COTSWOLD DISTRICT COUNCIL

Office of the Police and Crime Commissioner Gloucestershire

"A sad soul can kill you quicker, far quicker, than a germ"
(John Steinbeck)

Research into the scale, extent and impact of loneliness and isolation in the Cotswolds

Research commissioned by Cotswold District Council, in partnership with the Gloucestershire Police & Crime Commissioner

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Executive summary

The funding climate for services to alleviate isolation and loneliness is challenging but, as this research shows, the need for these services is strong and growing.

This research, with residents aged 65+, confirms both national and international findings, that key influencers on the life stage of older residents, which can include the loss of employment, family, friends, income, mobility and the loss of health, make this age group more likely to suffer from loneliness and isolation than any other.

The negative impact of loneliness and isolation on mental and physical health has been widely researched and these stark findings are confirmed by participants in this local study.

When these acknowledged vulnerabilities to loneliness and isolation, and the associated risks to health, are augmented with a district whose ageing population is growing faster than the national average with nearly a third of residents past retirement age, a rural district which is in the lowest 10% for national accessibility ratings, and a district with 23% of retired residents dependent on pension credits, the need for a comprehensive strategy to prevent and alleviate loneliness and isolation is self evident.

The economic and social cost of loneliness and isolation is beginning to be revealed to both local healthcare providers and local communities. There is still more work to do in this field but the initial findings of this study show large differences between the lower costs of preventative services, which are provided by the local community, and the much higher costs of intensive healthcare services which are increasingly needed when local community services are not available or fail to meet older residents needs. These studies point out that not only is there a quality of life cost to the individual and an economic cost to the healthcare provider, there is also a community cost as unsupported residents lose their capacity to continue their caring and volunteering roles.

Some research has been undertaken, both nationally and internationally, to identify those community services which are most effective at preventing and alleviating loneliness and isolation for older residents, and again they were confirmed by this local study. These are community transport, befriending, community navigators (such as village agents and dementia advisors) clubs, groups and social activities and providing full-time carers with respite.

Fortunately all these services exist in the Cotswold district although quality, consistency and availability does vary widely from area to area.

Priority areas of highest vulnerability have been identified across the district and these need to be aligned with the required community services. Where services do exist, and are praised by some local residents for their effectiveness, many other local residents of similar need, have not heard of the services which could be so beneficial to them. A common problem across the services is poor marketing; many services mainly rely on

word-of-mouth to reach target groups and yet when your target group is cut off from their community, and has almost no social contact, this method is unlikely to be successful.

A comprehensive marketing plan is needed for all required services; this plan not only needs to effectively make contact with lonely and isolated residents, but also needs to offer what people want in such a way that they are motivated to contact the services they need. This will be challenging when some residents are so demotivated and alienated from their local community that they do not identify with the community services on offer. It is possible that several contacts will need to be made, by different communication channels before residents are motivated to make contact themselves. Building good relationships with referrers like GPs, village agents, church outreach workers, dementia advisors, and cross referrals between services will be key to the success of this strategy.

Government national policy, beginning in 2007, and in the current 'Vision for Adult Care: Capable Communities and Active Citizens' highlights prevention as a key principle. The policy states that councils should work with others to commission early intervention services, they point out the value of community self help and the contribution that older people can make. This theme is repeated in Gloucestershire's Health and Wellbeing Strategy 2012 – 2032 'Fit for the Future' where the aim of the vision is 'To improve the health of all Gloucestershire residents and protect the most vulnerable' by 'working with our communities to co-produce health, wellbeing and resilience.' Within this strategy 'Ageing Well' is one of the four priorities for action and it highlights the need to work with communities and local organisations to build vibrant healthy communities where people feel included.

So it is clear international, national and local research, national and local policy are all in agreement, we must work together to provide sustainable community services, which have been identified as being successful, at preventing and alleviating loneliness and isolation, in priority areas of need. The implementation of this strategy will bring substantial benefits to individuals, communities and healthcare providers.

At the end of this report, recommendations have been made for future service development which would begin the process of implementing this strategy.

