by social isolation and loneliness

Risk factors increasing the chance of someone being socially isolated

- Single pensioners; Widowed
- Retired; Struggling financially; Not employed
- Poor health; Permanently sick; Suffering from depression
- Suffering from poor mobility; Visually impaired; Hard of hearing
- Unlikely to meet friends or family regularly; Unlikely to interact with neighbours
- Less-educated (no further education, no degree)

CAUSES of Social Isolation and Loneliness⁹

The Bristol City Council diagram shows the wide range of contributing factors for social isolation and loneliness. By considering these factors we can improve the environment by design.

Society:

- People: living longer, more on our own, families further apart;
- Socio-economic drivers - link of societal factors with individual people, for example, through age, ethnicity, education, employment status;
- Places: housing, planning and transport

Community:

- People: access to social networks – family, friends and wider networks;
- Places: access to amenities, transport, crime and safety.

Individual:

- People: personality, confidence, health, resilience, use of technology;
- Life Events: related with loss – early life events, moving, identity crisis, loss of job, loss of partner, loss of health.



We have talked about the characteristics of individuals which make them more at risk of being adversely affected as well as the life events. But place is important too, the assets of the community where the individual lives can make a huge difference. If there are high levels of social capital, that means there are groups and activities that people can be connected with. Also if crime levels are perceived to be low then people feel more confident to go out and build those connections.

So, why are they important issues for Lancashire?

We estimate at least 22,000 households or 35,000 people across Lancashire are socially isolated or lonely, and that households in Wyre, Lancaster, Fylde and Preston have the highest numbers of social isolation.

Public services are stretched and, if we do not do more to tackle this issue early by preventing the health impacts of social isolation and loneliness, our health

and social care services will be unable to cope with the resultant demand.

Tackling social isolation and loneliness is identified as a key priority in a number of policies and strategies across partner organisations in Lancashire

Lancashire County Council's draft Corporate Strategy

Within its [draft corporate strategy](#)¹⁰ the County Council aims to take a neighbourhood approach. Universal services will be delivered from a number of neighbourhood centres and more targeted services will be resourced based on need. This is [Marmot's](#)¹¹ proportionate universalism in practice. Reducing demand for Adult Social Care services is a key priority for the County Council and tackling social isolation and loneliness will be one of the ways it seeks to achieve this.

Lancashire's Director of Public Health Annual Report

In his [annual report](#)¹², the Director of Public Health in Lancashire makes improving support for older people affected by social isolation and loneliness a key priority by ensuring a joined up, whole systems approach

Lancashire Fairness Commission

The [Lancashire Fairness Commission](#)¹³ looked at fairness across the life-course and recognised that whilst social isolation and loneliness increases with age it is not inevitable (p.42). It cautioned against an over-dependence on digital services as a substitute for face-to-face contact. The Commission recommended the use of asset based approaches within communities, since the evidence which was presented to the Commission identified improving social capital as the best method of addressing isolation and building stronger communities overall.

NHS Five Year Forward View¹⁴ and Sustainability and Transformation Plan (STP)

To deliver the [Five Year Forward View](#) vision of better health and better patient care, the NHS shared planning guidance 2016/17 to 2020/21 outlines a new approach to help ensure that health and care services are built around the needs of local populations. The guidance requires every health and care system in England to produce a multi-year [Sustainability and Transformation Plan \(STP\)](#)¹⁵ with associated funding available. South Cumbria and Lancashire STP sets out the case for change and has identified eight priority areas. One of the priority areas is Prevention, which has a key objective in Promoting wellbeing and addressing socioeconomic and environmental determinants.



Chapter 2: How do we know social isolation and loneliness is an issue in Lancashire?

To inform our approach to tackling social isolation in Lancashire, we needed to understand both the current situation, and what would work to reduce social isolation and loneliness - helping to tackle the issue and improve the situation. This Chapter reviews the current situation from a technical viewpoint, and explains how we know social isolation and loneliness to be an issue in Lancashire. It looks at:

- **Who is socially isolated or lonely?**
- **Where do those socially isolated or lonely people live?**
- **How many people are affected?**
- **How much does it cost the health and social care system?**

What we did

Since social isolation and loneliness tend to be by their nature, hidden, we have very little actual data on how many people are affected in Lancashire and where they are, although it is recognised

that some local areas may have done their own work on this in more detail. Lancashire County Council's Adult Social Care Survey suggests that roughly half of both adult social care users and their carers consider themselves as socially isolated. Whilst this is useful, the information only relates to those people in contact with Adult Social Care and gives no more detail within Lancashire. To further understand where and for who social isolation and loneliness could be important issues across Lancashire we have used modelling. This complex technique can help estimate facts and figures about a topic like social isolation and loneliness which is hard to measure directly. It combines existing information, using assumptions, to estimate the answers we are looking for.

Essentially, we applied our understanding of what makes people more likely to be socially isolated¹⁶ to the [data](#)¹⁷ on who lives where in

Lancashire to estimate who is socially isolated and where. You can access more detailed information on our method used in Lancashire County Council [here](#).

Results from this modelling should be treated as educated guesswork rather than necessarily a true picture on the ground. They could be thought of as one part of a jigsaw puzzle to be used where possible with other local information.

Through modelling, we have produced local maps with key estimated facts and figures which can be used for a number of purposes:

- Planning whether and where to target activities thinking about both location and the people at risk of isolation
- Monitoring and evaluation of activities
- Funding considerations

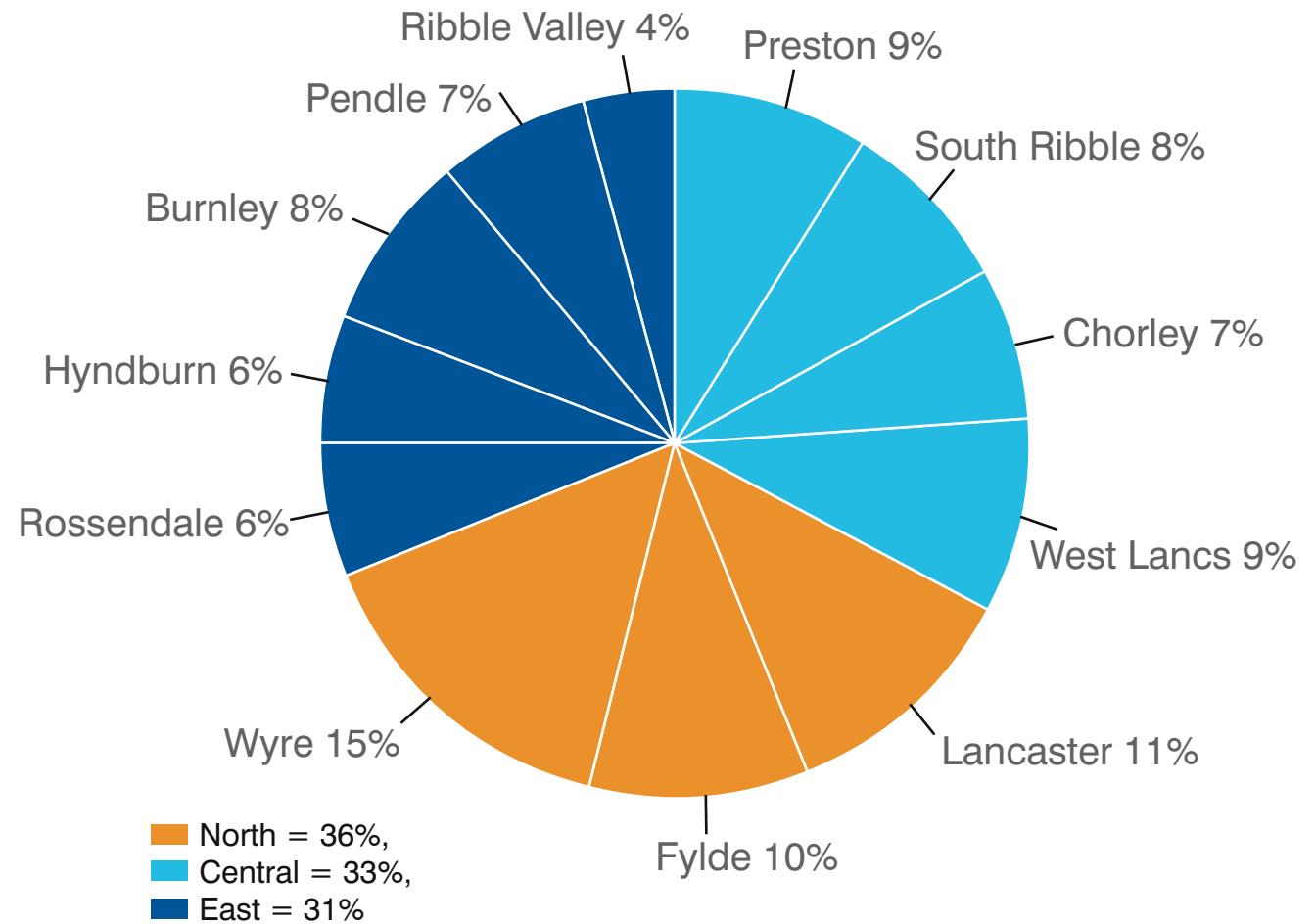
Note: We have not specifically modelled loneliness since a [method](#)¹⁸ for this has only recently become available. Because of this, our modelled results will underestimate the true issue, although we may assume that many people affected by loneliness will also be included in the results.

How many people are affected, and where are they?

At District level

We estimate using modelling that about 22,000 households across the Lancashire County Council area are affected by social isolation and could potentially benefit from help. By district, the greatest numbers of households estimated to be socially isolated are in Wyre (3,000), Lancaster (2,500), Fylde (2,400) and Preston (2,300). These figures are approximate and are shown as a percentage of the total 22,000 households estimated to be affected in the following pie chart.

