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Loneliness and Social Isolation Among Older People in North Yorkshire

Project commissioned by North Yorkshire Older People's Partnership Board

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Introduction

This report was commissioned by the Loneliness Task Group of the North Yorkshire Older People's Partnership Board (NYOPPB). Its purpose was to build on the findings from the 'Voice of Ripon' loneliness survey carried out in 2009 on behalf of NYOPPB[1] . The report aims to provide a review of current literature that brings together knowledge about the extent and nature of loneliness among older people. This will help to clarify current thinking about what a 'good practice' or service looks like and start to identify likely models of good practice in North Yorkshire.

The report looks at how loneliness and social isolation are understood in the literature, why they should be important concerns of local strategic organisations, such as health and wellbeing boards, and what might be done. This evidence is set in the context of the geography and demography of North Yorkshire and suggestions for future work are made.

Chapter 1 looks at the twin concepts of loneliness and social isolation, the prevalence of loneliness and its rural dimension. It highlights key risk factors for loneliness and associated statistics and looks at ways of identifying and measuring loneliness.

Chapter 2 examines the impact of loneliness on individual health and wellbeing and on and quality of life in local communities.

Chapter 3 examines interventions in tackling loneliness, their type and range. Evidence of their effectiveness is presented with a selection of case studies.

Chapter 4 looks at how loneliness has become an issue for government nationally and locally and identifies recent associated policy initiatives. It examines the local context in North Yorkshire. It presents some information on demographic factors relevant to the issues of loneliness and social isolation and examines the draft health and wellbeing strategy. Possible future directions are discussed.

Background

There has been a growing academic literature on the topic of loneliness over a number of years, including several reports that draw together both what is currently understood conceptually, and evidence about the types and range of possible interventions. Notably these have included reports by Age UK, [2,3,4] reviews of the literature by SCIE [5,6] and material collated by the Campaign to End Loneliness [7] . There is a significant body of evidence that can provide information and guidance and create pressure on strategic organisations to tackle loneliness in older age.

Chapter 1: Understanding Loneliness

Key Messages

- Loneliness and social isolation are distinct concepts.
- Loneliness includes emotional loneliness and social loneliness.
- Approximately ten per cent of people over the age of 65 in the UK are lonely all or most of the time.
- 23 per cent of the rural population are over retirement age compared to 18 per cent in urban areas.
- There may be differences between rural and urban areas in how loneliness is experienced.
- Understanding the experience of loneliness in different populations influences the types of intervention employed to alleviate the problem.

1.1 Introduction

Loneliness is part of the human condition that affects all ages, but older people are particularly vulnerable. Experiences commonly associated with ageing, such as loss of family and friends, poor health, decreased mobility and income; as well as trends in wider society, such as greater geographical mobility, reduced inter-generational living, less cohesive communities, mean that older people may become more socially isolated, potentially leading to increased loneliness.

1.2 Concepts of loneliness and social isolation

The terms 'loneliness' and 'social isolation' are often used interchangeably, but are distinct concepts. People can be socially isolated without feeling lonely, or feel lonely amongst others. Research on loneliness has split the concept into different elements [(8)]. However, it is most widely defined as a subjective negative feeling that can encompass emotional loneliness – the absence of a significant other (for example, a partner or close friend), and social loneliness – the absence of a social network (for example, a wider group of friends, neighbours) [(9).] In contrast, social isolation tends to be defined as an objective state referring to the number of social contacts or interactions.

The relationship between social isolation and loneliness is a complex one, and is likely to change over the lifecourse. Research, for example by Savikko *et al*., Victor *et al*. [10,11,12] and from the English longitudinal study of ageing (ELSA) [13] has identified a number of predictors of loneliness relating to personal circumstances (for example, widowhood), life events (for example, bereavement, moving into residential care), poor physical and mental health, or perceptions such as the expectation of declining health and dependency, and low socio-economic status. However the Age UK evidence review on loneliness and social isolation[2], concluded that physical isolation was the single factor most closely associated with feeling lonely.

1.3 The experience of loneliness and social isolation

How the concepts are understood and experienced is important, as it influences not only how they are measured, but also the types of intervention that might be appropriate to tackle the negative impacts of loneliness and/or social isolation in different populations.

There is evidence to suggest that men and women experience loneliness differently. Loneliness in men is more often associated with the quality of their relationship with a spouse or partner, whereas for women, the absence of wider social networks is particularly important [3]. Different patterns of loneliness are evident, so that for some older people it is a chronic condition, typical of their longstanding difficult or limited relationships with family, friends and neighbours. For others, it is linked to the impact of particular life events, such as becoming a widow, and may be more transient [14,15]. Although older people living alone are most likely to experience social isolation, those living in residential care may experience loneliness, especially if they lack opportunities to participate in the community outside the care home.

1.4 Rural/urban differences

Loneliness and social isolation in older people are particularly important issues for rural areas.

- 23 per cent of the rural population are over retirement age compared to 18 per cent in urban areas.
- The older population is projected to rise, with those aged over 85 increasing by 186 per cent by 2028 in rural areas, compared to 149 per cent for the UK as a whole [16].

In the UK, research conducted in rural North Wales suggested that older women living alone in sparsely populated areas and experiencing poor physical and mental health were at greater risk of loneliness. In contrast, population density was not a

significant predictor of loneliness for men [17]. This may be linked to the different types of loneliness noted earlier and the importance of a wider network of relationships for women in particular.

There is little research comparing levels of loneliness between rural and urban areas, in the UK at least. A Canadian study suggested that the predictors of loneliness may be different between rural and urban areas. For example, the perception that future income was inadequate was an important predictor in rural areas, while being widowed was more important in urban areas [18]. In the UK, older people are more likely to be lonely if they live in a deprived urban area, or an area in which crime is an issue [19].

A report in 2012 by the Commission for Rural Communities on social isolation experienced by older people in rural communities, highlighted a number of particular challenges for rural areas to consider around social care, transport and housing in the context of current public sector austerity measures [16].

- With dispersed populations, provision of social care services is more costly in rural areas, but a historical and persistent urban bias in formulae for calculating funding allocation leaves rural areas at a disadvantage.
- Eligibility criteria for services tend to have become limited to 'critical' and 'substantial' needs only, so that there is reduced scope for preventive services.
- Difficulties around transport costs and economies of scale mean that it is more difficult for personal budgets in social care to offer greater choice in a rural context.
- There was also concern expressed about the financial security of voluntary sector services and their continued support from the statutory sector. Such services and partnerships were seen as playing a significant role in sustaining rural communities and tackling social isolation.
- Some of the most rural areas are those hardest hit by public and community transport cuts.
- Planning for age-appropriate housing needs to consider the importance of location close to services and friends or family.

The report called for a more equitable distribution of government funding between rural and urban areas based on need. It concluded that a more joined-up approach, focusing on the needs of older people in rural areas would go some way to reducing the risk of social isolation and also had the potential to reduce public expenditure.

1.5 The prevalence of loneliness

Studies have reported rates of loneliness among older people living in the community of between two per cent and 16 per cent[20]. Higher rates (approximately

50 per cent) were reported amongst the oldest older people (aged over 80) in the ELSA [21]. There is less research about people living in institutional care, but one study found that more than half of nursing home residents reported feeling lonely [22]. Based on such studies, it has been suggested that, overall, about ten per cent of people over the age of 65 in the UK are lonely all or most of the time [23]. The extent of loneliness does not appear to have worsened over time, although the relative relationship between those who are never lonely and those who are sometimes lonely has changed, with a higher percentage reporting they are sometimes lonely in more recent studies[23]. Ageing populations are changing over time, with more people from ethnic minority groups, or those with complex health conditions who are surviving into old age, so that responses may need to be qualitatively different.

1.6 Key facts

The Campaign to End Loneliness, as part of their drive to tackle loneliness and social isolation, provide key facts and statistics to help identify those likely to be at risk or experiencing loneliness[24] :

Key risk factors

- **Personal circumstances**
  - Living alone
  - Being divorced, never married,
  - Living on a low income
  - Living in residential care
- **Transitions**
  - Bereavement
  - Becoming a carer or giving up caring
  - Retirement
- **Personal characteristics**
  - Aged 75 plus
  - From an ethnic minority community
  - Being gay or lesbian
- **Health and disability:**
  - Poor health
  - Immobility
  - Cognitive impairment
  - Sensory impairment
  - Dual sensory impairment
- **Geography i.e. living in an area**
  - With high levels of material deprivation
  - In which crime is an issue

Key statistics around 'trigger' factors

- **Contact with friends and family**
  - 17 per cent of older people are in contact with family, friends and neighbours less than once a week, and 11 per cent are in contact less than once a month.

- **Getting out and about**
  - 12 per cent of older people feel trapped in their own home.
  - Six per cent of older people leave their house once a week or less.
  - Nearly 200,000 older people in the UK don't get help to get out of their house or flat.
  - Nine per cent of older people say they feel cut off from society.