Project aims

This project aims to identify the scale and extent of loneliness and isolation, in the Cotswold district, amongst people over the age of 65; to understand the impact that loneliness and isolation have on residents' physical and emotional health and wellbeing; and to identify current initiatives and services designed to help prevent and alleviate this condition. Additionally the project aims to assess the success of these identified services and initiatives and make recommendations for future service development across the Cotswold district. Finally the project aims to use this information to influence health and social care commissioners in their commissioning of early intervention and preventative services.

Much has been researched and written about the definitions and differences between loneliness and isolation, the causes of loneliness in people aged 65+ and the impact on health and wellbeing. However less work has been undertaken to assess the impact that loneliness has on healthcare services, the availability and success of preventative services, particularly at a local level, and the economic value of these preventative services to health and social care providers, individuals and communities.

Definitions of loneliness and isolation[1,2,3]

Loneliness and isolation are different conditions.

Loneliness is defined as a personal subjective sense of loss. Isolation is defined as being separated from social contact, community involvement, or access to services by loss of mobility, poor health etc.

Therefore you can be lonely but not isolated or isolated but not lonely.

However they are often connected in older age and reducing the impact of both of these conditions is the desired outcome of this project.

A local issue[4]

Cotswold district has an older population, with a longer life span, than the national average. Over 24,000 people are past retirement age, which represents nearly a third of the total population, and 1,700 of these are living with dementia, which in itself is an isolating condition. Significant growth in the older population in the district is anticipated over the next 10 years; people aged 75 and older are projected to increase each year by an average of 1,500 between 2010 and 2020 and by 2,300 each year between 2020 and 2035. The number of people aged 85+ living alone is expected to rise by 25% in the next 10 years.

Many older people do not drive (60%) and this can increase their feeling of isolation and loneliness – especially since this particularly rural district mainly falls within the lowest 10% in the national accessibility rankings.

Impact on health[1,2,3,5,6,7,8]

Older people are particularly vulnerable to social isolation and / or loneliness owing to loss of friends, family, mobility, health or income.

Loneliness and isolation are harmful to health. Research shows that a lack of social connections is as damaging to our health as smoking 15 cigarettes a day (Holt-Lunstad, 2010). Not only this but we recover more slowly when we do fall ill (Marmot, 2010).

In summary research has found that the effect of loneliness and isolation:

- exceeds the impact of obesity on mortality (Holt-Lunstad, 2010)
- has a similar impact as cigarette smoking (Holt-Lunstad, 2010)
- increases the risk of high blood pressure (Hawkley et al, 2010)
- increases the risk of the onset of disability (Lund et al, 2010)
- puts individuals at a greater risk of cognitive decline (James et al, 2011)
- leads to a 64% increased chance of developing clinical dementia (Holwerda et al, 2012)
- makes us more prone to depression (Cacioppo et al, 2006, Green et al, 1992)
- is predictive of suicide in older age (O'Connell et al, 2004).

Economic pressures on local health and social care services[3]

Research is clear that preventing and alleviating loneliness and isolation is vital to enable older people to remain as independent as possible. Lonely people are more likely to:

- visit their GP, have higher use of medication, higher incidence of falls and increased factors for long term care (Cohen, 2006)
- undergo early admission into residential or nursing care (Russell et al, 1997).

National policy[1,5]

In 2007 the 'Putting People First' concordat was signed by central government, the NHS, local government, professional bodies and regulators, and adult social care and health providers; it began a strategic shift to prevention and early intervention and identified the alleviation of loneliness and isolation as a major priority. It recognised that independence is founded on interdependence and social relationships. This led to the Department of Health Local Authority Circular 'Transforming Social Care' in 2008, which sets out the role that adult social care services should play in increasing people's independence and promoting inclusion in communities, through preventative approaches and the promotion of wellbeing rather than intervention at crisis point. It recognised the need for more help to support people to maintain their independence and feel part of society, to combat loneliness and isolation for older and vulnerable people and carers.

In 2008 the Audit Commission's review of the preparedness of local councils for an ageing population made recommendations which included:

- councils targeting services to tackle social isolation and support independent living
- councils leading local statutory agencies and the community and voluntary sector in making the most effective use of resources
- making use of the many older people who are willing to contribute to community life.

Guidelines were produced to help achieve these goals which included befriending, lunch clubs and inter-generational initiatives.