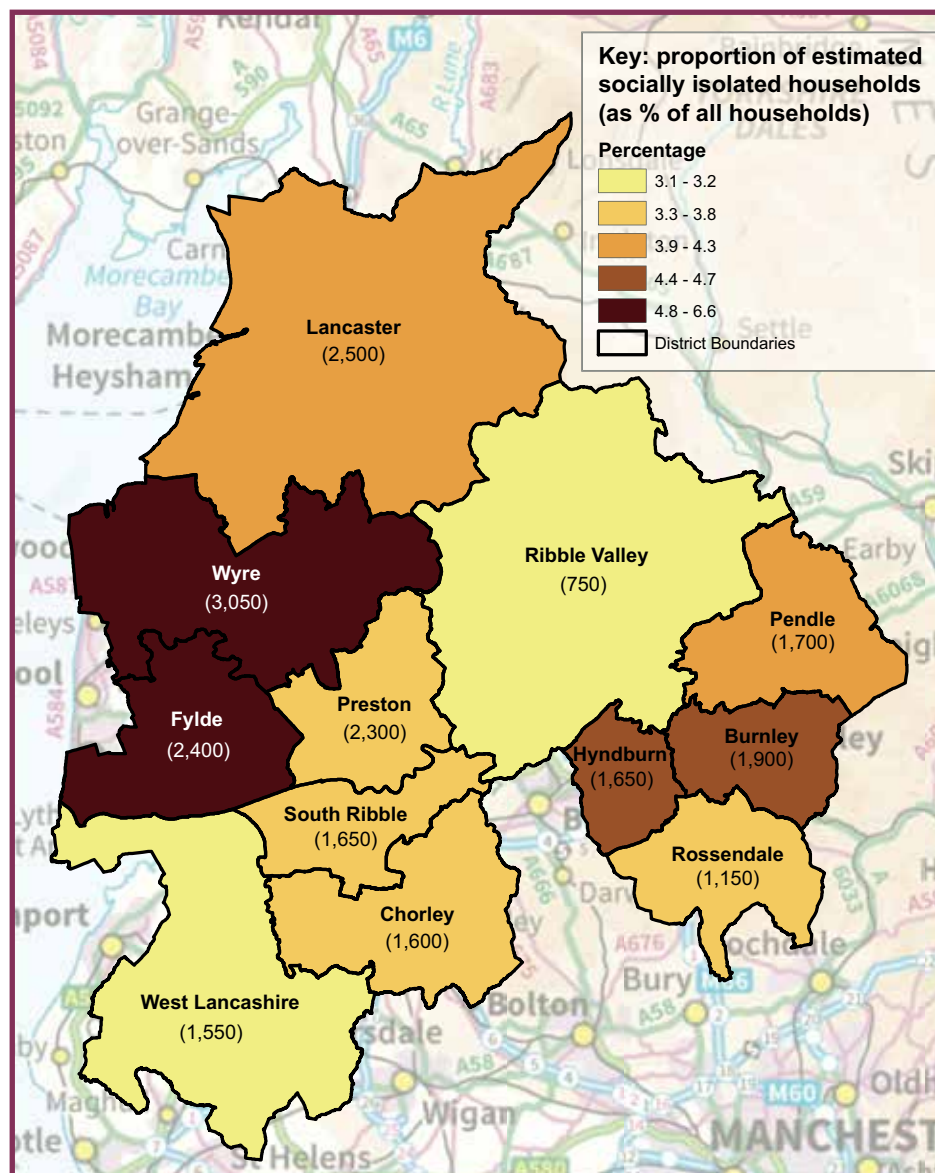
Households at risk of social isolation (% by District)



North/Central/East refer to Lancashire County Council 'localities'

It can be seen that North (36% of total), Central (33%), and East (31%) Lancashire County Council localities all have fairly similar numbers of households affected. However, in terms of individual Districts, the three districts in North locality, that is Wyre, Lancaster and Fylde, have the highest proportions of affected households.

These figures do not take into account the different population sizes in each District. To get proportions, we divided the number of households in each District estimated to be socially isolated by the total number of households. Districts with the highest proportion of households estimated to be socially isolated are Fylde (7% of households) and Wyre (6%); Burnley and Hyndburn also show high proportions. The following map combines the figures for District proportions and estimated numbers of households affected. See also [Table](#).



Estimated proportion and number of socially isolated households, for the 12 Lancashire districts

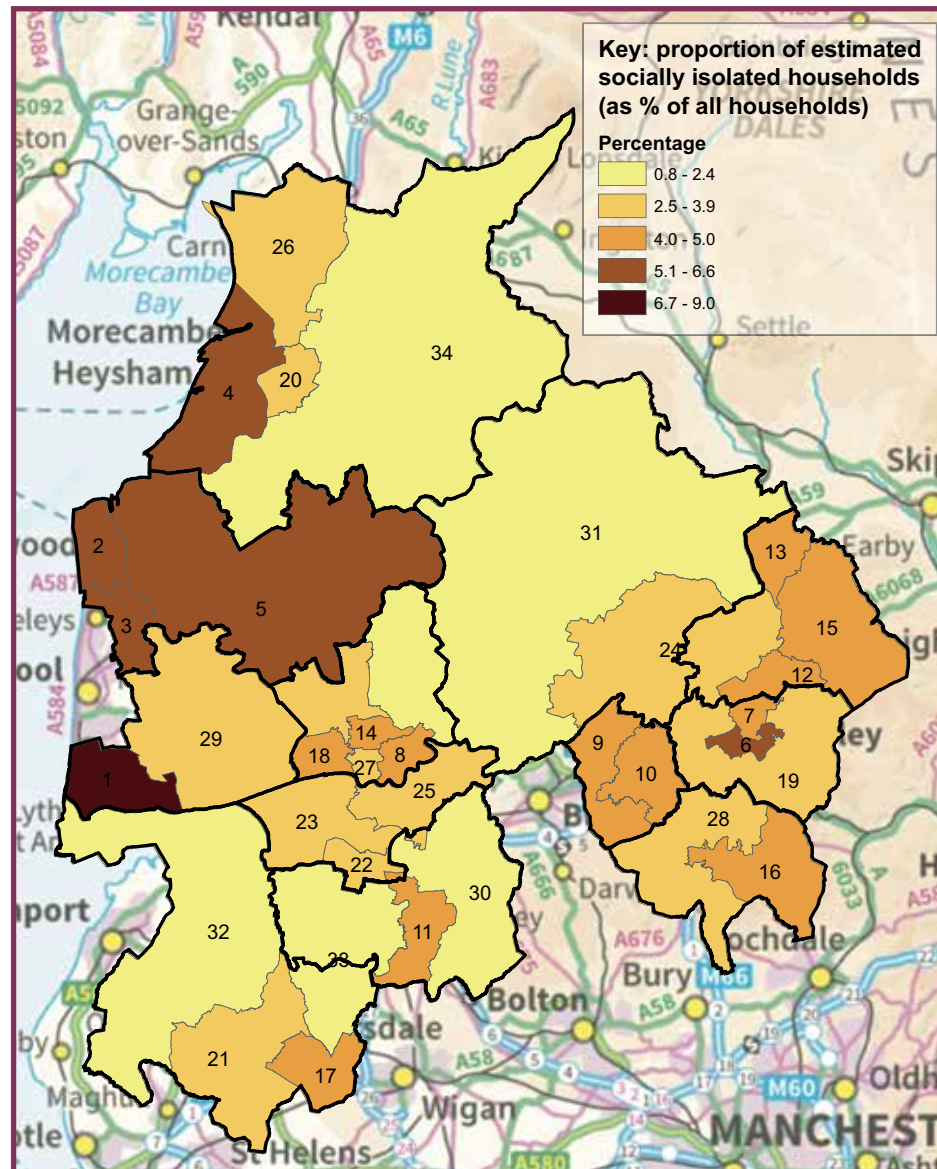
(Estimated number of socially isolated households below each district name).

Source: Mosaic 2014 and social isolation and loneliness index figures
Mapped by: Business Intelligence, LCC. Ordnance Survey 100023320

At Service Planning Area (SPA) level

We have modelled social isolation for the proposed 34 Service Planning Areas across the County as per [the draft Lancashire County Council Corporate Strategy](#). Service Planning Areas are a new local geography for which LCC plan to offer services through neighbourhood centres. Lytham St Anne's, Thornton and Cleveleys, Morecambe and Heysham, Hyndburn East and Chorley Central are each estimated to have between 1,000 and 2,000 socially isolated households in total.

Taking the different population sizes into account, Lytham St Anne's, Fleetwood, and Thornton and Cleveleys had noticeably high proportions of estimated isolated households, at 9%, 7% and 6% of households respectively. Between 5 and 6% of households in Morecambe and Heysham, Wyre Rural and Burnley Central are estimated to be socially isolated, followed by other areas within East Lancashire as well as Preston. The following map shows proportions of socially isolated households for the



Estimated proportion of socially isolated households, for the 34 Lancashire service planning areas (SPAs)

SPA ranking shown on map, from highest proportion of socially isolated households (1) to lowest (34).

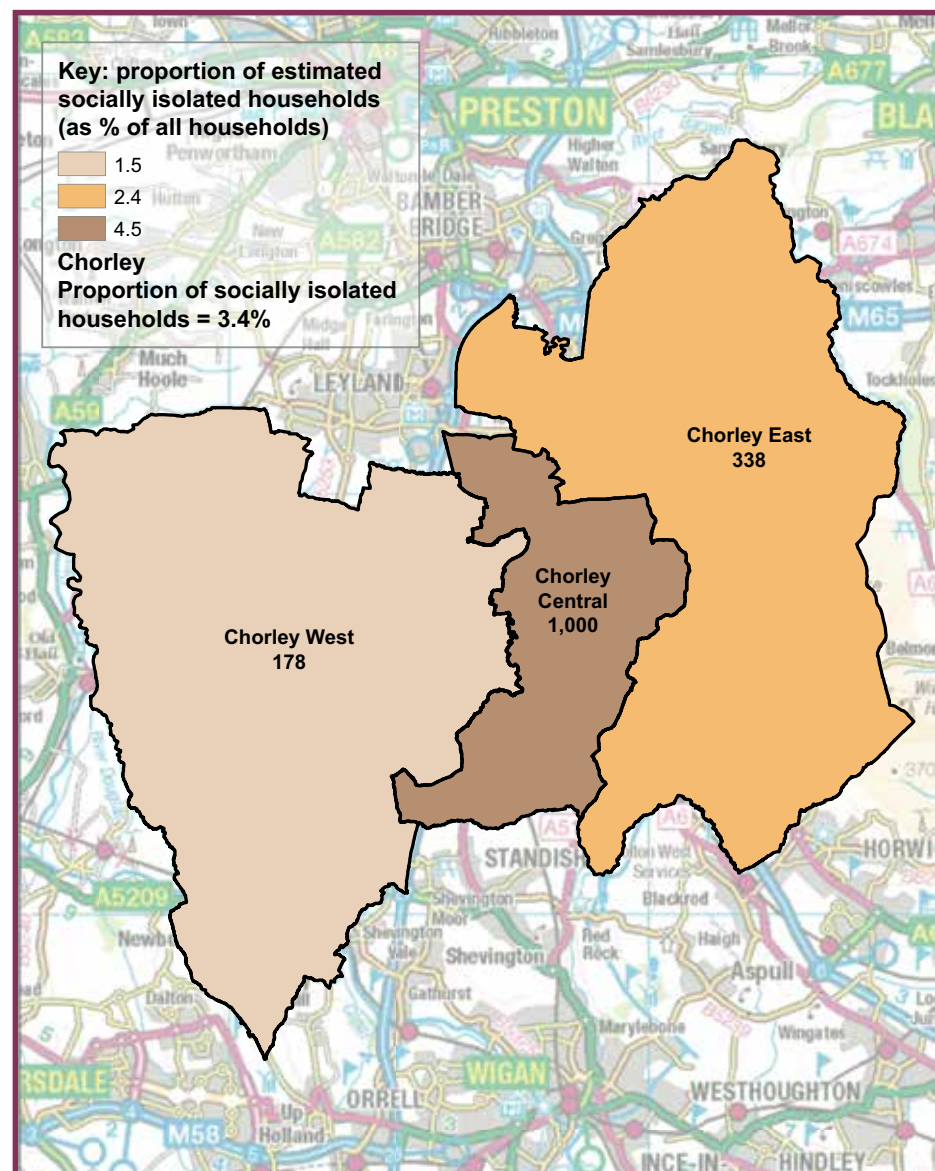
Source: Mosaic 2014 and social isolation and loneliness index figures. Mapped by: Business Intelligence, LCC.
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Ordnance Survey 100023320