- **Living alone**
  - About 3.8 million older people live alone.
  - 70 per cent are women over 65.
  - Over half (51 per cent) of all people aged 75 and over live alone.
  - It is predicted that between 2008 and 2031 the increase in the number of 65-74 years olds living alone will be 44 per cent and the increase in those aged 75 plus living alone will be 38 per cent.

1.7 Identifying loneliness

Although there is growing evidence on the array of risk factors for loneliness, the challenge of identifying individuals and supporting their needs remains. As part of its strategy to tackle loneliness and social isolation, one London borough has developed a tool to help identify isolated older people[25]. The on-line tool starts with a menu of key themes, or triggers for loneliness, for example, no local family, or recent discharge from hospital. Clicking through the themes provides advice on possible solutions and direct links to local services that may be able to help, including a referral form to the council. The tool can be used by anyone, by professionals referring people thought to be at risk and by older people themselves and is available at, http://www.rbkc.gov.uk/healthandsocialcare/peoplefirst/triggertoolpages.aspx.

1.8 Measuring loneliness

Developing and sharing tools to measure loneliness has been a recent priority for the Campaign to end Loneliness[26]. The Campaign also provides fact sheets about validated scales for measuring loneliness that have been used reliably with older people[27]. These include:

- De Jong Gierveld scale [28]
  - The scale consists of 11 items - six formulated negatively and five formulated positively – around people's situation of being alone.

Participants self-report on the extent to which statements apply to their situation. The model is based on the so-called cognitive theoretical approach to loneliness. Characteristic of this approach to loneliness is the emphasis on the discrepancy between what a person wants in terms of interpersonal affection and intimacy, and what they have; the greater the discrepancy, the greater the loneliness.

- Duke social support index [29]
    - This comprises two sub-scales that measure social interaction and subjective support. An 11-item index was adapted from the original 35-item index developed by Koenig *et al.*. (1993) [30]. Used together, the two sub-scales address the measurement of both social isolation and loneliness, including subsets of perceived loneliness, social participation, social skills and social networks.

Chapter 2: The Impact of Loneliness

Key Messages

- Loneliness and social isolation have direct effects on older people's health and life span.
- The effect is comparable to cigarette smoking.
- Lonely and isolated older people use more healthcare resources.
- Lonely and isolated older people are more likely to need long-term care.
- Loneliness and isolation is detrimental to quality of life and sustaining 'healthy' communities.

There is a public awareness that loneliness affects a significant proportion of the population and that being lonely is a struggle emotionally. The links between loneliness and poor physical health are well-established, but perhaps less widely known.

2.1 Health impacts

The Social Care Institute for Excellence (SCIE) reviewed the evidence on loneliness and social isolation in 2011[5] and highlighted how being lonely has a significant and lasting effect on people's health. Further evidence was presented in Age UK's 2012 report [4]. Loneliness adversely affects cardiovascular health (independent of other factors that may be related, such as smoking) and immune function [4,5,20]. Disrupted sleep, with its related health problems, is associated with loneliness [4]. The link between loneliness and depression as both a cause and a consequence is well-established [4,5]. It has also been shown to affect cognitive behaviours such as encouraging a more negative outlook and greater focus on self-preservation with associated impacts on relationships [4]. Loneliness has been linked with cognitive decline and dementia. A Swedish study of people living at home found that an extensive social network appeared to protect against dementia, while in the US, a follow-up of 800 older adults over four years found that lonely people were more than twice as likely to develop Alzheimer's disease than those who were not lonely [20].

Lonely or isolated older people are at greater risk of dying prematurely.
A meta-analysis of 148 longitudinal studies published in 2010 estimated that individuals with strong social ties have a 50 per cent greater likelihood of survival

than those with poor social relationships and networks [31]. This effect was compared to smoking 15 cigarettes a day and is greater than other well-established risk factors for mortality such as physical inactivity and obesity. However, in comparison with these more well-known factors, much less is known about the mechanisms through which loneliness affects health. As well as possible physiological mechanisms, such as neuro-endocrine or hormonal effects, health behaviours may also be important. Loneliness makes it harder for people to regulate for example, drinking, smoking and over-eating, while social relationships have been shown to promote healthy behaviours [32].

2.2 Social and economic impacts

The physical, mental and emotional effects of loneliness discussed above, inevitably have consequences for quality of life and the wider community, as well as costly health and social care service use.

A recently developed quality of life measure based on the needs and aspirations of older people, found that most older people ranked social relationships as the key dimension [33]. Engaging in a large number of social activities and feeling supported; good community facilities and infrastructure such as transport; and feeling safe in one's neighbourhood were among the main factors contributing to a good quality of life in older age. Loneliness and social isolation encourages fear and distrust and fragments communities. By contrast, keeping older people connected to their neighbourhoods harnesses economic and social capital and helps to promote social cohesion. Older people's engagement in volunteering and/or caring activities brings benefits, not only to individuals, but to sustaining communities [5]. In terms of pressure on health and social care services, research has shown that socially isolated and lonely adults are more likely to be admitted earlier to residential or nursing care, are at greater risk of emergency admission and re-admission to hospital, although the impact on consultations with general practitioners (GPs) is less clear [20].

Given the growing understanding about the impacts of loneliness and social isolation and the recognition that it is a serious problem, there is a pressing need to bring the issue to the forefront of national and local policy agendas.

Chapter 3: Interventions to Reduce Loneliness and Social Isolation

Key Messages

- Interventions may target the problem of loneliness; others are part of wider community engagement initiatives.
- Interventions include: information and signposting, support to individuals, group interventions, wider community engagement.
- Evidence is mainly descriptive with few evaluations.
- Knowing the target population and what works for which people is key.
- Loneliness and isolation may require different inputs.

There is a wide variety of services that address the problem of loneliness and social isolation. Some interventions have tackling loneliness as their main purpose; others are part of wider community engagement initiatives where effects are secondary. Evaluations of different initiatives tend either to be lacking, or do not use consistent or robust methods for assessing their effectiveness. Different target groups and varying outcome measures make comparisons difficult.

3.1 Types of intervention

There have been several reviews of the literature examining interventions and their effectiveness [2,5,6,34,35,36,37]. The Campaign to End Loneliness in their toolkit for health and wellbeing boards, provide a briefing note that categorises services that can help to reduce loneliness and isolation[38]. Services include, but are not limited to, interventions delivered by both the voluntary and the public sector.

Campaign to End Loneliness briefing note: services that can help to prevent or alleviate loneliness in older age

Information and signposting services

- websites or directories including information about social support services;
- telephone help-lines providing information about social support services;
- health and social support needs assessment services (postal or web based questionnaires or visits).

Support for individuals

- befriending – visits or phone contact, it may include assistance with small tasks such as shopping;
- mentoring – usually focused on helping an individual achieve a particular goal, generally short term;
- buddying or partnering – helping people re-engage with their social networks, often following a major life change such as bereavement;
- Wayfinders or Community Navigator initiatives helping individuals, often those who are frail or vulnerable, to find appropriate services and support.

Group interventions – social

- day centre services such as lunch clubs for older people;
- social groups which aim to help older people broaden their social circle, these may focus on particular interests for example, reading.

Group interventions – cultural

- initiatives that support older people to increase their participation in cultural activities (e.g. use of libraries and museums);
- community arts and crafts activities local history and reminiscence projects;
- health promotion interventions;
- fitness classes for people over 50;
- healthy eating classes for people over 50.

Wider community engagement

- projects that encourage older people to volunteer in their local community (for example, local volunteer centres and Time Banks)

Source: Loneliness and isolation: a toolkit for health and wellbeing boards. Campaign to End Loneliness http://wwww.campaigntoendloneliness.org.uk/toolkit/

3.2 Impact of interventions

The SCIE reviews[5,6] explored the impact of different intervention types across three outcomes: loneliness, health and wellbeing (including mental health) and health service use. One-to-one interventions such as befriending and community navigator services appear to be successful in alleviating loneliness and are valued by service users, although 'before and after' evaluations tend to be lacking. Evidence in the Age

UK (2010) report also suggested that there can be problems in both attracting users and recruiting volunteers [2]. However, regular one-to-one contact is considered to be particularly successful for people who are frail and housebound [6]. Befriending can be important in providing much-needed companionship, while community navigator services are successful in identifying people most at risk and helping them to access other services.

The success of group services in combating loneliness is unclear, with different studies reporting inconsistent findings, but they appear to be effective in improving health and wellbeing. Improved physical health, a reduction in falls and improved survival rates have been reported in a number of studies of group interventions [5].These sorts of interventions have also been found to have a positive impact on health service use, such as GP visits, hospital bed days and out-patient attendance[39,40]. Services can vary widely, including lunch clubs and social support circles. Those that support group activities and have a creative, therapeutic or discussion-based focus seem to be particularly successful [39].

A review of lunch clubs and day services by a county council found that they were successful in reaching large numbers of vulnerable people. Most people using the services were aged 75 and over and socially isolated, describing the lunch club as their only social activity. The review concluded that there was greater potential for using the services to address health and wellbeing outcomes, and for improving networking and information sharing between local services [41].