The Social Exclusion Unit in the Office of the Deputy Prime Minister did much research in this area and concluded that ending poverty is not enough on its own to end exclusion. It identified loneliness and social isolation as key factors leading to the exclusion of older people and had a significant impact on subsequent government policy in this area.

In 2010 the Government published its Vision for Adult Care: Capable Communities and Active Citizens and prevention is the first of seven principles upon which the vision is built. It states that councils should work with others to commission a range of early intervention services. The value of community self-help is emphasized, as is the contribution that older people can make.

Local Policy[15]

The Gloucestershire Health and Wellbeing Strategy 2012-2032 'Fit for the Future' outlines 6 key principles which underpin and guide the strategy priorities. These are:

- Supporting communities to take an active role in improving health
- Encouraging people to adopt healthy lifestyles to stop problems from developing
- Taking early action to tackle symptoms or risks
- Helping people take more responsibility for their own health
- Helping people to recover quickly from illness and return home to their normal lives
- Supporting individuals or communities where life expectancy is lower than the county average or where quality of life is poor.

It outlines the challenges of an aging population and identifies priorities for action within the following areas:

- Starting well age 0-4
- Developing well age 5-18
- Living and working well age 19+
- Ageing well age 65+

The priorities for Ageing Well focus on:

- Ensuring people enter later life in the best possible physical and mental health and wellbeing
- Are able to maintain control and independence for as long as possible and live their lives with dignity and to their full potential

- Ensuring people are resilient, can cope with adversity and can have a positive role in their local community which may include volunteering and caring roles which add significant community value.

It identifies dementia, falls and winter deaths as priority areas for Ageing Well and it highlights the high economic and social costs of these problem areas.

To make a lasting difference to the health of the people of Gloucestershire the strategy highlights the need to work with communities and local organisations to build vibrant healthy communities where people feel included.

Context

Acceptance that loneliness and social isolation exist, particularly in older populations; that the Cotswold District has an older population than the national average which is growing rapidly; that loneliness and isolation are damaging to both mental and physical health; that this damage to health has a negative impact on the quality of life experience for many older people contributing to their loss of independence and increased dependence on healthcare services; that this puts pressure on local healthcare services and has associated costs; and that communities suffer, not just through the increased pressure on their local healthcare services, but through the loss of valuable community members and carers; led to the commissioning of this research and the requirement to investigate, at a more local level, what action can be taken to prevent this situation from arising.

Methodology

In order to identify the scale and extent of loneliness and isolation in the Cotswold district the CACI Acorn Customer Segmentation Tool was used to map those residents that may be vulnerable to social isolation and loneliness, based on an isolation index, which is described more fully below. This exercise produced a shaded map of the Cotswold district, the darker shaded areas being more vulnerable to loneliness and social isolation. Additionally some individual households, which showed 'most vulnerable' ratings were within areas of lower vulnerability and so were mapped individually to give a more comprehensive picture of loneliness and social isolation in the Cotswold district.

Desk research was used to explore definitions of loneliness and isolation, the likely impact on the Cotswold district based on demographic data, the impact on health, the impact on healthcare services and to give an overview of national and local policy.

Qualitative surveys in the form of in-depth interviews and focus groups were used to ask local residents, aged 65+, about their experiences of loneliness and isolation, how it has affected their health and what local services they have used to help alleviate the problem; the strengths and weaknesses of local services were discussed and currently unavailable but required services were identified.

Finally local experts were contacted to provide cost / benefit data for service provision versus costs of GP appointments, A&E admissions and a local hospital bed, so that we can begin to understand the financial value of these preventative services.