proposed 34 Service Planning Areas, in ranking order with 1 being the area with the highest proportion, Lytham and St. Anne's. See also [Table](#).

Although Fylde and Wyre Districts are estimated to have the highest overall proportions of socially isolated households, there are also proposed Service Planning Areas with high estimated proportions of socially isolated households within Lancaster, Burnley, Preston, Hyndburn, Pendle and Chorley districts.

Knowing where there are pockets of higher social isolation, and who lives in these areas, can help target activity to find and help people appropriately, and to understand where there may be gaps in support.

We have modelled social isolation down to individual household level and published it down to Lower Super Output Area (LSOA) level, averaging 1,500 households, through [interactive mapping](#). See following example for Chorley, as part of [Transformation Challenge Award work](#), showing further pockets of social isolation at LSOA level within the SPAs:



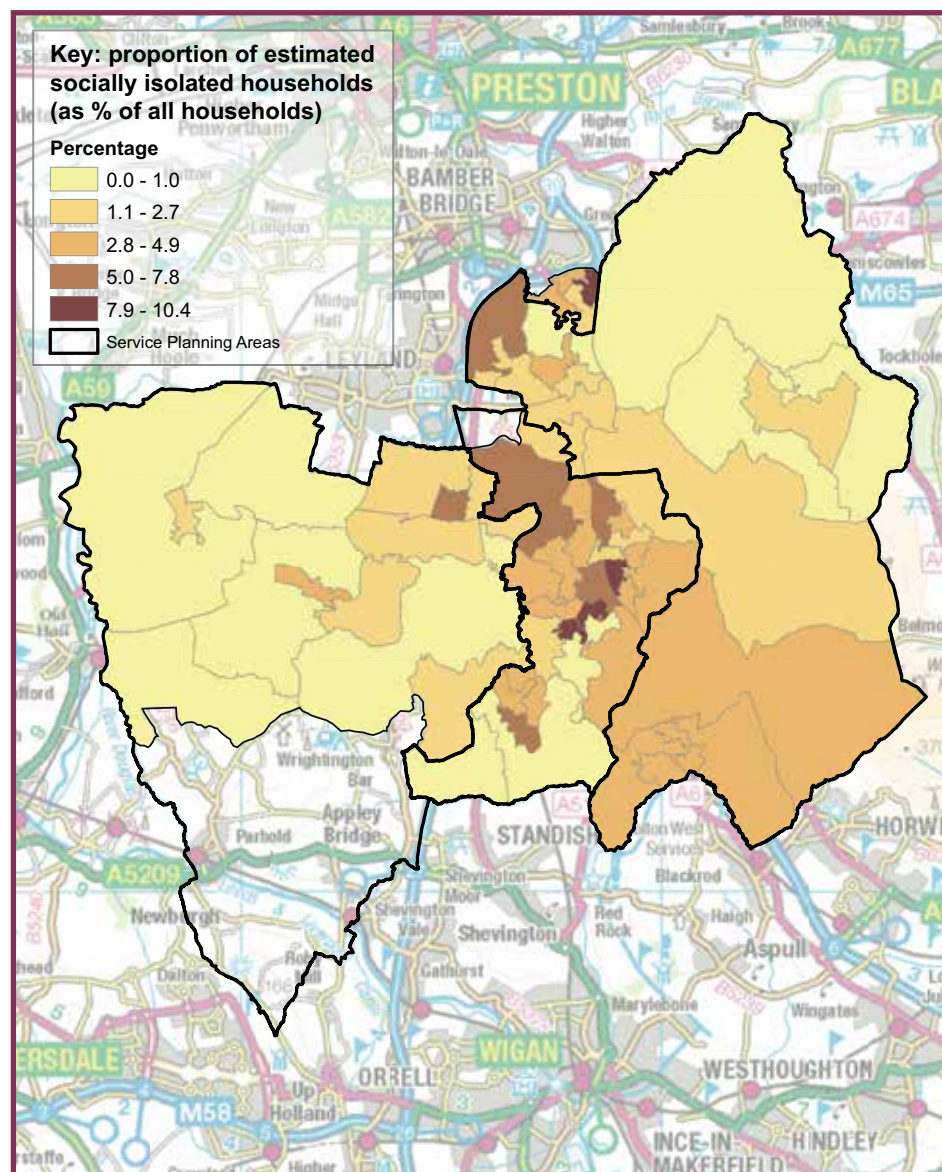
Estimated proportion and number of socially isolated households, for the 3 Chorley district service planning areas (SPAs)

(Estimated number of socially isolated households below each SPA name).

There are 34 service planning areas across Lancashire. The proportion of socially isolated households varies from 0.8 to 9.0.

Ranks within Lancashire:
 Chorley Central - 11
 Chorley East - 30
 Chorley West - 33

Source: Mosaic 2014 and social isolation and loneliness index figures. Mapped by: Business Intelligence, LCC.
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Estimated proportion of socially isolated households, for the Chorley lower super output areas (LSOAs)

(Note each LSOA ~ 1,500 households).

Source: Mosaic 2014 and social isolation and loneliness index figures
 Mapped by: Business Intelligence, LCC.
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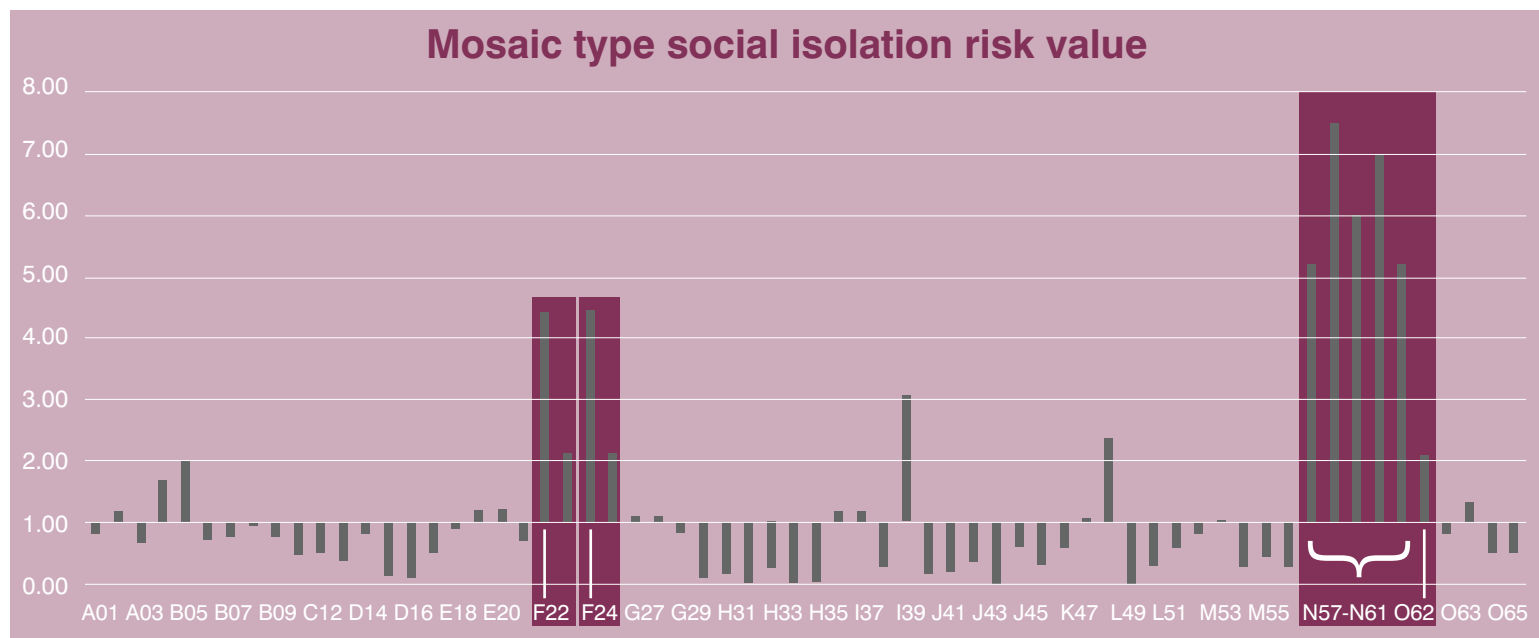
Who is socially isolated or lonely?

Although potentially anyone could become chronically socially isolated or lonely, this is more likely to happen to some than others, the risk factors used to model social isolation are given in [Box 1, Chapter 1](#). Applying these risk factors to [MOSAIC¹⁹](#) data for Lancashire, we were able to identify the [MOSAIC groups most likely to be socially isolated](#). Each

MOSAIC group has a code such as N58, and describes people with roughly similar characteristics.

The following chart shows the estimated social isolation risk for each MOSAIC group, relative to a group of average risk of 1. So, for example, group N58, Aided Elderly, is nearly 7 times more likely to be socially isolated as the average for all groups.