3.3 Cost-effectiveness of interventions

Befriending services are calculated as being relatively low cost, and by targeting at-risk groups, for example, older people discharged from hospital, such services can potentially offer worthwhile returns on investment in improving quality of life for older people [42]. Knapp *et al.* [43] demonstrated the economic impact of community capacity-building initiatives, such as befriending and community navigator services, compared to what would have happened in the absence of such initiatives. A typical befriending service was estimated to cost about £80 per older person in the first year providing around £35 of 'savings' in the reduced need for treatment and support for mental health needs. Factoring in additional quality of life improvements, the monetary value was estimated at around £300 per person per year. Community navigator schemes may carry a higher initial cost, but the calculated economic benefits were estimated to be even greater [43]. Decision modelling suggested that the cost of such a service was just under £300 per person, with economic benefits amounting to approximately £900 per person in the first year. As with befriending services, including quality of life improvement, as a result of better mental health, yielded even greater economic benefits.

The study of social group services mentioned earlier [39], noted that the total cost of health service use was lower for those involved in group activities than the comparison group, and the savings were significantly greater than the cost of the intervention. The evaluation of the Department of Health programme, Partnerships for Older People Projects (POPPS), showed that a range of preventive interventions, from low level lunch clubs to more formal hospital discharge and rapid response services, were cost effective. Their impact was on not only reducing emergency bed days, but also improving wellbeing outcomes. For every £1 spent on the POPP services, there was an approximate £1.20 additional benefit in savings on emergency bed days [44].

Wider community engagement projects, such as time banks, have been shown to be more successful than traditional forms of volunteering in attracting socially excluded groups. Participants contribute their skills, practical help or resources, in return for services provided by fellow time bank members. Running costs are low, but the value of the economic consequences have been calculated at around £1300 per member [43].

3.4 Effective strategies

A consistent message in evidence reviews is that there is a need to distinguish between the many different types of service and their diverse aims, and a need for improved research on their evaluation. Knowing the target population and what works for which people is key. Loneliness and isolation may require different inputs. Practical support or the provision of transport may help isolation, and those experiencing loneliness may require social support, but targeted to specific needs and interests. For example, older men have been found to respond to schemes that help maintain or pass on skills. In focusing on active pursuits and skills, 'Men in Sheds' schemes in rural and urban areas have been successful in engaging traditionally 'hard to reach' older men. Much of the research has emanated from Australia [45], but there are examples in the UK from Age UK [2,46].The benefit of such schemes in restoring a role in society and a sense of worth is also seen as key to combating loneliness in this group. The successful focus for older women, especially in sparsely populated rural areas, may be to focus on maintaining networks of social relationships [47].

There is widespread agreement that to be effective:-

- Consultation is important. Older people should be involved in the planning, development, delivery and assessment of interventions.
- Services need to be flexible and adaptable.

- Better use should be made of partnership arrangements between statutory organisations and also between statutory and voluntary sector organisations.

3.5 Case studies

There are a number of reported examples of different schemes and approaches.

Information and signposting services

Suffolk Rural Coffee Caravan

- A caravan stocked with leaflets and information that visits rural villages.
- This provides a social occasion in itself, but it has extended its visits to provide additional social attractions, or support to villages to set up their own social events.
- It now runs as a scheme with joint voluntary and statutory support from Suffolk County Council.

Source: http://www.campaigntoendloneliness.org.uk/

Support for individuals

West Moors Befrienders

- This service was originally set up as a telephone befriending service by a GP, to support older patients identified as needing emotional support for older people who, for example, had been recently bereaved or had a history of depression. The project was explicitly designed to increase self-confidence and also to reduce the pressure on NHS resources. Some patients were making numerous visits to the surgery, sometimes with unexplained symptoms and were also seeking admission to hospital at night. It was considered that the main causes were loneliness, panic and an inability to cope with life, incurring costs to the NHS.
- The scheme, now managed by WRVS, offers face-to-face as well as telephone befriending. Befrienders initially visit in pairs and offer practical help for example, with small jobs, taking the older person to doctor's appointments, to have hearing aids fitted, or to buy essential items. Generally, befrienders, either on the phone or in person, offer support and reassurance and encourage the older people to engage in social activities.
- Some of the volunteer befrienders were previously isolated and depressed themselves and the project has also made a significant positive difference to their health and wellbeing.
- GPs are reporting fewer appointments for the older people involved and participation in the scheme indicates significant cost savings for the NHS.

Dorset Wayfinders programme

- Initially funded under the Department of Health's Partnerships for Older People Projects (POPPS) and now jointly funded by the PCT and Dorset County Council, a network of

locally-based navigators or 'wayfinders' provide information, signposting and support.

- They take referrals from a wide range of services, including GPs and also self-referrals, and contact people via home visits but also through regular presence at libraries, council offices, community centres, wherever older people might meet locally.
- Once the referral and contact has been made, 'wayfinders' use a diagnostic tool to identify other issues, including social isolation, providing support that can reconnect people to local activities.

Source: http://www.campaigntoendloneliness.org.uk/

Group interventions

Friendship groups

- National charity, 'Contact the Elderly' hold monthly Sunday afternoon tea parties for small groups of older people aged 75 and above – who live alone without nearby family and friends – in local communities across England, Scotland and Wales.
- A different person in the group hosts the tea party each month, but guests and volunteer drivers remain the same. This ensures that over the months and years, acquaintances turn into friends and loneliness is replaced by companionship.
- The majority of the people using the service fall into the category of the 'oldest-old'.
- Many have social care needs, due to mobility issues and hearing and visual impairments, and cannot leave their home without the assistance provided by the charity's volunteer network.
- Benefits extend beyond the one-Sunday-a-month gathering. The charity reported:
  - 95 per cent have made friends with the volunteers
  - 86 per cent feel less lonely
  - 83 per cent now feel part of a community
  - 61 per cent feel more confident
  - 22 per cent see their doctor less.

Source: SCIE (2012). *At a glance briefing 60: Preventing loneliness and social isolation among older people*.

'Men in Sheds'

- Age UK support a number of these projects based on the successful Australian 'Men's Shed' movement.
- In Nottinghamshire the 'Men in Sheds' project is aimed at men aged 60 years and over. It provides a well-equipped workshop where men can work together on a range of practical activities. Activities mainly focus on wood-working and furniture restoration. The products made are sold to support the project and the work of Age UK Nottingham & Nottinghamshire.
- Members can make new friends, put their skills to good use and share their knowledge, while supporting their local community.

Source: http://www.ageuk.org.uk/professional-resources-home/services-and-practice/health-and-wellbeing/men-in-sheds/

Wider community engagement

Time Banks

- One of the first UK time banks was established at Rushey Green Group Practice medical centre in 1999.
- In 2009 there were over 200 member individuals and organisations.
- Befriending, providing lifts, checking up on people following hospital discharge were typical of services contributed.

Source: Knapp, M. Bauer B., Perkins M, Snell T (2010) Building community capacity: making an economic case. PSSRU Discussion paper 2772. London: PSSRU. Available at http://www.pssru.ac.uk/pdf/dp2772.pdf.

Local Area Coordination (LAC)

- This is a model being tested and developed in some councils (with pilots in Middlesbrough, Derby City, Stroud, and Cumbria), having originated in Western Australia.
- It focuses on community assets and the skills and resources that individuals, families and communities already possess.
- Local Area Co-ordinators provide a consistent point of contact and support people to develop practical (non service) responses to needs and build partnerships with and between individuals, families, communities and services.
- An independent evaluation of the early Middlesbrough experience of LAC confirmed "largely positive" results, and in particular LAC could:
    - focus on the results that people wanted to achieve;
    - provide a universal service available without the need to satisfy any eligibility criteria based on need;
    - offer support without time limits providing different types of support including practical help;
    - build up a detailed knowledge of local resources and direct people towards these;
    - reach and work with people who are often reluctant to engage with statutory services.

Source: Henwood, M. (2012) Beyond eligibility: universal and open access support and social care. A report to Age UK from Melanie Henwood Associates. Also in Combating loneliness – a guide for local authorities http://www.campaigntoendloneliness.org.uk/

Strategic approaches

Manchester's Valuing Older People (VOP) programme

- The city of Manchester identified loneliness as a key challenge for the city, through feedback from older people, professionals and research.
- The authority's 'Ageing Strategy' was launched in 2009 and its work to combat loneliness takes place under the umbrella Valuing Older People (VOP) programme.
- Tackling loneliness and isolation have been explicitly integrated into local regeneration frameworks.
- A locality approach means that VOP networks are organised at ward level throughout the city.
- Concerns, collective actions and solutions are addressed through local action plans.
- VOP networks help to co-ordinate provision in an area, provide information, small grants and other support and act as a hub for older people's services and issues.
- City-wide objectives are translated into local delivery through practical means.
- Manchester has been designated the UK's first age-friendly city and is part of the World Health Organisation's Global Network of Age-friendly cities.