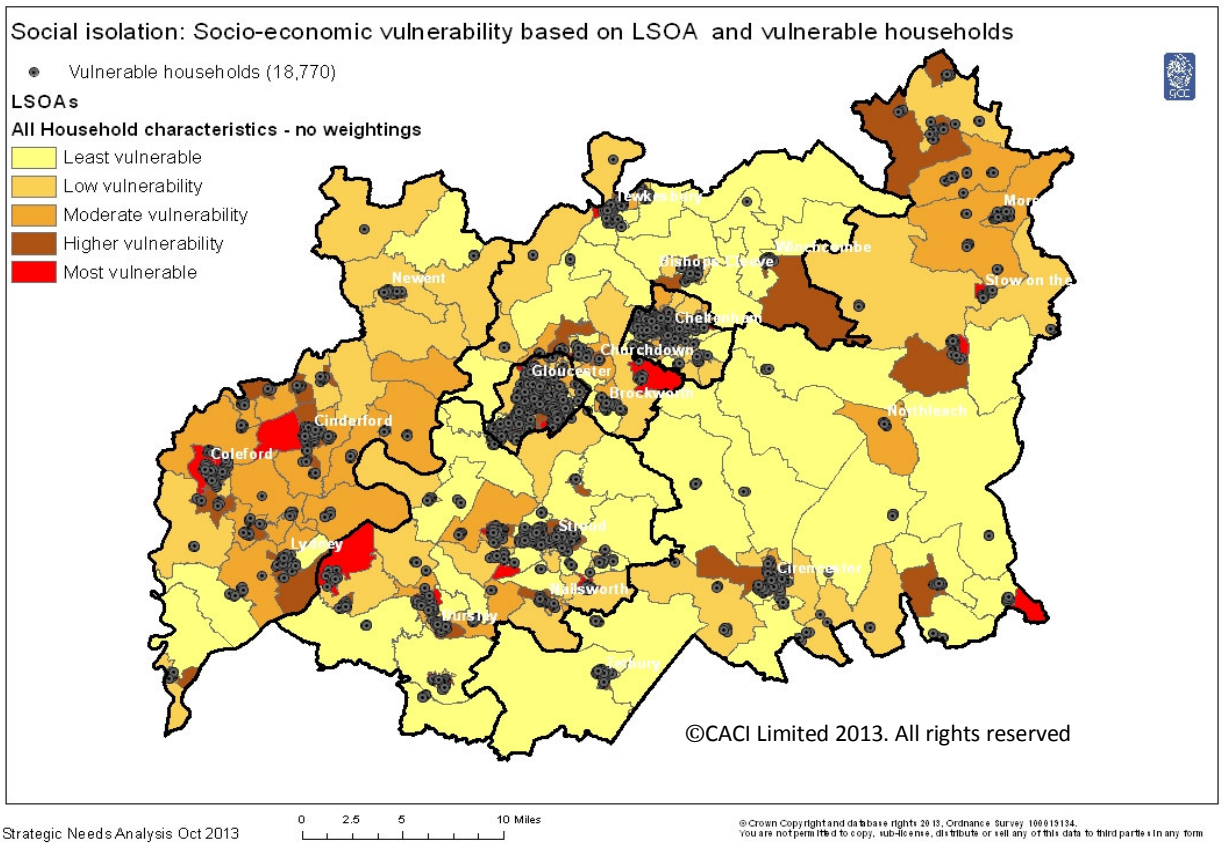
Identifying and mapping loneliness and isolation in the Cotswold District - CACI Acorn Customer Segmentation Social Isolation Mapping Report

The Strategic Needs Analysis Team of Gloucestershire County Council produced a report on Social Isolation in Gloucestershire, which covered the Cotswold district. This report used the CACI Acorn Customer Segmentation Tool to map those residents that may be vulnerable to social isolation and loneliness. Although all people who are at risk of isolation are included in this analysis a key variable in determining isolation is age (65+). The variables used to determine whether or not households / areas are vulnerable to loneliness are:

- Age 65+
- People living alone
- People having no formal educational qualifications beyond the age of 18
- People suffering from mental illness including anxiety / depression / nerves
- People who do not own a car
- People who spoke to neighbours less than once a month
- People who stated that they did not have anyone to talk to
- People who stated that they did not have anyone to help in a crisis
- People who stated that they did not have anyone to relax with
- People who declared themselves to be not satisfied with their social life
- People who had an annual income less than £20,000

- People who never used the internet

These variables were used to create an Isolation Index that was divided into quintiles of least vulnerable areas, areas of low vulnerability, moderate vulnerability, higher vulnerability and most vulnerable. It was found that the most vulnerable areas were associated with the main urban centres and fringes of market towns and also in areas of least accessibility. Additionally individual households, which fell into the top quintile of vulnerability, were also mapped. The household mapping data included the variables of age, single occupancy, low income and socially rented housing; it was found that older people occupied a third of these households.