The tables on pages 25-27 describe characteristics for the three MOSAIC groups identified as most likely to experience social isolation. Further relevant MOSAIC profiles are available [here](#). All of these groups are older adults, from age 70 upwards, except for group O62 aged 55 to 60, who are more likely to become isolated through becoming carers rather than directly themselves.



Note: The modelling we used to estimate who is at most risk of being socially isolated only considers risk factors for individuals, and does not consider a number of other important aspects such as:

- Crime and fear of crime, sense of community, rural isolation, and urban deprivation;
- Existing amenities, activities and support available in an area.

N58 (SI value of 6.5) – Aided elderly, living in specialist accommodation including retirement homes and complexes of small homes

Who We Are

| | |
|---------------------------------|--------------------------------------|
| Age 86-90 | Household Income <£15K |
| 14.4% 927 | 51.2% 251 |
| Household composition Single | Number of children No Children |
| 77% 203 | 99.7% 139 |
| Tenure Owned | Property type Purpose built flats |
| 64.5% 100 | 79.2% 510 |

Key Features

- Developments for the elderly
- Mostly purpose built flats
- Most Own, others rent
- Majority are living alone
- Have income in addition to state pension
- Least likely to own a mobile phone

Source: Experian Ltd. MOSAIC Public Sector data 2014.



N60 (SI value of 6.0) – Dependent Greys, ageing social renters with high levels of need, living in tiny homes within small centrally-located developments

Who We Are

| | |
|--|---|
| Age 66-70 17.2% 260 | Household Income <£15K 59.3% 291 |
| Household composition Single 76.8% 203 | Number of children No Children 99% 138 |
| Tenure Council / HA 71.2% 387 | Property type Purpose built flats 72.4% 466 |

Key Features

- | | |
|--|---|
| <ul style="list-style-type: none"> • Ageing singles • Vulnerable to poor health • 1 bedroom socially rented units | <ul style="list-style-type: none"> • Disabled parking permits • Low income • City Location |
|--|---|

Source: Experian Ltd. MOSAIC Public Sector data 2014.



N59 (SI value of 5.0) – Pocket pensions, elderly singles of limited means renting in developments of compact social homes

Who We Are

| | |
|--|--|
| Age 71-75 16.6% 324 | Household Income <£15K 61.6% 302 |
| Household composition Single 74.9% 198 | Number of children No Children 99.2% 138 |
| Tenure Council / HA 87.1% 473 | Property type Bungalow 42.5% 429 |

Key Features

- Retired and mostly living alone
- 1 or 2 bedroom small houses
- Rented from social landlords
- Low incomes
- Prefer contact by landline telephone
- Visit bank branch

Source: Experian Ltd. MOSAIC Public Sector data 2014.



Link with MOSAIC analysis page for Lancashire, including interactive atlas

Lancashire County Council's [online MOSAIC interactive atlas for Lancashire](#) groups people living in each place by their MOSAIC type. When viewed together with our [interactive mapping of social isolation](#) (referred to on p.22), this can show which particular MOSAIC groups are likely to be affected by social isolation and loneliness for a particular place, and where precisely they are located. This can usefully inform the [Reach-Understand-Support](#) approach described later.

A note on the relationship between deprivation, age, and social isolation and loneliness

As outlined in Chapter 1, older people (especially aged 70+) are in general more likely to experience social isolation and loneliness due to contributing factors such as loss of a partner, work, or health. Living in more deprived

circumstances also tends to increase the chance of being socially isolated and lonely through, for example, higher likelihood of ill-health, and reduced access to financial and material resources.

We would expect then that older people living in more deprived households are generally at the highest risk of being socially isolated or lonely, and this tallies with, for example, the MOSAIC groups categorised as N60 and N59 (above). Typically with health-related issues we see a social gradient - meaning that, on average, as we go lower down the socio-economic scale (with people living in economically poorer or more deprived circumstances), people are both more likely to experience the health issue and also likely to be worse-affected by it. Bearing this in mind, we analysed modelled results for social isolation across Lancashire, and compared them with place deprivation (using the well-known Index of Multiple Deprivation, or IMD score). Unusually we found no direct statistical link between how deprived a place is, and its estimated level of social isolation, so no social

gradient for social isolation and loneliness by place. This is explained since, on average, places where more elderly people live also tend to be less deprived – so the two factors of age and deprivation tend to balance one another.

So, what is the estimated cost of social isolation and loneliness?

There is a growing interest and evidence base around costs and scale of social isolation and loneliness, and ways to both prevent and reduce it. This is due to both potential future cost increases, as we see more elderly people with greater health and social care needs, and also opportunities for savings through prevention.

The overall cost to local government, social care services and to the NHS is very difficult to determine but has been considered in work produced by [Social Finance and Age UK Herefordshire and Worcestershire](#). They have combined best practice and on-the-ground experience to develop a model focusing on loneliness, in which they used

national averages for baseline service usage of older people. They estimated that increases in service usage create a **cost** to the public sector of on average £12,000 per person over 15 years²⁰.

These direct costs are borne due to people being:

- 1.8 times more likely to visit their GP;
- 1.6 times more likely to visit hospital Accident and Emergency department;
- 1.3 times more likely to have emergency admissions;
- 3.5 times more likely to enter local authority-funded residential care.

In addition to these short-term impacts, loneliness also influences the likelihood of developing other health issues, which will increase cost in the medium- to long-term. Older people who are often lonely can be over three times more likely to suffer depression and twice as likely to develop dementia. They may also be more likely to be physically inactive, leading to a 7% increased likelihood of diabetes, 8% increased likelihood of stroke and 14% increased likelihood of

coronary heart disease.

Often the focus is on cost savings through reduced spending on intensive health services, rather than on benefits such as better physical and mental health, enhanced quality of life and increased contribution to society - which are all difficult to quantify in monetary terms. Indeed an economic model for the Lancashire Well-being Service produced by Social Finance Ltd, looking at the value to commissioners of reducing social isolation and loneliness, includes losses in quality and length of life due to longer-term health impacts – but not losses due directly to social isolation and loneliness. Benefit claims and costs borne by wider family and carer networks are also not included. Overall, since the model is based on a number of broad assumptions, the estimates are uncertain – hence the wide-ranging estimated cost of social isolation and loneliness in Lancashire. The model also used average (rather than marginal) costs, which can fluctuate greatly as costs of treatment are scaled up or down, so further work is needed to improve these estimates.

These costs can be applied to the population of Lancashire based on research suggesting that about 10% of the general population aged over 65 in the UK is lonely all or most of the time, increasing to 15% among ethnic minority elders¹.

Using parameters from the above model and average cost estimates from research, the estimated costs of loneliness and social isolation to Lancashire in year 2012 (in this case using only in-year costs) are as follows:



| | |
|---|------------------|
| Population of Lancashire (2012) | 1,176,000 |
| Over 65s † | 211,000 |
| Of which: | |
| • Non-BME | 206,500 |
| • Black and Minority Ethnic Groups >65 | 4,500 * |
| Lonely non-BME >65s (prevalence 10%) | 20,650 |
| Lonely BME >65s (prevalence 24 to 50% **) | 1,050 to 2,250 |
| Total lonely (>65s) | 21,750 to 22,900 |
| Average annual cost (lower estimate) *** | £1,950 |
| Average annual cost (upper estimate) **** | £12,000 |
| Estimated direct annual cost to Lancashire health and social care economy | £42m to £275m |

* Based on population proportions in >65s of 4.65% (Pakistani); 7.27% (Indian); 4.25% (Bangladeshi) [Ref], modified for Lancashire to reflect comparatively higher numbers of Pakistani and Bangladeshi groups

Ref: 'Older BME people and financial inclusion report – Runnymede and Center for Policy on Ageing 2010'

** Ref: Victor C et al, Minority elders in Great Britain : an exploratory study. J. Cross Cultural Gerontology 2012 27(1) 65-78

*** Lower estimate of £1,950 - Based on cost in Euros²⁸ and converted to British Pounds.

[This Finnish study used 2001 costs applied to a single year's healthcare use in 2004]

**** Upper estimate of £12,000 - Fulton Lauren (2014)³

[This UK-based estimate includes residential costs, as well as costs of depression and dementia, averaged over several years]

† Calculation based on over 65 age group, since experiencing social isolation and loneliness at this age is likely to have greatest financial implications for the health and social care system



Chapter 3: What is the current picture and what is already happening?

It is important that we understand as much as possible about who is affected by social isolation and loneliness and how. As discussed, the exact scale of the problem is not known, as by the very nature of the issue it is a hidden problem. We are not starting from nothing in Lancashire, we have a thriving and vibrant Voluntary, Community and Faith sector which is a huge asset in addressing this issue. There have also been a number of approaches to tackling social isolation and loneliness systematically at a local level; for example: in Wyre developing on from its bid for Big Lottery funding; and in Chorley and Rossendale recently under the [Transformation Challenge Award](#).

So, what is the current picture?

As we have covered in [Chapter 2](#), the evidence about the scale of the problem is extensive, as is the research into what works to tackle the issue. However we wanted to know what is happening

and what would work in Lancashire, so we held five Stakeholder Engagement [Events](#). This Chapter complements Chapter 2 by reviewing the current situation from the partners' viewpoint.

How did we seek your views?

Over the summer 2015 we held five events, at which local partners were invited to give their views on how social isolation and loneliness affected local communities and its impact on people and their families. These events were held in the areas within Lancashire covered by the six Clinical Commissioning Groups (CCGs).

A single Central Lancashire stakeholder event covered the two CCG areas of Preston, and of Chorley and South Ribble. These events provided a looking glass into how local organisations were providing services and where they were not.

These views were sought through the use of an online survey, two workshops for professionals and five events for local stakeholders, that is, those groups and organisations with an interest in this issue. Your views have shaped the whole nature of the system being designed, into one which suits the needs and aspirations of stakeholders in the various Lancashire localities.

Summary of the Events

All the feedback from the events was analysed and it was identified that there were both issues which were unique to each local area, and also some key themes which came up at all of the events.