Source: Combating Loneliness - a guide for local authorities. Available at, http://www.campaigntoendloneliness.org.uk/

Chapter 4: Policy and Practice Nationally and Locally

It is only relatively recently that the alleviation of loneliness and isolation has become recognised in its own right as a major priority for national and local government policy. In a recent paper on 'Loneliness, isolation and the health of older adults', Valtorta and Hanratty concluded:

> *'A drive to address loneliness and isolation could prove to be one of the most cost-effective strategies that a health system could adopt, and a counter to rising costs of caring for an ageing population'* [20].

4.1 National policy

The National Service Framework for Older People, when first published in 2001, acknowledged isolation in relation to falls and depression [48]. However, it was not until the mid-point review that particular interest was taken in rural issues. The differential access to services between rural and urban areas was clearly linked to problems of social exclusion and isolation [49, 50]. In 2007, 'Putting People First' was a cross-sector government concordat that explicitly prioritised the alleviation of loneliness and isolation[51]. In placing the promotion of independence at the heart of a strategic shift in social care, it recognised the importance of 'interdependence' and strong social relationships. These themes continued in subsequent policy documents and guidance. The importance of loneliness and social isolation in the promotion of health and wellbeing and in tackling inequalities was reinforced in the Marmot Review [52].

Growing evidence that loneliness and social isolation directly influence health outcomes has strengthened their importance as hitherto neglected areas in the promotion of public health. Loneliness has been accepted as a clear public health issue. A commitment was made in the Care and Support White Paper in 2012[53] to include measures of loneliness and social isolation in the Adult Social Care and Public Health Outcomes Frameworks. The Adult Social Care Outcomes Framework for 2013/4 contains a new measure of social isolation[54]. It is shared with the Public Health Outcomes Framework and initially it will focus on users of care and support services and their carers. The proportion of people (who use services) and their carers, who reported that they had as much social contact as they would like will be recorded. By drawing on self-reported levels of social contact, the measure will provide an indicator of social isolation. Local authorities will be able to identify areas where older people suffer most acutely from loneliness.

Strategies and programmes that can be implemented at a local level are required. Since 2010, the 'Campaign to End Loneliness', a coalition of organisations and individuals, has shared evidence and ideas for action around tackling loneliness. The campaign provides information and resources for individuals and organisations keen to address the problem (http://www.campaigntoendloneliness.org.uk/). The Local Government Association and Campaign to End Loneliness have compiled a guide for local authorities setting out a framework for tackling loneliness at a strategic level, in local communities and through work with individuals[55].

In the recent changes in national and local responsibilities for health, health and wellbeing boards have become the important forum for understanding the problem of loneliness locally and a vehicle for agreeing priorities and addressing needs in a joined up way.

4.2 Local responses in North Yorkshire

The North Yorkshire Older People's Partnership Board set up a Loneliness Task Group to raise the profile of the problem of loneliness and social isolation within North Yorkshire policy agendas and to explore ways of tackling the problem. As a first step, it commissioned the 'Voice of Ripon' loneliness survey that explored the issue of social isolation and loneliness in Ripon and the surrounding rural area[1]. A total of 55 people over 60 years of age were interviewed during the summer of 2009. Over half were over 80 years old.

Key findings from the survey were:

- 56 per cent of people had lived alone for over 15 years.
- 69 per cent had long-term physical health problems.
- 27 per cent said that they had felt lonely in the past month 'often' or 'frequently'.
- 22 per cent found evenings and weekends particularly difficult.
- 39 per cent found particular occasions for example, Bank holidays, anniversaries their loneliest times.
- 29 per cent had attended lunch clubs in the last year.
- 65 per cent expressed satisfaction with support services. For others, the main areas of concern were affordability and transport difficulties.
- 'Safety' and 'confidence' stopped about a third of people going out.
- 40 per cent said someone to talk to would help them feel less lonely.

North Yorkshire County Council has contributed to the national debate, participating in the Campaign to End Loneliness and supported a number of projects provided by voluntary sector partners through its innovation fund. Social isolation was a key theme in the Joint Strategic Needs Assessment (JSNA) published in 2012 [56] and was incorporated into the health and wellbeing draft strategy published during

summer 2012 and updated in December 2012 [57]. Challenges were identified as covering six main areas:

- Rurality.
- An ageing population.
- Deprivation and wider determinants of health.
- Financial pressures.
- Killer diseases.
- Emotional and mental wellbeing.

Loneliness and social isolation were specifically mentioned as priorities and areas of focus within four of the six 'challenges': rurality, ageing population, deprivation and wider determinants of health, and emotional and mental wellbeing. However, ways in which local agencies might tackle these priorities has not yet been determined.

4.3 Local information

There are a number of available sources of information that can be used to compile data on loneliness and its risk factors, nationally and by local authority area.

- Population statistics and data from large scale surveys are available through the Office of National Statistics (ONS) http://www.ons.gov.uk/ons/index.html . Data from the 2011 census with key statistics started to become available in 2012.
- Projecting Older People Population Information (POPPI) is a programme designed to help explore the possible impact that demography and certain conditions may have on populations aged 65 and over and provides a range of demographic data for older people www.poppi.org.uk.
- North Yorkshire's JSNA reports population densities for the county and seven districts based on ONS 2010 mid-year estimates and a range of demographic summaries. http://www.northyorks.gov.uk/jsna.
- The Yorkshire and Humber Public Health Observatory (part of Public Health England from April 1st 2013) provides information and intelligence on a range of health and related topics at a county and district level http://www.yhpho.org.uk/ .
- The local information system for North Yorkshire and York, STREAM, provides access to statistics, research and mapping, bringing together a wide range of data relating to North Yorkshire and York including information from local partner organisations www.streamlis.org.uk/ .

In 2011 an estimated 20.6 per cent of the population of North Yorkshire were aged 65 and over, considerably higher than the national average of 16.6 per cent and the regional percentage, 16.5 per cent. This was also an increase of 2.4 per cent from the 2001 census figures (18.2 per cent) for those aged 65 and over in North Yorkshire. Within the county, the proportion of people aged 65 and over was highest

in Scarborough and Ryedale at 23.2 per cent, an increase from 21.4 per cent (Scarborough) and 20.4 per cent (Ryedale) in 2001. Selby had the lowest proportion of people aged 65 and over at 16.8 per cent, although this was an increase from the 2001 figure of 14.7 per cent. The biggest percentage increase in North Yorkshire in the population aged 65 and over between the 2001 and 2011 censuses was in Hambleton district, 17.5 per cent to 21.5 per cent, an increase of four per cent.

Table 1 shows the number and percentages of the population aged 65 and over for England, the Yorkshire and Humber region, North Yorkshire and its districts, taken from the 2011 census. A table showing the numbers and percentages by different age groups of the population aged 65 and over appears in Appendix A.

Table 1: Population of people aged 65 and over (numbers and percentages)

District Council	Population 65 & over (numbers)	Population 65 & over (percentages)
Craven	12,610	22.7
Hambleton	21,658	21.5
Harrogate	35,510	19.7
Richmondshire	10,180	17.5
Ryedale	13,590	23.2
Scarborough	37,515	23.2
Selby	22,570	16.8
North Yorkshire County	123,199	20.6
Yorkshire & the Humber	874,571	16.5
England	8,660,529	16.4

Source: Office for National Statistics. Age Structure (KS102EW), dataset produced from 2011 Census.

The percentage of one person households aged 65 and over in North Yorkshire was 14.4 per cent in 2011, higher than either the regional (12.7 per cent) or national (12.4 per cent) percentages. Scarborough had the highest percentage of one person households aged 65 and over in North Yorkshire, 16.5 per cent. Table 2 shows the number and percentages of one person households aged 65 and over for England, the Yorkshire and Humber region, North Yorkshire and its districts, taken from the 2011 census.

Table 2: One person households aged 65 and over (numbers and percentages)

District Council	One person households aged 65 & over (numbers)	One person households aged 65 & over (percentages)
Craven	3,931	16.0
Hambleton	5,581	14.6
Harrogate	9,261	13.8
Richmondshire	2,505	12.4
Ryedale	3,557	15.8
Scarborough	8,163	16.5
Selby	3,913	11.3
North Yorkshire County	36,911	14.4
Yorkshire & the Humber	281,870	12.7
England	2,725,596	12.4

Source: Office for National Statistics. Household Composition (KS105EW), dataset produced from 2011 Census

Data retrieved via STREAM showed that,

- 90 per cent of people aged 65 and over in North Yorkshire were satisfied with both their home and neighbourhood.
- Selby and Scarborough districts reported the lowest percentages of satisfaction, (84 per cent and 89 per cent respectively).
- This still compares favourably with the figure reported for England as a whole (83 per cent).
- 41per cent of all pensioner households in North Yorkshire were without a car.
- 31 per cent of the resident population of North Yorkshire live in the most deprived fifth Lower Super Output Areas (LSOAs) in the country in relation to barriers to housing and other services.

Based on the UK estimate that ten per cent of people over the age of 65 are lonely all or most of the time [23], Table 3 provides estimates of the numbers likely to be lonely, in the county as a whole and by district. Figures are taken from projected population numbers for the county and districts, derived from Projecting Older People Population Information (POPPI) data version 8.0, www.poppi.org.uk.