Within the Cotswold District, areas which are most vulnerable to loneliness and social isolation, are on the fringes of Stow-on-the-Wold, Bourton-on-the-Water and Lechlade. Higher vulnerability areas include the north of the area around Mickleton, Saintbury, Chipping Campden, Bourton-on-the-Water and in the south at Tetbury and Fairford and the area to the west of Cirencester. Moderate vulnerability is also concentrated in the north of the area and around Northleach. Most vulnerable households generally follow this pattern but some of the most vulnerable households do occur in least and low vulnerability areas, particularly in areas of lower population.

(Please see Appendix One for the full report of Social Isolation In Gloucestershire).

Local service identification and mapping exercise

Having identified the likely areas of vulnerability in the Cotswold District local services, designed to combat loneliness and isolation, were then identified and added to the vulnerability map. Desk research and a consultation process were used to identify these services which included two Cotswold Conversation events with members of the public, agencies, voluntary and community groups. Over 40 services were identified which included befriending, community transport, carer respite, memory clubs, village agents, dementia advisors, social clubs, lunch clubs, exercise classes, art groups and volunteer time-banking. Each service was contacted to confirm their activities and contact details.

Clearly these services change over time and services may exist which were not identified during this exercise. This document will require regular updates.

(Please see Appendix Two for full details of the local services mapping exercise.)

On the whole a good correlation existed between areas of vulnerability and service availability. However some services, such as carer respite, social groups, lunch clubs and community transport were not available across the whole area or offered significantly different levels of service, by the different service providers. This means that vulnerable people across the district do not have equal access to comparable services.

The majority of the service providers are from the voluntary / charity sector and cover very local areas of need. For example community transport in the north of the area is predominantly provided by voluntary drivers, using their own cars, and taking individual clients to medical appointments and for journeys for social purposes. In the south of the area community transport is more geared for medical appointments or, in some areas, there is a community transport bus for shopping and group activities.

Likewise carer respite is offered in the north of the area, as part of a befriending service, but it is not currently offered in the south. Intergenerational befriending is available in the south of the area but not the north. Social clubs, in particular lunch clubs, also had limited availability across the area and were mainly available in the towns. Without transport people living in more rural areas would not have access to them.

Qualitative analysis of the extent and impact of loneliness and isolation, the availability of local services, and their success in alleviating / preventing the condition

Clearly identifying the existence of services alone was not sufficient to assess their success in combating loneliness and isolation. A qualitative research exercise was undertaken to determine what local services people used, the value of these local services, and what was required that was currently unavailable.

This qualitative analysis took the form of a series of focus groups and in-depth interviews, across the Cotswold District, between the 21st November 2013 and the 10th December 2013. In total seven sessions were held involving 44 participants aged 65+. Sessions were held in key areas of need and transport was provided as required.

The gender split was as expected for the age groups involved, 66% were female. A good age representation was achieved with almost 30% of participants aged between 65 and 75, 34% aged between 75 and 85 and 32% over 85 years old.

57% of participants lived alone and 18% classified themselves as carers, so representing a range of interest groups.

36% were non-drivers and 41% had mobility problems. We would perhaps have expected a higher proportion of non-drivers but participation required access to the venues where focus groups / interviews were held and, although transport was offered, very few requests for transport were received.

Over half (57%) of participants declared a long-term condition; the most common were: mobility problems, dementia, arthritis, heart conditions, diabetes, hearing and sight impairments. This number is a little lower than expected but some participants choose not to / were unable to declare this information.

Over 45% of participants lived in villages, with 34% living in towns, and just over 20% living in sheltered or supported housing, which was a good spread of location type. The sheltered / supported housing percentage was slightly higher than would be expected but four of the sessions were held in these locations.

The 10 discussion topics for the sessions are listed below:

- General discussion about loneliness and isolation
- Transport and ability / desirability to spend time outside the home
- Safety concerns
- Social contacts – desired and achieved
- Impact of loneliness and isolation on happiness, wellbeing and health
- What is preventing people from having the social life / social contacts they would like, what would help
- Local service availability
- Impact of local services on happiness, wellbeing and health
- Desired service availability

- Last words

Full details from the in-depth interviews and focus group discussions by topic can be found in Appendix Three.