We have detailed these common themes here:

Key themes from the five Lancashire events for partners

- A huge array of activities relevant to tackling social isolation and loneliness already exist at local level;
- Activities which engage with people on their own terms, linking with their motivations and interests and emphasising the positives, appear popular and are well thought of;
- Activities tend to be generally un-coordinated, especially where many organisations in an area are offering activities, although they may sometimes also complement one another;
- There is often a huge challenge to reach people who could most benefit, and activities may not be fully accessible or suited to those who need them;
- It is often unclear whether people in an area with social isolation and loneliness needs are reached and helped effectively;
- Transport was often mentioned as a key issue for accessing activities
- Through better coordinating and joining up their work, groups and organisations could benefit - for example, through sharing information and best practice;
- Current competitive funding systems can tend to inhibit joining up of work;
- A systematic pathway would better enable people experiencing social isolation and loneliness to be found and helped;
- A single point of contact should be included for access and referral to support for social isolation and loneliness – ideally, though not necessarily, including a physical neighbourhood hub;
- Solutions should be flexible and arranged around the needs of individuals experiencing social isolation and loneliness, where possible;
- Longer-term, it would be good to destigmatise social isolation and loneliness;
- Key professional groups, for example GPs, need to be more consistently and fully engaged in tackling the issue.

More detailed summaries of the feedback from all the events are available [here](#).

Conclusions from stakeholder events

Partner organisations attending the five stakeholder events held in summer 2015 agreed that, in general, there are many relevant existing activities to help people who are isolated. The difficulties are mainly that:

- Activities are insufficiently coordinated or joined up;
- Many people who could benefit miss out through being hidden from view.

Through combining input from the stakeholder events with our review of how best to help people experiencing social isolation or loneliness, and our estimated figures for Lancashire, we have developed a proposed integrated whole systems approach for localities.

The new [Lancashire Wellbeing Service](#) can act as a hub for referral of individuals, holistically assessing their needs, and providing initial support. This can be supported by community groups and activities, with good information sharing, including via the new Live Well directory, as well as [innovative](#) approaches to find and engage with isolated or lonely people.

- Longer-term, it would be good to destigmatise social isolation and loneliness;
- Key professional groups, for example GPs, need to be more consistently and fully engaged in tackling the issue.



Chapter 4: What works to help people experiencing social isolation and loneliness?

What does the evidence tell us?

We carried out a wide-ranging evidence review aiming to identify the most effective interventions to tackle loneliness and social isolation. The following information highlights key interventions, including appropriate variations to help increase an intervention's chance of success. Interventions were identified to help those particularly vulnerable to loneliness and social isolation. The evidence suggests that before a successful intervention can be implemented a number of foundations need to be in place³²:

First it is of vital importance for the intervention to **reach** the right population i.e. those who are at particular risk. Only with effective screening for those who are lonely or socially isolated will the intervention have a chance of reducing loneliness or social isolation.

Second, it is important to **understand** the nature of each individual's loneliness and social isolation and develop a personalised response.

Third, to ensure **support** is available for any individual selected for the intervention. Making sure individuals are able to actually attend any given intervention is often overlooked and making sure support is in place before referral is essential. It is important to ensure that the support can be sustained for a minimum of at least 12 weeks, depending on the intervention.

Fourth, and finally, the evidence shows that where good partnerships are **sustained** activities are more likely to be effective.

Note for the reader:

There are two main ways to tackle social isolation, either with structural interventions or with direct interventions. Structural interventions are those which aim to reduce loneliness and social isolation at a societal level. For the purpose of the evidence review we focused on a person-centred approach using direct interventions³². Also, for clarity, the evidence used in this review was from a number of sources:

- Academic literature;
- Grey literature (non-peer-reviewed);
- Information from what stakeholders have told us;
- Sources of current work to tackle social isolation and loneliness in other locations across the UK, for example, as presented by Social Finance²³.

What does the evidence tell us about how to help someone who is experiencing social isolation or loneliness?

What works?

- **Group activities achieve good outcomes (79% of studies reviewed)** ³³
- **One-to-one interventions achieve good outcomes (55% of studies reviewed)** ³³
- **Telephoning befriending services do not have good evidence for reducing loneliness** ³⁴

In summary, group activities with an educational or arts component have the greatest chance of reducing loneliness and social isolation. However, one-to-one activities such as befriending remain the most realistic intervention for those in the later stage of their senior years.

One-to-one activities are also effective in reducing loneliness and social isolation when consideration has been given to ensure that those being paired-up have enough in common. Whilst both group and one-to-one interventions are concerned with making new connections, people in the later stages of life tend to be more concerned with quality and frequency of their existing relationships. Technology offers the potential to incorporate this into both interventions with the use of communication applications, such as Skype or social media. We have developed some practical documents to help partners understand what works to help prevent and reduce social isolation and loneliness, both for [group activities](#) and [for individuals](#). Readers may find these a useful complement to the main report findings below.

A note on interpreting the findings from the research evidence

Due to the large amount of research evidence available, we focused on reviewing collections of studies (called systematic reviews), rather than on individual studies. The figures given above for achieving good outcomes, that is, 79% of group activities and 55% of one-to-one interventions, are an indicator (no more, no less). It means that 79% of group activities from a particular systematic review³³ showed success in reducing social isolation or loneliness, and 21% did not. 55% of one-to-one interventions were successful, and 45% were not. While this suggests that, on average, group activities tend to be most successful, it is important to understand which particular interventions were successful and why. Also, studies do not always reveal how strongly effective an intervention is (even if it is successful), or how effective it is when costs are also taken into account.

Direct interventions

Direct interventions work with a person directly rather than at general population level, aiming to achieve any or all of the following outcomes for that person³⁵:

- Improving their existing relations;
- Creating new connections;
- Changing the way they feel about their current situation.

To achieve this, three different approaches can be used ³²:

- **Person-to-person (One-to-one);**
- **Group-based;**
- **Psychological approaches.**

Person-to-person (One-to-one) key findings

These can be broken down into face-to-face working, telephone befriending, and computer-/Internet-based activities.

Face-to-face:

- One-to-one interventions were only effective in certain circumstances such as when befriender and recipient have enough in common³³;
- One-to-one interventions do not appear to reduce the use of health services³³;
- Some evidence that a volunteer belonging to the same generation and sharing common culture or background is likely to be more effective in building a relationship with the person receiving the intervention³³;
- Being of similar age is not essential for one-to-one interventions³³;
- One-to-one activities aimed at specific groups may offer more benefit than trying to reach all older people³³;
- One-to-one activities remain the most realistic intervention for providing support for older people around the age of 65 years or over³³.

Telephone befriending:

- Very little evidence of effectiveness of reducing both loneliness and social isolation using this method ³⁴;
- Good evidence for using this method as part of self-care to support people suffering from long-term conditions;
- Evidence that telephone befriending is effective in reducing depression and suicidal thoughts, noting that depression and loneliness are also be linked³⁶.

Computer/Internet-based activities

- For services that could reduce social isolation and loneliness by rekindling or improving quality of existing relationships, transport and technology were seen as key enablers;
- Adherence is often overlooked and needs special attention. Evidence shows that interaction with a counsellor or someone to guide, as well as the use of technology, can increase adherence to an intervention or activity;

- Older adults are often quick learners with technology and may need little encouragement due to high enthusiasm; however, they may need support in building confidence to engage.

Group-based activity key findings

Effectiveness:

- Evidence suggested that the most effective interventions were group interventions with an educational or social support input for specific groups of older people³⁵;
- Support groups or discussion sessions also appeared beneficial for specific populations such as those who were suffering bereavement or a chronic condition. However, the evidence also shows that whilst this is the case, this was only for interventions involving people with the social skills to participate and where the intervention was sustained for five months or more³⁶;
- Interventions which provide activities that enhance self-esteem and personal control offer long term effectiveness; for example: skills; training; and involving older people in the planning and development and delivery of activities;³³.
- Group based activities which included art reported success in 95% of [evidence reviewed](#)³⁶
- Participatory initiatives, where members were actively involved in the design of activities, were shown to be the most beneficial in 80% of the [studies reviewed](#) in comparison to 55% for non-participatory initiatives³³.
- Due to the lack of evaluations on the actual processes involved, it is unclear why group interventions with educational social support were more successful ³⁵.
- Community based group activities, such as exercise programmes, reduced loneliness in those who were physically inactive.

See also note above, on [interpreting the findings from research evidence](#)

Psychological approaches key findings

- One study review suggested that interventions aimed at addressing negative thoughts have greater effect than interventions aimed at providing social support, social skills or opportunities for social interaction. Groups included in the study who showed benefits included: widowed, divorced or separated, unemployed or economically inactive, those in debt, women aged 35-45³⁴.
- Psychological approaches are of particular interest in tackling loneliness, due to its more subjective nature.

Intervention design key findings for all interventions

Every intervention could benefit from these key findings:

- Success of an intervention or activity will depend on the ability to identify and engage people who are socially isolated or lonely³⁴;
- Important to match interventions to needs, attitudes and preferences of the recipient³⁴;
- Flexibility and choice are key attributes³⁴;
- Consider possible transport issues for those engaging in the intervention^{34&33};
- Important to involve voluntary organisations as much as possible, as they often have the skills and networks to facilitate interventions³⁴;
- Strong partnerships should be in place to ensure interventions are sustained³⁴;
- No studies directly compared interventions for their effectiveness. Neither did any study compare or evaluate the processes involved for

designing and implementing the interventions³⁶;

- For any intervention to be successful it needs to be sustained for at least three months and preferably six months³⁴.

Findings relevant for more specific interventions or population groups

For some specific interventions or subgroups, these additional findings may be useful.

For more elderly people:

- As people move into the later stages of life more focus is placed on the quality and frequency of existing relationships than new ones³⁷;
- One-to-one activities are the most realistic intervention for the elderly³³;
- Interventions and activities need to challenge negative attitudes to ageing³⁶;
- Incontinence is a major issue³³.

In general:

- Care should be taken when titling initiatives. They should not include the word 'lonely' or 'socially isolated', for example, and should portray a positive image (such as the "Just Good Friends" group)³³;
- People who are isolated and lonely should be involved in planning, implementing and evaluating activities, as well as being able to choose structure and content³⁶;
- Organisations working in localities need to be aware of community resources and to help build community capacity³⁴;
- Planning and implementation should include flexibility of delivery, being able to adapt to the needs of the relevant population³⁴;
- Community navigators have shown success at identifying people who are socially isolated. Community Navigators in this context are people who come into contact with individuals who are experiencing, or are at risk of, social isolation and loneliness. They would signpost

to various services and, in some circumstances, help and support people to find and attend appropriate interventions. Examples of Community Navigators include Wellbeing Workers (as part of the Lancashire Wellbeing Service), various staff in VCFS organisations, and potentially other frontline professionals, such as library staff³⁴.

What interventions at a population level, including prevention, are effective in tackling social isolation and loneliness?