Table 3: Estimated prevalence of loneliness in population aged 65 and over (based on ten per cent of population aged 65 and over)

Area	Loneliness - 2012 estimate of population aged 65 and over	Projection for 2020 - estimate of population aged 65 and over
North Yorkshire	12,980	15,540
Craven	1,330	1,630
Hambleton	2,030	2,480
Harrogate	3,250	3,870
Richmondshire	960	1,160
Ryedale	1,260	1,480
Scarborough	2,640	3,020
Selby	1,510	1,910

Source: www.poppi.org.uk version 8.0.

Table 4 shows the percentages of the population in North Yorkshire aged 65 and over with a range of risk factors for loneliness. These percentages are based on projected population numbers for the county and districts, derived from Projecting Older People Population Information (POPPI) data version 8.0, www.poppi.org.uk. Over a third (37 per cent) of people aged 65 and over in North Yorkshire are living alone, and nearly a half (43 per cent) have a limiting long-term illness or a hearing impairment. Population numbers for each risk factor by county and district are included in Tables A1-A7 in Appendix A.

Table 4: Loneliness risk factors for population aged 65 and over in North Yorkshire

Loneliness risk factor	Estimated percentage of population aged 65 and over
Aged 85 and over	14
Living alone	37
Limiting long-term illness	43
Dementia	7
Depression	9
Moderate or severe visual impairment	9
Moderate, severe or profound hearing impairment	43

Based on 2012 estimates of population aged 65 and over from POPPI data

Figures B1-B7 in Appendix B provide graphs of numbers of people aged 65 and over with different risk factors for loneliness, estimated and predicted up to 2020, for North Yorkshire. Where possible these are broken down into separates older age groups. These graphs are produced from POPPI data www.poppi.org.uk.

4.4 Future directions

The current report provides:

- evidence about the nature and impact of the problem of loneliness and social isolation,
- examples of 'good practice' in tackling the problem, in terms of effective strategies and types of services,
- tools for identifying those in the population who may feel lonely and/or socially isolated,
- ways of measuring loneliness that could be used in evaluating new or existing initiatives,
- demographic data and future trends that can indicate the scale of the problem locally.

A mapping exercise to identify and describe the range of services that exist throughout the county is planned for the next phase of work.

Future work will need to focus on developing a strategy for:

- identifying those in the population who feel lonely and/or socially isolated,
- understanding the range of experiences in different localities,
- consulting about the types of services older people in different localities want and identifying the gaps,
- ways of targeting and meeting needs in a difficult financial climate that harnesses the potential of available resources and makes best use of partnership arrangements.

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Appendix A

Tables A1 to A7 show population estimates for a range of risk factors for loneliness for North Yorkshire County and districts, estimated for 2012 and projected for 2020. These tables are produced from POPPI data www.poppi.org.uk, and are based on Office of National Statistics (ONS) data, http://www.ons.gov.uk/ons/index.html.

Table A1: Groups at highest risk of loneliness – people over 85

Area	2012 estimate of population over 85	Projection for 2020
North Yorkshire	17,600	23,700
Craven	2,000	2,700
Hambleton	2,600	3,600
Harrogate	4,800	6,700
Richmondshire	1,100	1,700
Ryedale	1,600	2,200
Scarborough	3,600	4,500
Selby	1,900	2,500

Source: www.poppi.org.uk version 8.0.

Table A2: Groups at highest risk of loneliness – living alone

Area	2012 estimate of population aged 65 and over living alone	Projection for 2020- estimate of population aged 65 and over
North Yorkshire	47,496	57,362
Craven	4,888	6,042
Hambleton	7,386	9,171
Harrogate	12,112	14,613
Richmondshire	3,483	4,298
Ryedale	4,539	5,444
Scarborough	9,733	11,135
Selby	5,346	6,796

Source: www.poppi.org.uk version 8.0.

Table A3: Groups at highest risk of loneliness – limiting long-term illness

Area	2012 estimate of population aged 65 and over with limiting long-term illness	Projection for 2020- estimate of population aged 65 and over
North Yorkshire	55,368	66,882
Craven	5,546	6,836
Hambleton	8,665	10,797
Harrogate	13,052	15,664
Richmondshire	4,073	4,942
Ryedale	5,101	6,059
Scarborough	11,979	13,784
Selby	6,923	8,858

Source: www.poppi.org.uk version 8.0.

Table A4: Groups at highest risk of loneliness – dementia

Area	2012 estimate of population aged 65 with dementia	Projection for 2020- estimate of population aged 65 and over
North Yorkshire	9,053	11,695
Craven	955	1,251
Hambleton	1,356	1,838
Harrogate	2,390	3,119
Richmondshire	634	826
Ryedale	850	1,100
Scarborough	1,864	2,242
Selby	984	1,316

Source: www.poppi.org.uk version 8.0.

Table A5: Groups at highest risk of loneliness – depression

Area	2012 estimate of population aged 65 and over with depression	Projection for 2020- estimate of population aged 65 and over
North Yorkshire	11,202	13,320
Craven	1,140	1,398
Hambleton	1,752	2,124
Harrogate	2,819	3,352
Richmondshire	833	1,003
Ryedale	1,072	1,273
Scarborough	2,291	2,596
Selby	1,283	1,616

Source: www.poppi.org.uk version 8.0.

Table A6: Groups at highest risk of loneliness – moderate or severe visual impairment

Area	2012 estimate of population aged 65 and over with visual impairment	Projection for 2020- estimate of population aged 65 and over
North Yorkshire	11,335	13,850
Craven	1,180	1,463
Hambleton	1,763	2,219
Harrogate	2,874	3,507
Richmondshire	816	1,024
Ryedale	1,100	1,311
Scarborough	2,308	2,684
Selby	1,294	1,654

Source: www.poppi.org.uk version 8.0.

Table A7: Groups at highest risk of loneliness – moderate, severe or profound hearing impairment

Area	2012 estimate of population aged 65 and over with hearing impairment	Projection for 2020- estimate of population aged 65 and over
North Yorkshire	55,922	69,585
Craven	5,797	7,353
Hambleton	8,562	11,102
Harrogate	14,394	17,906
Richmondshire	4,044	5,081
Ryedale	5345	6,647
Scarborough	11,476	13,248
Selby	6,218	8,115

Source: www.poppi.org.uk version 8.0.

Appendix B

Figures B1-B7 provide graphs of numbers of people aged 65 and over with different risk factors for loneliness, estimated and predicted up to 2020, for North Yorkshire. Where possible these are broken down into separates older age groups. These graphs are produced from POPPI data www.poppi.org.uk, and are based on Office of National Statistics (ONS) data, http://www.ons.gov.uk/ons/index.html.

Figure B1: Older people population North Yorkshire – population predictions 2012-2020