In summary it was agreed that an important factor in determining an individual's likelihood to experience loneliness and isolation is their personality. Put simply, some people need less social interaction than others. For some people hobbies, pets, keeping active, can all help to prevent feelings of loneliness. It does not matter if you live in a town, or a village, or a care home, if you live alone or with a partner, loneliness and isolation can be felt by us all.

However there are significant factors that are clearly causes of loneliness and isolation, which are mainly concerned with the experience of 'loss' and include bereavement, family moving away, being a full-time carer, living with someone with dementia, mobility problems, loss of driving licence / ability to drive, hearing and sight impairment and other isolating long-term conditions which can lead to the loss of independence.

Lack of transport is a major issue, and the most commonly reported problem by participants. Being isolated makes all other problems seem much worse. Infrequent or non-existent bus services, which do not co-ordinate with connecting services, and have routes which incorporate too many stops / villages, with poorly located bus stops were highlighted by many participants. Older people, with limited mobility, who are frail and unable to cope with adverse weather conditions, and struggle with short winter days, can find the public transport system very difficult to use and that is isolating.
People hold on to their driving licence as long as they can, using their cars for short local journeys, in daylight and good weather.

Some community transport is used but it is not well promoted across the area and service provision varied greatly. Better promotion of community transport and more consistent and flexible services are requested. Taxis are too expensive for many people.

Safety concerns focus more on the weather, as people fear falling in snow and ice, and darkness in the winter, than feelings of concern for personal safety due to crime. This challenges the assumption that older residents are fearful of crime; however concern for some alcohol related problems were voiced.
A need was expressed for more benches and repaired pavements to aid safe mobility.

Careline was widely used and thought to be very reassuring for people, although less helpful for those with a hearing impairment.

Generally people felt they did not have enough social contacts each week, with some people seeing less than 1 person per week. In some cases the postman, newsagent and carers were the main social contacts.

Befriending services were widely used and well regarded but some people had experienced a waiting list and others were not aware of them.

Telephone contacts with family and friends were seen as a lifeline but difficult for people with hearing impairment. Very little IT is used; very few participants were using Skype, Facebook etc to keep in touch with family. Most participants found IT intimidating, believing it to be both beyond their capabilities, and of no real interest to them.

Clubs and groups are used by many but availability is sporadic and more of these, including lunch clubs, board game and knitting groups, were requested. Similarly people requested more community outings (pub, theatre etc). Clubs need to be supported with transport to be of real value. Lunch club availability is limited and more creative ways of providing these social opportunities could be explored to make them less onerous to organize and therefore more widely available e.g. using pubs.

Women seem to find it easier to join in with group activities, and organize more, than men. Men felt less likely to join in and thought less was available for them. The perceived stigma of joining some of the groups on offer affected some people and some people found some of the available social groups to be patronizing.

Loneliness and isolation were widely accepted as having a detrimental impact on health and wellbeing, both mental and physical. It was felt that bereavement and physical pain were harder to endure if you were lonely and isolated; depression and anxiety were both considered to be caused by loneliness and isolation. It was felt that dependence on GPs and social services increased with loneliness and isolation. Dependence on alcohol and lack of exercise were also associated with loneliness and isolation.

Service availability was often better than people thought, but awareness of what was available locally was often low. Parish magazines, notice boards, press and PR were all seen to be important ways of promoting local service availability to potential users. Relying on word of mouth to attract participants did not appear to be working well.
Most people were prepared to pay 'reasonable' amounts for services provided but for some the cost of e.g. lunch clubs was prohibitive.

It was agreed that not enough is done to support carers and give them the respite they need so they can have an active social life. It was felt that their mental and physical health was at risk if they were unsupported. Carer respite services were thought to be good, and heavily praised by those who used them, but they needed to be better promoted and more widely available. At the moment there is more carer respite available in the north of the area than the south.

Village Agents, Young at Heart Memory Clubs, the British Legion and the U3A were all praised by participants. Again some participants were not aware of these services / groups.

Volunteering was seen as a way of keeping socially active, of providing structure and purpose and activity. People reported that it helped them to think less about their own problems and more about others and that it was beneficial to health, reducing depression and helping them to keep physically active.