The review of evidence tells us that effort should be made at every level of society to promote *positive ageing*. This approach recognises how negative mental states such as beliefs, thoughts, ideas, and attitudes, can have a detrimental impact on physical and emotional wellbeing as we age. For many different groups ageing is often seen in a negative light, with the process of getting older and associated deficits often seen as inevitable. This can and does have a significant impact on

people's willingness to get out, to socialise and to try new things.

Positive ageing promotes the message that one's senior years are to be looked upon as a time to enjoy life's many pleasures just as much as any other period throughout the life course, if not more. Older people make a significant and positive contribution to society both in economic activity and as important caregivers for young families. These are amongst the many things that should be used to celebrate, and in turn challenge, the current negative view of ageing. Positive ageing will lead to lower numbers of people being socially isolated or lonely³².

Note to the reader: In the evidence review, we focused on finding out what can best help people who are already socially isolated or lonely, rather than on a population-level approach to prevent social isolation and loneliness. While some evidence found did relate to a population-level prevention approach, there is likely to be more information available on this than we have summarised here.

What does the evidence tell us about interventions which are effective and also cost-effective in reducing social isolation and loneliness and their secondary outcomes?

An intervention that is not effective is never going to be cost-effective, and effectiveness of interventions to address social isolation has been covered [previously](#). As indicated, interventions need to be targeted to individual needs. Maximising the potential for larger gains, through relevant targeting of interventions and potentially upscaling them, should increase cost-effectiveness. Evidence of cost-effectiveness for interventions already described is mixed and, while there are some promising interventions, some claims are also made which, on further examination, are not clearly backed with good available evidence.

Befriending services can improve an individual's quality of life at relatively low cost, but are less likely to achieve public sector cost savings. In one study, total gross NHS cost savings from befriending were around £40 (at 2008/9 prices) in year 1 for every £85 invested in the intervention. Considering wider health benefits may make this more promising: by including quality of life benefits through reduced depressive symptoms, befriending schemes could potentially create improvements worth £270 per person. They would then likely be cost-effective, with an 'incremental cost effectiveness ratio' (ICER) of around £2,900²⁷. This means that, compared with usual care and support (possibly no intervention at all), befriending can on average achieve one extra quality-adjusted life year (QALY) for the befriended individual for every £2,900 spent. This study did not, however, explicitly consider potential reduced social care costs, which is a key aim of current [Transformation Challenge Award](#) work in [Chorley](#) and

Rossendale. The authors noted that targeting of at-risk groups, such as older people discharged from hospital or mothers at risk of postnatal depression, could potentially offer better returns on investment in befriending. This could also link with our Lancashire work on [identifying households most at risk of being socially isolated](#).

For group-based activities, a study from Finland demonstrated a reduced total cost of health service use for those involved, relative to the comparison group, with savings significantly greater than the cost of the intervention²⁸.

Some interventions, even though not aimed explicitly at tackling social isolation or loneliness, may nevertheless reduce costs through doing so. The evaluation of the Department of Health programme, Partnerships for Older People Projects (POPPS), showed a range of 146 preventive interventions, for which two thirds of the interventions were addressing social isolation and

the 146 interventions in totality were cost-effective. Their impact was on both reducing emergency bed days, and also improving wellbeing outcomes. For every £1 spent on the POPP services, approximately £1.20 was saved on emergency bed days. Within the overall package of 146 interventions, some are likely to be more cost-effective than others, with probable gains therefore from targeting specific interventions.

Much of the evidence is based on few and small studies, which tend to consider whether or not an intervention is effective, rather than how strongly effective it is. Studies use average costs which can underestimate true 'marginal costs', as interventions are scaled either up or down. This suggests that further work is needed to obtain more precise estimates, linking in also with the [need to monitor and evaluate](#).

Many published [economic evaluations](#) are unclear about where any [cost savings](#) are achieved within the health economy – a key consideration for better integrating health and social care. With this in mind, cashable savings and improved outcomes for one area of the health economy may need to be reinvested in interventions provided by another. This means building a system around the needs of the individual, carers and family, to get the most out of every penny spent. By preventing an issue developing, managing a condition properly, and avoiding poorer health, not only is better care provided for the individual but it could also mean less pressure on the system.

Monitoring and evaluation of activities

We understand the effects of social isolation and loneliness better than how to tackle it effectively, although there has been much work on researching interventions, especially in the last two decades. Where there is uncertainty over how worthwhile an intervention is based

on its effectiveness or cost effectiveness it is important to monitor and evaluate appropriately.

How people could be identified and how they could be found?

Using a Making Every Contact Count approach:

Making Every Contact Count (MECC) is an approach to healthcare that encourages all those who have contact with the public to use these opportunities to talk about their health and wellbeing. It encourages health and social care staff to use opportunities arising during routine health and care interactions with patients to have brief conversations on how they might make positive improvements to their health or wellbeing, fitting into and complementing existing professional clinical, care and social engagement approaches, rather than creating additional work. Evidence suggests that adoption of this approach across health and care could potentially have a significant impact on the health of our population.

In the context of social isolation and loneliness, MECC can be applied to identifying people who could benefit from intervention both in their own homes and out in the community.

In Sheffield, as part of their '[Age Better in Sheffield](#)' [Big Lottery-funded initiative to tackle social isolation](#), 1,000 frontline workers, including housing officers, community pharmacists and supermarket staff, are being trained to recognise loneliness and link people with 'Age Better champions'.

For more information on implementing Making Every Contact Count and examples of case studies you can visit [Health Education England](#). Example case study which identifies social isolation as an important factor can be accessed [here](#).

Where could I find out more about MECC?

Implementing MECC can support your organisation in meeting its core responsibilities towards your local population. It can also support health improvement activity within local communities, and provide an approach that reaches out to community members and groups. MECC can provide a lever to support communities in collaborating together. From a local systems perspective MECC can provide a useful tool for commissioners and providers to facilitate local discussions on how behaviour change activity can be supported and undertaken.

The benefits of MECC can include improving access to healthy lifestyles advice improvement in morbidity and mortality risk factors within your local population; and cost savings for your organisation and local health economy. It can assist organisations in meeting responsibilities towards their workforces,

for example by improving staff health and wellbeing; and in enhancing staff skills, confidence and motivation.

MECC activity can be incorporated as part of existing health improvement or workforce improvement initiatives, for example, when tackling access to healthier food options. It provides a means of maximising the benefit from existing resources for improving population health. For example, it can include advice on low or no-cost activity, such as persuading parents to walk their children to school; or, as part of physical activity advice, encouraging increased use of existing community resources such as leisure centres and swimming pools.

For more information on practical resources for Making Every Contact Count you can visit the website resource [here](#).

Implementation Toolkits and Organisational Checklists

Making Every Contact Count (MECC) is about supporting organisations and their staff to maximize the opportunity they have with the public in promoting health and enabling them to make changes to improve their health and wellbeing.

Having Health Conversations – Health Education England, Wessex:

This Making Every Contact Count (MECC) toolkit has been developed as a practical guide to support the implementation of the programme. An implementation guide and checklist for your organisational approach is available online to support your work (see link overleaf).

Health Education England – Wessex Team was also able to provide additional support to make Making Every Contact Count happen through:

- Coordination of the Train-the-Trainer programme
- The Making Every Contact Count network
- [Guidance and advice on implementation](#) and sustainability of Making Every Contact Count.

To find out more about the programme visit [Wessex Public Health Network](#).

National Institute for Health and Care Excellence [NICE] Guidance to support behaviour change PH6

The Department of Health asked NICE to produce public health guidance on the most appropriate generic and specific interventions to support attitude and behaviour change at population and community levels.

This guidance provides a set of generic principles that can be used as the basis for planning, delivering and evaluating public health activities aimed at changing health-related behaviours. The guidance should be read in conjunction with other topic-specific public health guidance issued by NICE. It does not replace any of this guidance.

For more information to support your work, you can view [NICE](#).

NHS Yorkshire & Humber - Making Every Contact Count

Making Every Contact Count (MECC) encourages conversations based on behaviour change methodologies (ranging from brief advice, to more advanced behaviour change techniques), empowering healthier lifestyle choices and exploring the wider social determinants that influence all of our health.

You can download a suite of information from this website to support your development of [MECC](#) within your organisation.

Other methods for identifying and finding people who are socially isolated or lonely

As well as the Making Every Contact Count (MECC) approach described above, two other approaches may help identify individuals who are socially isolated or lonely, or are at greater risk:

- Data-/intelligence-driven approach;
- Public awareness-raising.

Both of these approaches are outlined further in [Chapter 6](#).

Chapter 5: Putting it all together to tackle social isolation and loneliness at a local level

How can we use the information gathered to help reduce social isolation and loneliness effectively at a local level?

The [five stakeholder events](#) held across Lancashire suggested that social isolation and loneliness is seen as an important and pressing health and wellbeing issue for Lancashire which is being tackled with varying degrees of success. [Stakeholder input](#) helped to identify gaps, issues and good practice, suggesting a more systematic and joined-up approach would be more effective in tackling social isolation and loneliness. This would also help to ensure a more equitable approach across Lancashire.

Such an approach could incorporate agreed pathways for people with isolation or loneliness needs:

Finding and engaging people through to their referral and assessment

Onwards into effective and sustainable help

Engaging where appropriate with activities in the community.

Essentially this is about how we identify people who are socially isolated or lonely, and connect them with relevant groups or other activities which are available locally.