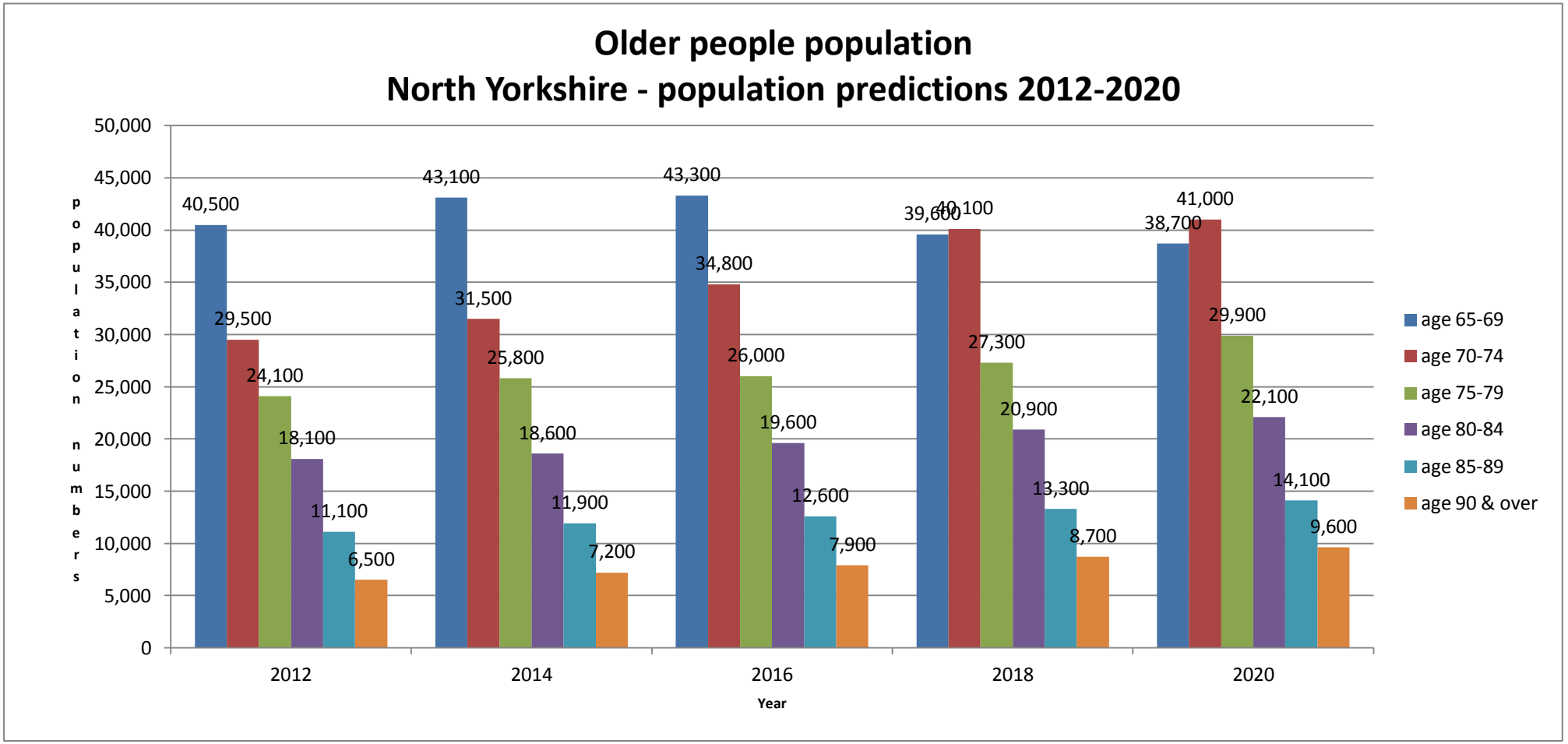

Table produced on 27/02/13 13:04 from www.poppi.org.uk version 8.0. Figures are taken from Office for National Statistics (ONS) subnational population projections by persons, males and females, by single year of age. The latest subnational population projections available for England, published 28 September 2012, are interim 2011-based and project forward the population from 2011 to 2021.

Figure B2: Older people living alone North Yorkshire – projected population 2012-2020

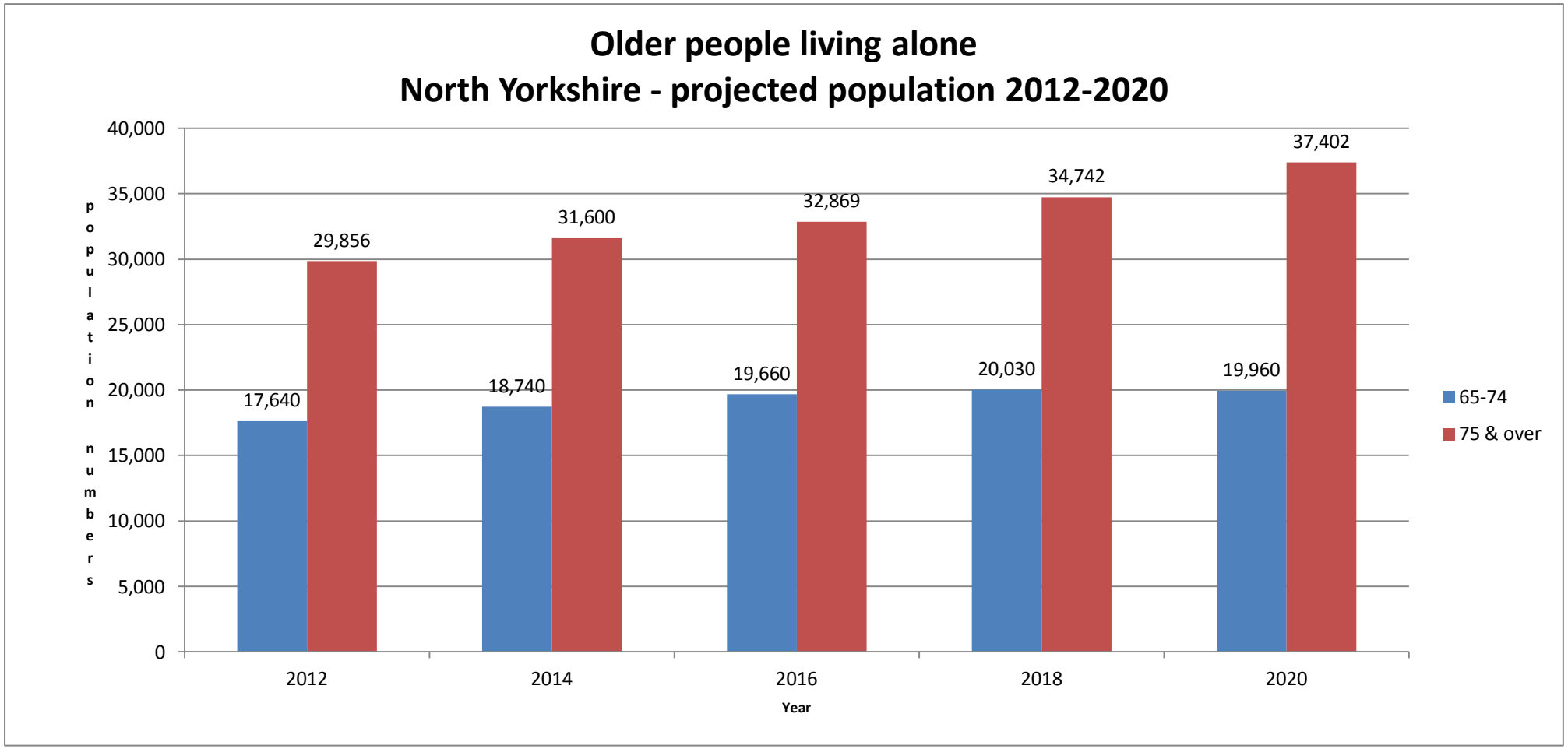

Table produced on 27/02/13 11:58 from www.poppi.org.uk version 8.0. Figures are taken from the General Household Survey 2007, table 3.4 Percentage of men and women living alone by age, ONS. The General Household Survey is a continuous survey which has been running since 1971, and is based each year on a sample of the general population resident in private households in Great Britain.

Figure B3: Older people with a limiting long-term illness North Yorkshire – projected population 2012-2020

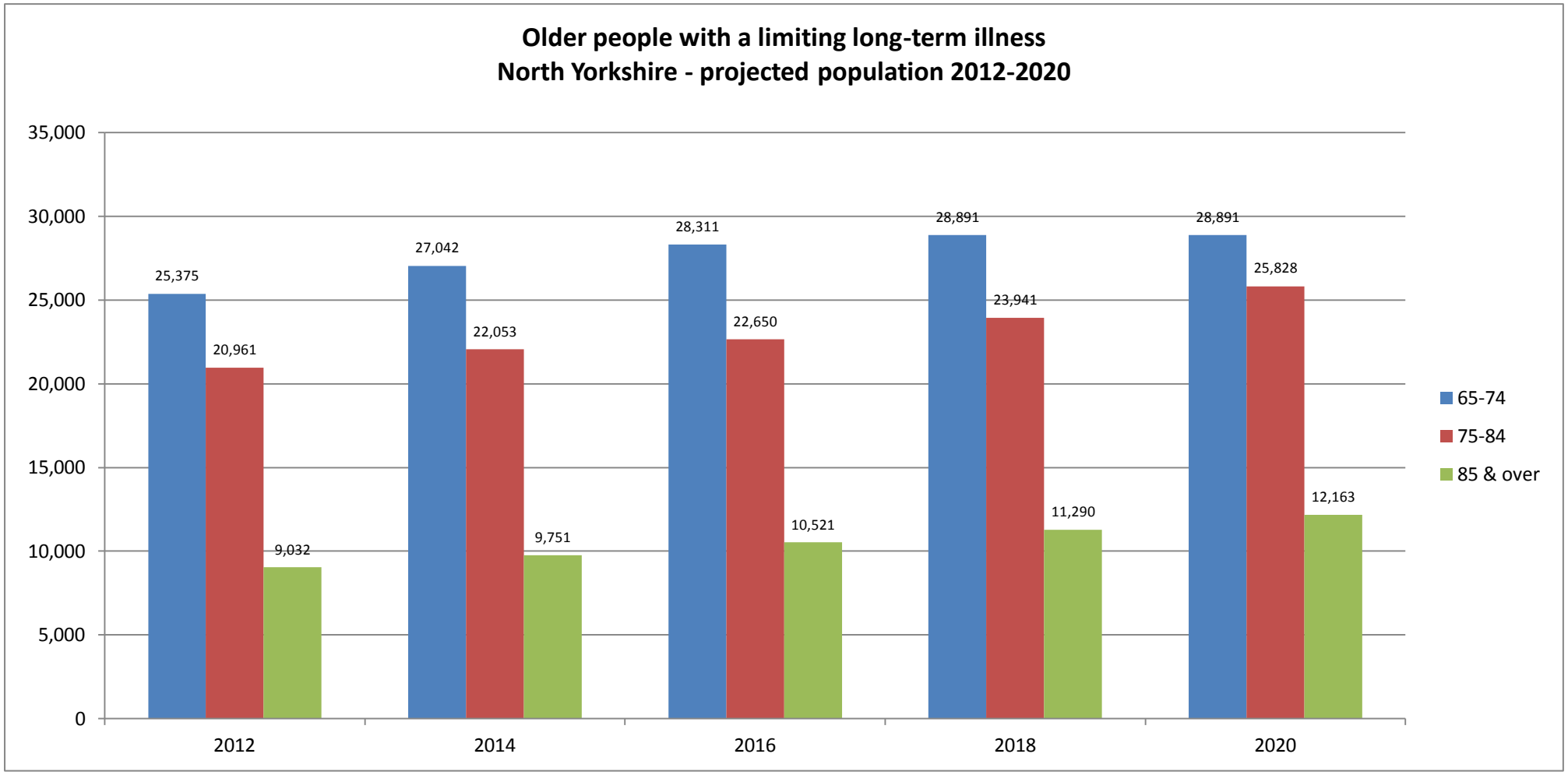

Table produced on 27/02/13 12:03 from www.poppi.org.uk version 8.0 . Figures are taken from Office for National Statistics (ONS) 2001 Census, Standard Tables, Table S016 Sex and age by general health and limiting long-term illness. The most recent census information is for year 2001 (data from the 2011 census is due to be published 2012-2014).