The opportunity of telephone befriending was welcomed as both a service in its own right and a complementary service to e.g. face-to-face befriending. It was thought that this may be of particular value to men.

Supporting people to stay independent, living in their own homes for as long as possible, was seen to be the most desirable outcome. Services to combat loneliness and isolation, including transport provision, were seen as an important way to achieve that. If these services could be adequately provided it was felt that this would have a positive impact on both mental and physical health and help to sustain independence for older residents.

The value of preventative services to local healthcare providers, individuals and communities[1,2,3,5,6,8,9,10, 11, 12, 13, 14]

Health and wellbeing

In recent years attempts have been made to assess the value of preventative services on loneliness and isolation.

Windle, Francis and Coomber[2] find that the more successful interventions include befriending, community navigators, such as village agents and dementia advisors and social group schemes, such as memory clubs and lunch clubs. They conclude that transport is often an issue and needs to be provided to allow people to participate in the services that are on offer, which reflects the findings of the local focus groups.

They report that people who use befriending or community navigator services, and participate in group activities, are less lonely and socially isolated following the intervention.

Where longitudinal studies recorded survival rates, older people who were part of an intervention, had a greater chance of survival than those who had not received such a service. One report concluded that people with stronger social relationships had a 50% increased likelihood of survival than those with weaker social relationships.[8]

These studies concluded that the benefits to individuals, and the wider community, of reducing loneliness and social isolation are self-evident. Improving both individuals' quality of life and limiting dependence on more costly intensive services. They also state that reducing loneliness and isolation also enables a possible 'harnessing' of potential contribution to the community through, for example, volunteering and caring responsibilities.

Financial benefits

It is claimed that:

- reducing age-specific dependency rates by 1 per cent per year would reduce public expenditure by £940m per year by 2031[1,5]
- reducing the rate of institutionalisation by 1 per cent a year could save £3.8bn[1,5]

The costs of providing a befriending service vary significantly across the UK between £25,000 and £50,000pa depending on the type of service that is provided and the number of people who are helped. This breaks down to a per unit cost of between £80 and £900,[9] the more expensive schemes offer more intensive services e.g. to families.

A recent survey[10] identifies the average annual cost of a befriending and mentoring service, which has up to 50 volunteers and helps more than 50 clients, to be £25,000. This report gives case studies to illustrate the financial value of befriending services such as in Portsmouth where a befriending scheme with 90 volunteers, supporting 200 housebound older people, is funded by Portsmouth City Council at a cost of £80,000pa. This scheme has a large impact on health outcomes by reducing bed blocking, winter deaths and falls at home and by improving mental health. This service significantly

reduces the domiciliary care costs for Portsmouth City Council, which are currently £315,000pa.

At a local level, within the Cotswold District, the per unit cost of providing befriending services ranges from £155 - £215pa, which equates to less than £5 per visit.

By comparison some local healthcare costs are shown in the table below:

Service	**UK average cost per unit**
GP appointment	£25
Hospital day bed	£300
Visit to A&E	£59 - £117

The Campaign to End Loneliness asked over 1000 GPs how many lonely people they were seeing and over three quarters of GPs said that were seeing between one and five lonely people a day.[12]

Other research has found that:

- Lonely people are twice as likely to visit their GP[11]
- Some people are visiting A&E departments over 50 times a year[13]
- Loneliness is a factor in unnecessary visits to A&E departments[14]

Additionally there are many case studies that demonstrate that older people, who are lonely and isolated, are more likely to visit their GP, attend the A&E and be admitted to hospital or residential care.

The costs of providing these intensive services are far greater than the costs of funding successful preventative services and the impact on quality of life is significant.

Recommendations

General

1. **Areas / households which are at greater risk** to isolation and loneliness should be prioritised for the provision of preventative services. The most vulnerable areas are the fringes of Stow-on-the-Wold and Bourton-on-the-Water and Lechlade. Higher vulnerability areas are around Mickleton, Saintbury, Chipping Campden, Bourton-on-the-Water, Tetbury and Fairford and to the west of Cirencester. Moderate vulnerability is concentrated in the North of the area and around Northleach. Additionally some most vulnerable households do occur in least and low vulnerability areas.