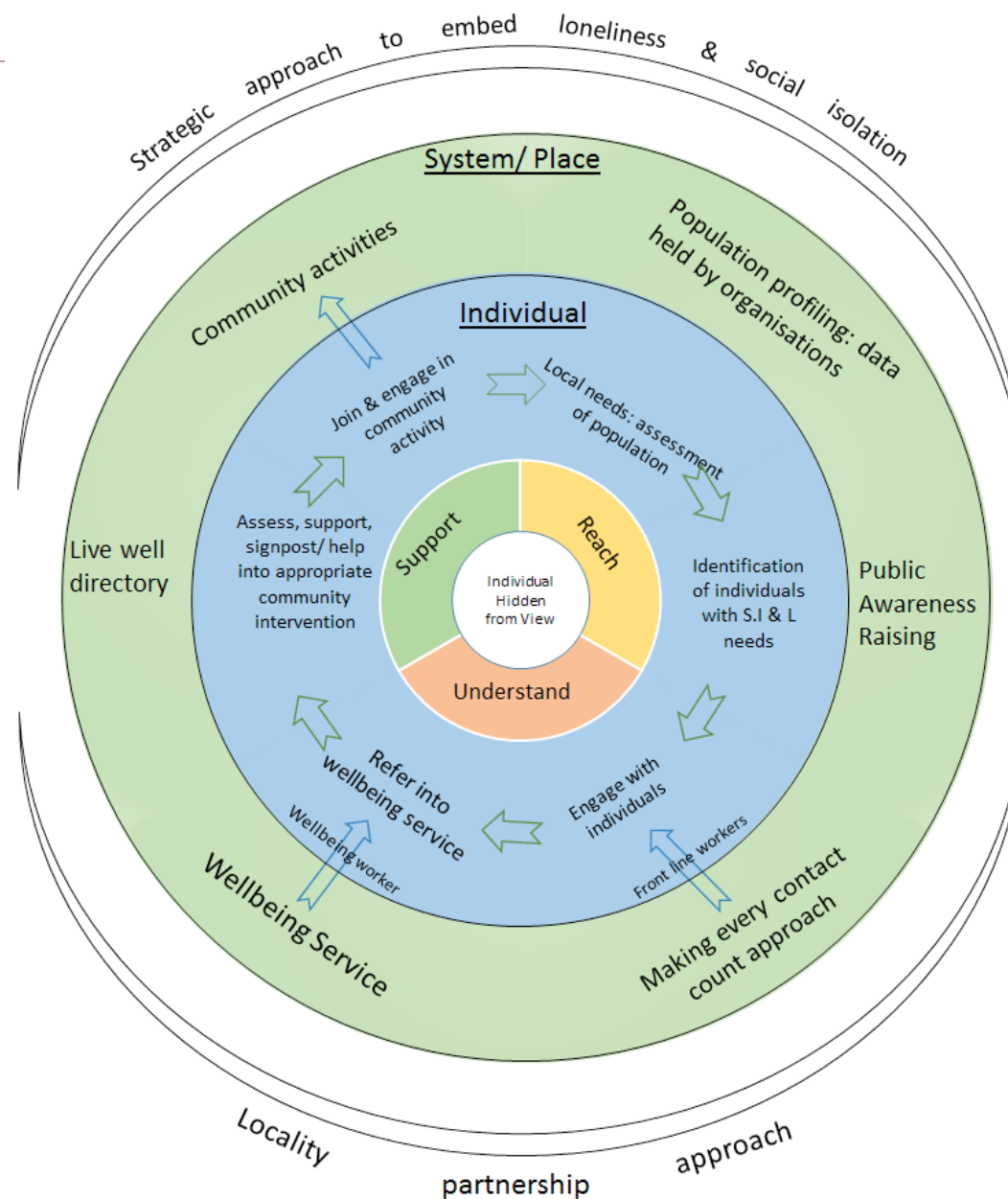
We have developed a suggested integrated whole systems approach for use at a local level, building on:

- Your input from the stakeholder events;
- Our LCC review of how best to help people experiencing social isolation or loneliness;

- Our LCC estimated figures for who is experiencing social isolation and loneliness and where, for Lancashire.

The new LCC-commissioned [Lancashire Wellbeing Service](#), with its single point of referral, and accessibility at a local level, could act as a hub for individuals who are isolated or lonely. Wellbeing Workers holistically assess people's needs, and provide initial support. They link people with community groups and activities, making use of good information. Innovative approaches can help to find and engage with isolated or lonely people, who may otherwise be hidden in the community. The system is supported by good partnership working aiming to understand needs and assets of populations. This can form a 'whole systems approach' to finding and helping individuals with social isolation and loneliness needs:

Whole systems approach with partner organisations working together in communities at a local level



This model integrates the **reach – understand – support** approach for individuals as suggested by our evidence review. It is shown here with current systems, services and activities in Lancashire based on what you said should happen at the five stakeholder events. It starts off with the idea of working in a PLACE which could be at various levels ranging from the whole of Lancashire down to district, town or community level. Each place has a local population, some of whom will be socially isolated or lonely, and potentially hidden from view.

Some population groups will be more likely to be isolated or lonely, as described in [Chapter 2](#). This can be analysed at a local level to understand both who lives in a place and who is most likely to be affected by social isolation and loneliness. At the same time, each place has characteristics tending to make people more or less isolated or lonely. This includes sense of community spirit, and local activities, services and amenities which may be considered community assets in addition to skills of individuals.

A major challenge is to **reach** the individuals or population groups who are isolated or lonely. This involves first finding these people using any or all of:

- The Making Every Contact Count [MECC] approach described in [Chapter 4](#);
- Data-intensive approaches to identify individuals most at-risk of social isolation and loneliness;
- Public awareness approaches, for example: that social isolation and loneliness is an issue; that help is available; and that people are encouraged to seek help both for themselves and for other people they are aware of.

As well as finding people who would benefit, reaching also includes successfully engaging both individuals and whole groups. To encourage and motivate people, we may need to include both removing the stigma of loneliness and emphasising the positives of social support and networks. Finally, the 'Reach' component involves referral to

the Lancashire Wellbeing Service, which helps individuals with social isolation and loneliness amongst other wellbeing issues. Key to the Lancashire Wellbeing Service are Wellbeing Workers who work at a local level and are skilled in assessing and supporting referred individuals, including navigation to community activities. The Wellbeing Workers act as enablers, providing person-centred one-to-one support using their knowledge of a range of suitable activities within the community. By referring and supporting people into other local activities, Wellbeing Workers are able to move on to helping other individuals, ensuring a sustainable service.

For socially isolated and lonely individuals the **support** element includes both support from Wellbeing Workers and from the community including groups and activities. These in turn may be supported by funding and other resources, based on how well they fulfil needs of the local population. The approach then returns full circle into understanding needs and assets in each place.

The elements of the whole systems approach connect at many levels. For example, Wellbeing Workers will use the Live Well online directory to help them understand what activities are available in local communities. Wellbeing Workers can then guide individuals into suitable supportive activities, giving them flexibility and choice where possible. Groups and activities in turn can use the Live Well directory to promote themselves. And partnerships in local areas can promote use of the Live Well directory to local groups and organisations, and use it to inform local assets assessment.

It is important to consider monitoring and evaluating social isolation and loneliness related programmes, projects and activities at a local level. This will help to understand what is and what is not working, whether programmes are working as expected, and what improvements might be made. Precisely what is measured will depend on, for example, whether we wish to assess

effects of an activity on individuals or at programme level.

We can distinguish between:

- **Assessment tools** which move people along a pathway, for example:
 - Screening tools and questions for a [Making Every Contact Count \(MECC\) approach](#);
 - Detailed initial person-centred needs assessment by the Lancashire Wellbeing Service.
- **Monitoring and evaluation tools** which help judge how successful an activity or service has been.

It is important to understand what we are measuring and to measure the right thing. For example, there are different tools^{30&31} to [measure loneliness](#) versus social isolation. General wellbeing measures such as [WEMWBS](#) only touch on social isolation and loneliness, so it is better to use a specific rather than a general tool where possible (this is expected to be trialled as part of the current TCA work in Rossendale).

It is also important to use validated assessments where possible and to balance these with service and user needs. For example, asking people more positively-worded questions may improve both their experience and the results.

Some activities may be good at helping certain individuals reduce their social isolation or loneliness, yet not have much impact at population level. They may only reach a very few people in an area where there is much remaining unmet need. Local partnerships and groups should also consider prevention, that is, [potential for preventing people from becoming social isolated or lonely](#), as well as finding and helping people already experiencing isolation and loneliness.

An activity may be successful at reducing social isolation and loneliness and have population impact, yet not be [cost saving](#), or possibly even cost effective. Especially given the limited

evidence and uncertainty on which interventions are cost effective, partner organisations may especially wish to consider including cost aspects when evaluating effectiveness.

Delivering a whole systems approach to tackling social isolation and loneliness at a local level

Throughout the development of this report the emerging findings have been used to support the development of the Living Well, Living Better Pilot in Rossendale. The pilot is part of a piece of work under the Transformation Challenge Award for which Lancashire County Council has received funding from central government.

The overall aims of the pilot are to:

- Improve health and wellbeing outcomes including
 - reducing GP attendance
 - reducing attendance at A & E departments

- reducing or delaying the need for residential care
- improving mental health
- Improve service standards
- Help create a more financially sustainable health and social care system
- Improve connections in the community to enable people to help themselves and support each other.

The Project is using the **reach, understand** and **support** model outlined in chapter 4. A menu of supportive interventions will be developed using the [evidence found of what works](#), to try new ways of dealing with social isolation and loneliness amongst adults in Rossendale. The aim is to achieve a better quality of life for lonely and socially isolated people in Rossendale and contribute to public health outcomes.

The project group have used the modelling and mapping to identify pockets of social isolation and loneliness in the four townships in Rossendale, providing a focus for developing a 'Good Neighbour

Scheme' for the borough. A number of themes have been identified as key to unlocking social isolation, for example transport. The project group is working to identify specific issues, which are different across each town, and exploring developing solutions within the community, to ensure sustainability.

Chapter 6: Bringing social isolation and loneliness into focus

We began our report by identifying that within our different local populations and places across Lancashire, some people will be socially isolated or lonely, and often they will be **hidden from view**. Efforts to tackle this important determinant of health and wellbeing across Lancashire now need to be **brought into focus**.

The purpose of this report is to provide some of the motivation, information and ideas necessary for success – while not being too prescriptive in the structure and process used. We have therefore provided a vision and [model](#) of a joined-up local system to tackle social isolation and loneliness, together with pointers on an approach to achieve this, with key principles.

Interventions to tackle loneliness and social isolation are **part of everybody's business**, we all have a role to play, whether that is as a good neighbour,

looking out for those who are affected in our own communities or as service providers and policy makers. What we have seen is that interventions will be most effective if they are part of a strategic, whole systems approach. There is an opportunity to bring this into focus as part of the NHS Five-Year Forward View and associated Sustainability Transformation Plans for Lancashire, as well as potential to link in with New Models of Care, Vanguard sites and Healthy New Towns.

Resources and examples of where approaches are already being developed and are working across Lancashire are highlighted throughout this chapter.

All partners at a local level should aim to embed thinking about issues relating to social isolation and loneliness in a deliberate and systematic way. This can include both an approach to finding and helping people affected by social

isolation and loneliness (as per diagram in [Chapter 5](#)), and a wider whole systems approach considering and embedding prevention of social isolation as a norm in our activities. The approach can involve, for example:

- Where partners come into contact with people experiencing triggers for increased risk of social isolation and loneliness - to incorporate this contact in pathways to identify, engage and refer people as appropriate;
- Where partners operate in settings, such as Housing Associations, in which people are at risk of becoming socially isolated or lonely - to systematically help with both identification of and support to isolated or lonely individuals, as well as preventive measures to ensure people are supported in the first place.