Figure B4: Older people with dementia North Yorkshire – projected population 2012-2020

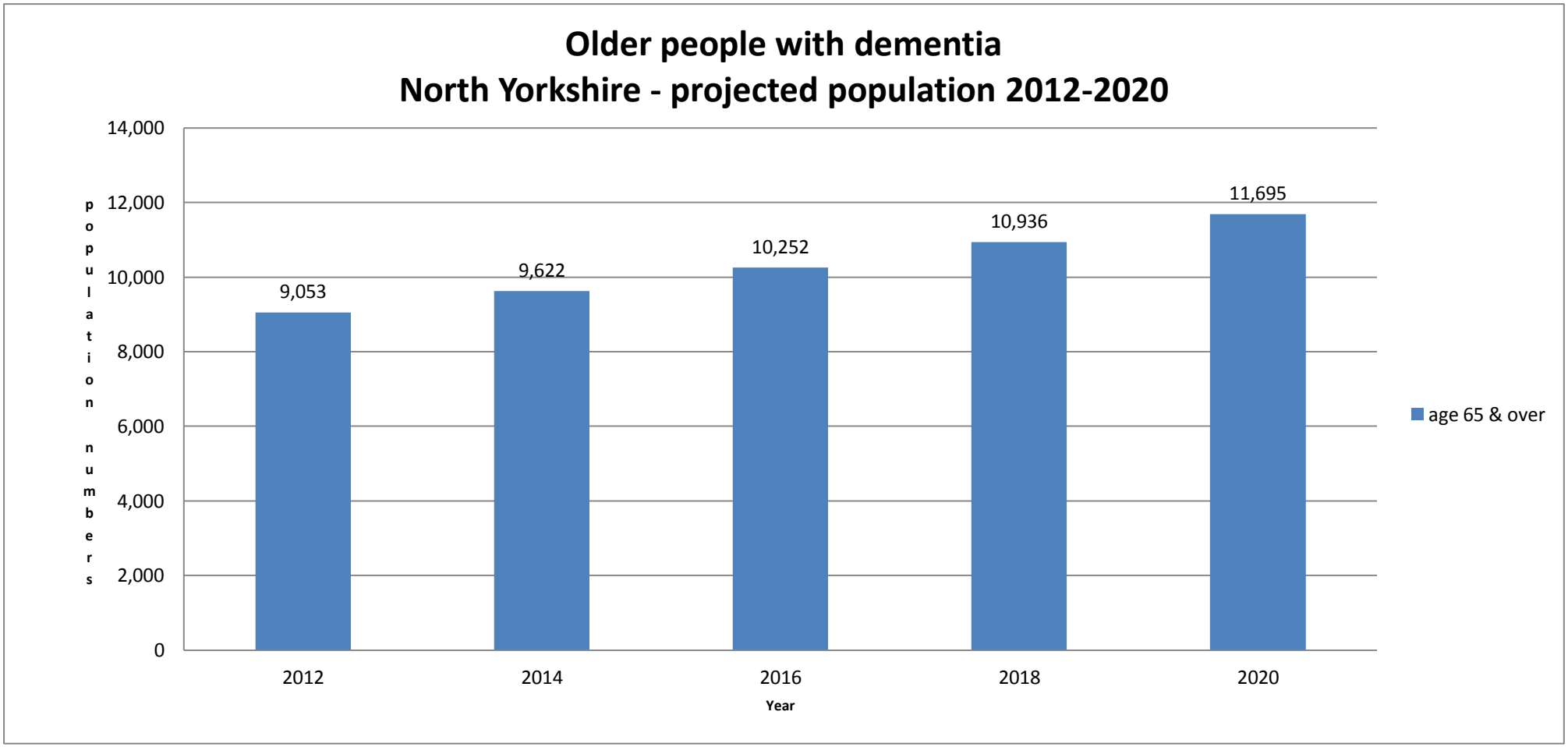

Table produced on 27/02/13 12:04 from www.poppi.org.uk version 8.0. Data source, Dementia UK: A report into the prevalence and cost of dementia. PSSRU, London School of Economics & Institute of Psychiatry, King's College London, for the Alzheimer's Society 2007. Prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers of people predicted to have dementia to 2020.

Figure B5: Older people with depression North Yorkshire – projected population 2012-2020

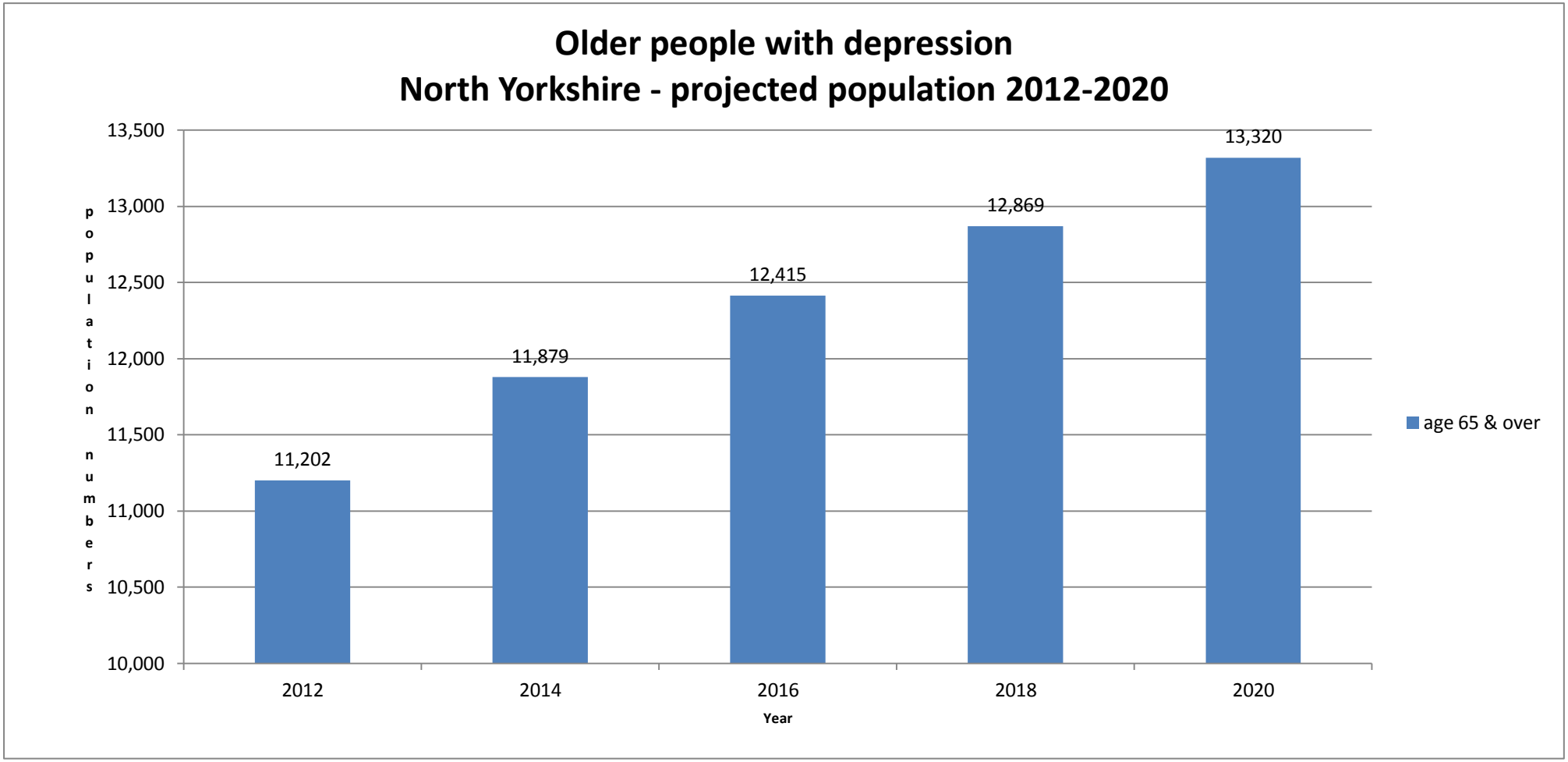

Table produced on 27/02/13 12:04 from www.poppi.org.uk version 8.0 . Figures from McDougall *et al.*, Prevalence of depression in older people in England and Wales: the MRC CFA Study in Psychological Medicine, 2007, 37, 1787-1795. Prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers predicted to have depression, to 2020.