2. **Commissioners and funders** should recognise the value of early intervention and prevention, particularly those services that have been identified here as being most successful at preventing / alleviating loneliness and isolation, by investing in those services and ensuring they are made available and accessible to residents, e.g. through the social prescription model.

3. **Decision makers** should work together to understand the impact of broad policy decisions on the overall health and wellbeing of older or other vulnerable residents e.g. the removal of seating from bus stops to prevent young people from hanging around.

Priority services / developments

4. **Community transport** – a review of community transport availability across the district should be carried out and funding sought, and plans put in place, to improve, standardise and more widely promote, these services.

5. **Befriending services** – recent Big Lottery funding has allowed increased availability of befriending services to cover the whole district. However recruitment of volunteers, to facilitate expansion, and marketing campaigns to more widely promote this improved availability, need to be increased. Telephone befriending should be considered as a future service development.

6. **Carer respite services** – are more widely available in the north of the area although funding for carer respite is very limited across the whole area. A review should be undertaken in partnership with Carers Gloucestershire to look at the feasibility of providing these services more widely in the north and a partner and funding sought to provide carer respite in the south.

7. Lunch clubs, social groups and community events – provision of these services are sporadic. Each priority area should have access to group activities, which need to be supported with transport and carer respite. These community resources should be developed in consultation with the local residents who will use them and take into account specific local issues, e.g. lack of activities on a Sunday, and be run by volunteers who will attend them. Professional support should be made available to ensure that best practice guidelines and health and safety regulations are met, and to offer

marketing expertise to ensure that the availability of these services reaches those people who would most benefit from them.

8. Community navigators, including but not limited to village agents and dementia advisors are an important community asset**.** They direct residents to the resources they need and, in some cases, provide much needed social opportunities for lonely and isolated older people. A review of their availability and workload should be carried out and, more specifically, the findings of this fed into the forthcoming review of the dementia advisor service. Their services should then be more widely promoted, so that more residents can benefit from them.

9. IT – the use of IT to improve social networks and keep in touch with family and friends was very limited. Opportunities for older people to have access to and use these technologies should be improved**.**

10.Men – encouraging men to more fully participate in their local community, possibly by providing specific social opportunities which meet their needs, should be explored.

11.Volunteering – promoting volunteering as a way of increasing social networks, keeping active and fit, and maintaining mental and physical wellbeing should be more widely employed.

Appendix One	Social Isolation in Gloucestershire, Strategic Needs Analysis Team, 2013
Appendix Two	Local Services Mapping Exercise
Appendix Three	Qualitative Analysis of the Impact of Loneliness and Isolation and Services

References

1. Loneliness and Isolation Evidence Review – Age UK – 2010

2. Preventing Loneliness and Social Isolation: Interventions and Outcomes – Windle, Francis and Coomber, Social Care Institute for Excellence – 2011

3. Campaign to End Loneliness http://www.campaigntoendloneliness.org

4. Understanding Gloucestershire 2012 http://www.gloucestershire.gov.uk/

5. Making Life Better for Older People, Office of the Deputy Prime Minister

6. Preventing Loneliness and Social Isolation among Older People, Social Care Institute for Excellence, 2012

7. Loneliness In Later Life: analysis of the English Longitudinal Study of Ageing, Christina Victor, Brunel University, 2013

8. Social Relationships and Mortality, Holt-Lunstead et al, 2010

9. Funding for Mentoring and Befriending, Mentoring and Befriending Foundation, 2011

10. Promising Returns – a commissioners guide to investing in mentoring and befriending programmes, Mentoring and Befriending Foundation, 2012

11. A Better NHS – Loneliness – 2013
http://abetternhs.wordpress.com/2013/05/04/loneliness/

12. Campaign to End Loneliness, 2013 -
http://www.campaigntoendloneliness.org/blog/lonely-visits-to-the-gp/

13. BBC News Health 2014 http://www.bbc.co.uk/news/health-25628009

14. Campaign to End Loneliness, 2014
http://www.campaigntoendloneliness.org/blog/loneliness-health-care/

15. Gloucestershire Health and Wellbeing Strategy 2012 – 2032 – Fit for the Future