Partners can mobilise the outlined approach to reaching, understanding and supporting individuals experiencing or at risk of social isolation or loneliness as follows:

- Build on or set up new partnerships and networks to work more effectively together;
- Make use of existing organisational resources including Lancashire County Council and local partners;
- Gather locally relevant information, use the Live Well directory, and potentially Lancashire County Council's web site to share our work;
- Consider locally relevant approaches to find people who are isolated or lonely;
- Put pathways in place and follow them, integrating the [Lancashire Wellbeing Service](#) as a key element, as currently 35% of referrals relate to social isolation or loneliness.

We recommend partners to **come together** around the issue of social isolation and loneliness in appropriate localities and sub-localities (possibly working at multiple geographic levels,

such as CCGs, Districts and Towns and Parishes). This may be as part of existing arrangements, for example, a local Health and Wellbeing Partnership, incorporating social isolation and loneliness as an additional consideration, or alternatively as a bespoke arrangement focused on tackling social isolation and loneliness in particular.

We recommend that **consideration is given to who is best placed to take a lead on this work**, and whether to appoint a specific project manager and/or group. If a project approach is taken, consider how this is then going to be mainstreamed.

There are all sorts of ways in which social isolation and loneliness can be considered, including:

- when formulating and implementing policy and strategy;
- considering local assets and needs assessments;
- in local plans such as Neighbourhood Plans and Locality Plans;
- in making use of frontline workers as part of existing services.

We recommend that an initial **stocktake of both needs and assets relating to social isolation and loneliness is appropriate**, which can be informed by both modelling ([see Atlas mapping](#)) and local intelligence on the ground. The important aspect is to bring together local partners to share information and expertise, also identifying gaps and possible duplication. This helps with enabling a local pathway for people who are socially isolated or lonely, which is clear to partners and the public. This should link in also with the new Live Well Directory when it goes live, which can be used as a source of local activities; local partners need to be aware of this, so it is updated and used regularly.

When coming together, local partners, as part of the approach and a functioning system, should consider the details of their local places and populations, including who is more prone to being isolated or lonely and where they live (a population profile, for which [Atlas mapping](#) can be helpful). Also local assets must be considered, such as local knowledge, organisations and activities on the ground, both to prevent people

from becoming socially isolated or lonely, and to find and help individuals already experiencing social isolation or loneliness. A more detailed intelligence-driven approach can make use of data to identify individuals at risk of being socially isolated or lonely; with:

- Fire service list – ‘Safe and Well’ checks;
- Assisted bin collections;
- Those susceptible to scams;
- Those receiving home care;
- Utility companies’ lists of vulnerable people;
- Links to SPICE / Time Credits;
- Residents in Care Homes;
- Lancashire County Council modelling data at individual [household level](#).

Health-related services may have an important role in any pathway, as part of a [Making Every Contact Count](#) approach.

Intelligence needs to be combined with the evidence and knowledge of what works, through all parts of the system including interventions for people

assessed as being isolated or lonely. Tackling social isolation and loneliness as a vehicle for achieving health and social care savings is currently being explored as part of the Transformation Challenge Award (TCA) work in Rossendale and Chorley. This includes assessment tools which are expected to be trialled as part of this work and incorporating aspects to improve implementation, such as support to encourage people to persist with technological approaches.

- In Wyre District a Steering Group was formed building on a bid for Big Lottery funding to tackle social isolation, to help take forward recommendations collated by local partners including the District Council, Clinical Commissioning Group and Voluntary, Community and Faith Sector organisations (led by CVS).
- In Rossendale District a new Project Group was set up to formulate and implement an approach to tackling social isolation and loneliness as part of the Transformation Challenge

Award (TCA) from Communities and Local Government (CLG). This project partnership has a dedicated project manager and includes Rossendale District Council, blue-light services, the Clinical Commissioning Group (CCG), Lancashire County Council (LCC) and Voluntary, Community and Faith Sector (VCFS) representation. It is focusing on social isolation and loneliness as a key issue in which steps can be taken to reduce pressure on adult social care and health care and achieve savings.

There is a possible role for public awareness raising, making people aware of:

- The issue of social isolation and loneliness in general;
- Local pathways and activities, and that help is available - so that people can help themselves, their families, friends, neighbours and others in the community.

Public awareness raising may also include taking action to destigmatise social isolation and loneliness, to encourage it to be brought out more into the open and for people not to feel afraid or ashamed to seek help.

To help partners and individuals bring social isolation and loneliness into focus, this report, together with supporting information and various resources will make up a toolkit to help tackle the issue. Partner organisations are encouraged to share their work at a local level for the benefit of all. This may be in the form of, for example:

- Local needs and assets assessments relevant to social isolation and loneliness;
- Examples of best practice, including group or other activities to help people with social isolation and loneliness, or methods to find people with social isolation and loneliness;
- Monitoring or evaluation reports;
- Notes from workshops or key meetings.



Chapter 7: Resources

This report has looked at the vast array of evidence and supporting publications on the subject of Social Isolation and Loneliness, and the impacts on Health and Wellbeing. There are links throughout the report to some of the well-evidenced national campaigns, resources and tools.

What we have tried to do for Partners is to take that evidence and, together with valuable insight from yourselves, produce a locally-focused Lancashire guide. This aims to support Partners to work together across organisation boundaries, and in your unique localities, to tackle this very challenging Public Health issue.

As we have discussed throughout the report there are three key challenges:

- **Reaching** lonely individuals;
- **Understanding** the nature of an individual's loneliness and developing a personalised response;
- **Supporting** lonely individuals to access appropriate services.

This chapter is a repository for selected resources referred to throughout the report, and can be used as a checklist to help you develop your approaches going forward. The resources are grouped around the themes above to help you at each stage; within each theme the resources are split between:

- **National approaches** (from outside of Lancashire) - which are generic and give direction as to ways to reduce Social Isolation and Loneliness;
- **Local approaches** (documents produced as part of this project or from within Lancashire) – applying the approaches with Lancashire data, mapping and modelling, as well as including valuable stakeholder insight.

We hope you find the following helpful.

Reach – As has been discussed and is well documented, the nature of social isolation and loneliness means that people who are affected are very often hidden. This section contains resources to help you identify those most at risk.

As well as understanding how to reach individuals, ‘reach’ may also refer to identifying broader groups of people who are at risk (as with the modelling we have carried out in Lancashire using ‘[MOSAIC](#)’ groups)

| Resource | Description | Link |
|---|---|--|
| ● Wessex Public Health Network MECC web page | Guidance and toolkit on Making Every Contact Count (MECC) | www.wessexphnetwork.org.uk/mecc |
| ● Results and Method for modelling social isolation in Lancashire | Estimated numbers and proportions of people affected by social isolation in Lancashire, including detailed description of how this estimation was done | Methodology and Results Tables |
| ● Interactive Mapping of social isolation in Lancashire | Web mapping enabling the reader to explore estimates of social isolation for different geographies in Lancashire <ul style="list-style-type: none"> • Service Planning Area (SPA) level • Lower Super Output Area (LSOA) level (1 LSOA contains ~ 1,500 households) | SPA Web mapping LSOA Web mapping |
| MOSAIC interactive atlas for Lancashire | Web mapping enabling the reader to explore which MOSAIC groups are located within a particular place. (This can be used with the above interactive mapping of social isolation) | www.lancashire.gov.uk/lancashire-insight/area-profiles/mosaic-analysis.aspx |

Understand – There are many reasons why people are lonely or isolated and, in order to ensure any intervention is suitable, it is important to understand why an individual is experiencing social isolation or loneliness. The resources available in this section will help you identify the individual, community and structural causes.

As well as understanding the needs of individuals, ‘understanding’ may also refer to understanding the needs of broader groups of people.

| Resource | Description | Link |
|---|---|--|
| ● Notes from Locality Stakeholder Consultation Events | <ul style="list-style-type: none"> • Central Lancashire (Preston) • West Lancashire (Skelmersdale) • Lancaster (Lancaster) • Fylde (St Anne’s) • East Lancashire (Burnley) | Central Lancashire West Lancashire Lancaster Fylde East Lancashire |
| ● Assessing and Measuring social isolation and loneliness | Different ways to assess whether someone is experiencing social isolation or loneliness | Assessing social isolation and loneliness |

Support – It is important that any support for an individual is appropriate - for example, referring someone into a group activity if they are not physically able to get there will not be helpful. This section has some resources to help you identify, from the evidence of what works, appropriate supportive interventions

| Resource | Description | Link |
|--|---|---|
| ● Checklist for groups | Information to help groups better support socially isolated or lonely people | Checklist for groups |
| ● Short guidance for individuals | Short guidance to help individuals experiencing social isolation or loneliness | Short guidance – individuals |
| ● Full guidance for individuals | Full guidance to help individuals experiencing social isolation or loneliness | Full guidance – individuals |
| ● Wirral Council Evidence Review on social isolation and older people (2014) | Local Authority report reviewing ways of tackling social isolation and loneliness | http://info.wirral.nhs.uk/document_uploads/JSNA2015/Older_People_Social_Isolation_2015_FINAL.pdf |

Additional Useful Resources – Together with the above resources specifically aimed at helping to reach, understand and support people experiencing, or at risk of, social isolation or loneliness, we provide below additional useful resources:

| Resource | Description | Link |
|--|--|--|
| ● Campaign to End Loneliness (CEL) web page | Web page with useful information and tools - includes 'Reach-Understand-Support' model | http://campaigntoendloneliness.org/guidance/ |
| ● Bristol City Council report on social isolation | Local Authority report including causes of social isolation and loneliness | www.bristol.gov.uk/documents/20182/34732/Social%20isolation%20recommendations%20report_0.pdf/1c662a24-cfa0-4821-aeda-099595512289 |
| ● Making decisions of where to spend | How to consider where and whether money should be spent on tackling social isolation and loneliness | Making decisions on where to spend |
| ● Commission on Future of Public Services in Chorley – Report and Recommendations 2015 | Relates to Transformation Challenge Award (TCA) work in Chorley; N.B. TCA work also covers and Rossendale. | http://chorley.gov.uk/Documents/Unitary/Final%20report%20of%20the%20Commission%20on%20Public%20Services%20v1.pdf |

Acknowledgements

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