Figure B6: Older people with moderate or severe visual impairment North Yorkshire population projections 2012-2020

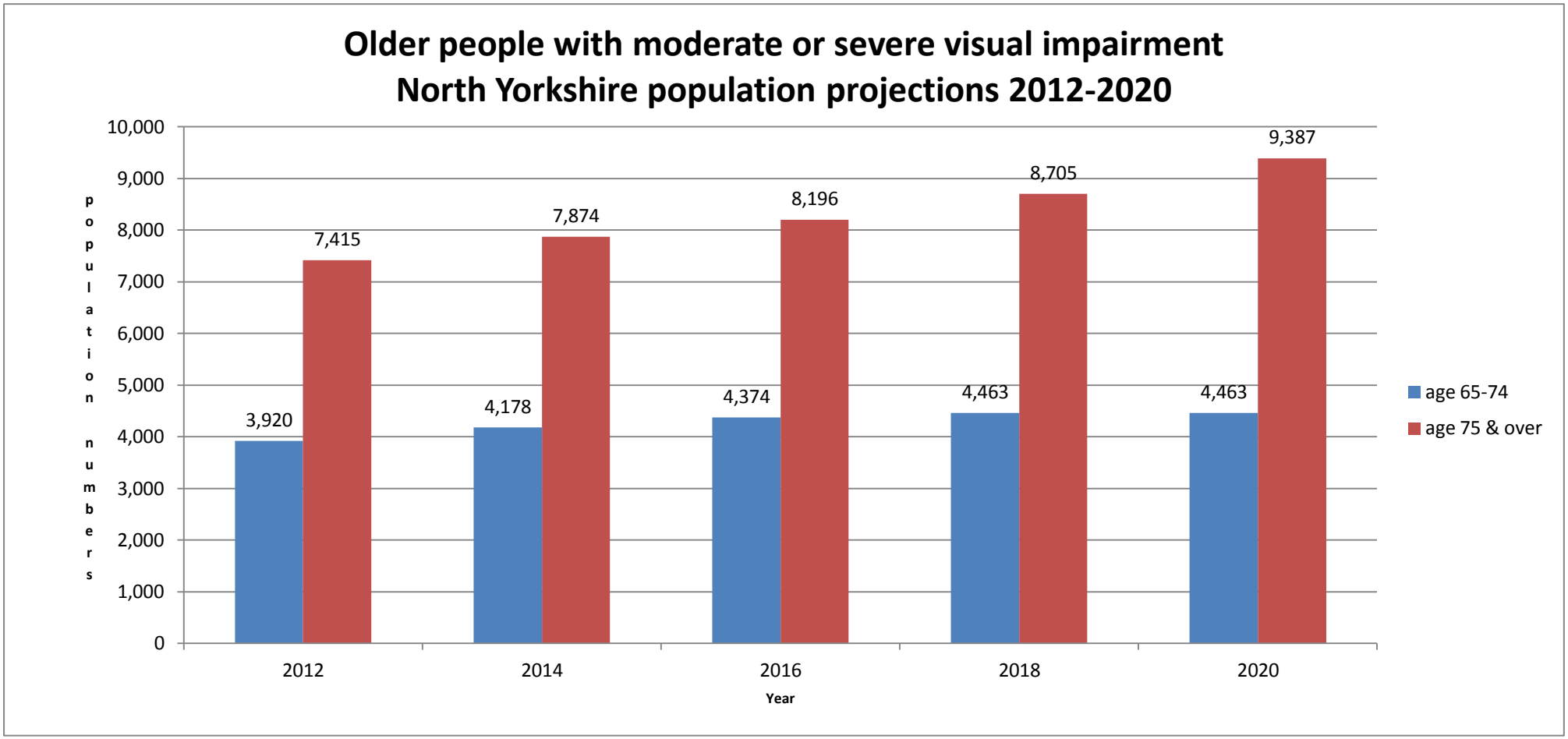

Table produced on 27/02/13 16:21 from www.poppi.org.uk version 8.0 . Figures are taken from 'The number of people in the UK with a visual impairment: the use of research evidence and official statistics to estimate and describe the size of the visually impaired population', Nigel Charles, RNIB, July 2006. The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers of people predicted to have visual impairment to 2020.

Figure B7: Older people with moderate, severe or profound hearing impairment North Yorkshire – population projections 2012-2020

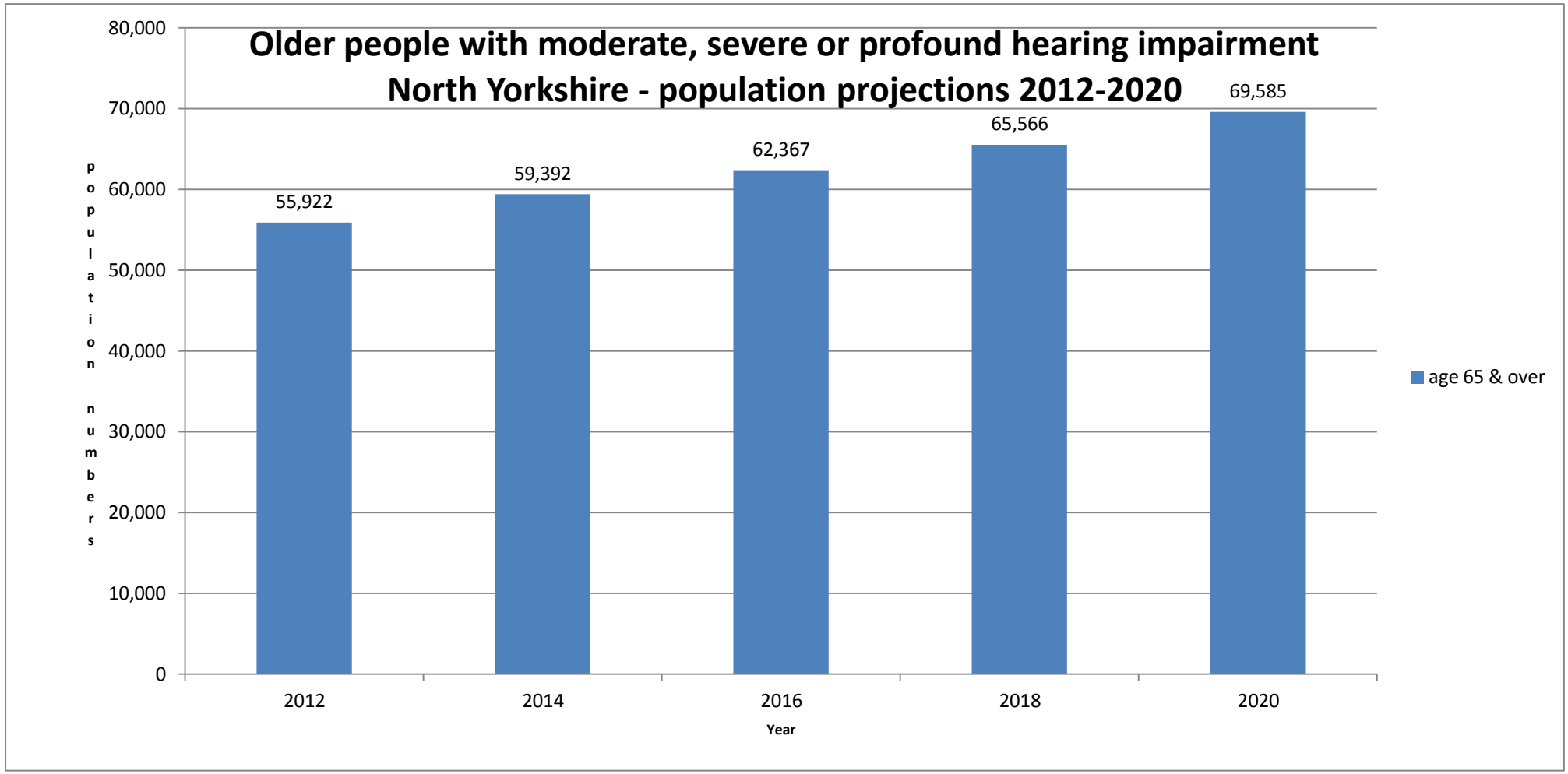

Table produced on 27/02/13 16:22 from www.poppi.org.uk version 8.0. The prevalence rates have been applied to ONS population projections of the 18-64 population to give estimated numbers predicted to have a severe or profound hearing impairment, to 2020.