KENT COUNTY COUNCIL

SELECT COMMITTEE - LONELINESS AND SOCIAL ISOLATION

MINUTES of a meeting of the Select Committee - Loneliness and Social Isolation held in the Wantsum Room - Sessions House on Wednesday, 19 September 2018.

PRESENT: Mr M A C Balfour, Mrs P M Beresford, Mr D L Brazier, Ms K Constantine, Ms S Hamilton, Mr A R Hills, Mrs L Hurst, Ida Linfield and Mr K Pugh (Chairman)

ALSO PRESENT:

IN ATTENDANCE: Ms L Adam (Scrutiny Research Officer), Mr G Romagnuolo (Research Officer - Overview and Scrutiny) and Miss G Little (Democratic Services Officer)

UNRESTRICTED ITEMS

8. Dr Kellie Payne (Research and Policy Manager, Campaign to End Loneliness)
(Item 1)

The Chair welcomed the guest to the committee and a short introduction was given by Members.

Q – Please introduced yourself and offer an outline of the Campaign to End Loneliness and its main objectives?

Dr Kellie Payne, Research and Policy Manager, Campaign to End Loneliness introduced herself to the committee. She said that the Campaign to End Loneliness which was launched in 2011 had limited resources with one Director and a team of three, however, due to the interjection of the Big Lottery Fund in 2017, the team was able to expand its resources and now had a team of fourteen with specialist functions i.e. social media. Initially, due to limited staffing the campaign focused primarily on service providers and academics, however, the Big Lottery Fund combined with increased capacity has allowed the campaign to change its ambitions and placed greater focus on businesses, public engagement, behavioural change, promoting social connections and tackling the stigma of loneliness. Campaign to End Loneliness is supported by Independent Age UK who provide the Human Resources side of the businesses, however the Big Lottery Fund and donations help to support the on-going work of the campaign. Dr Payne also informed the Committee that the Big Lottery Fund allowed the team to employ Campaign Manager's who were based in Belfast, the United Kingdom, West Wales and Glasgow, each of which had specific areas of focus depending on what part of the nation they were based.

Q – Who is impacted by loneliness and social isolation? What is the prevalence of loneliness in the country?

With regards to prevalence Dr Kellie Payne said that the most recent statistics within the Jo Cox Commission identified that over 9 million adults were often or always lonely, 4 million of those were older adults with 10% of those falling within the chronically lonely category, equating to 1.2 million. Those who are chronically lonely suffered from loneliness all of the time. Dr Payne said that it was important to recognise that everyone experienced loneliness at a point in their life as was an inevitable part of the human condition, however, it is those who suffer from chronic loneliness that required greater focus. One of the key factors that The Campaign to End Loneliness lobbied against was the cost to the health and social care system. Evidence showed that if loneliness was alleviated, it increased independent living and therefore reduced the strain on the Health Care System. Three out of four GPs said that they would generally see between 1 and 5 people a day because they were lonely. Dr Payne said that there was a report done by the Social Finance Commission in 2016 which estimated that the cost associated with patients who attend GPs and A&E's in relation to loneliness was £12,000 per person. Work was being carried out in conjunction with the London School of Economics (LSE) to look at the financial impact on the heath and social care system, however Dr Payne reminded the Committee that the key purpose of the campaign was to raise awareness and help those lives that were at stake of diminishing, this included individuals, family members and carers who were all at risk of suffering from loneliness.

Q – What are the main causes leading to loneliness and social isolation amongst adults over 65 and over?

Dr Payne said that the End to Loneliness Campaign was set up by Independent Age UK to focus on those over the age of 65, however, loneliness affected all age groups. In terms of the risk factors associated with loneliness, vulnerability was often characterised through loss of health, loss of confidence and loss of self-purpose, however, through restoring a person's confidence this helped them to reconnect with themselves and with other. It is also important to recognise that transition periods tend to happen later in life, therefore those who were older often experienced an accumulation of events which had more of an impact. The wider environmental issues were also a contributing factor for loneliness, this included unaffordable and irregular transport, some people lived in fear of crime and refused to leave their home for a number of days, others did not feel comfortable in their neighbourhood due to unfamiliar faces and new residents moving into the area, poor health and loss of mobility were also contributing factors. Dr Payne said that carers were also impacted by these factors and it was important to remember the wider sphere of those affected.

Q – What are the consequences of loneliness and social isolation on these people?

Dr Payne said that over the past 6 years the Campaign to End Loneliness helped to raise awareness on the impact that loneliness could have on mental health. Research showed that having social connections increased mortality rates, without social interactions the impact on mortality was equivalent to smoking 15 to 16 packs of cigarettes a day, it also increases the risk of heart disease and the risk of embrasure by 13%. Mental Health was also linked to cognitive decline such as dementia and Alzheimer's, those who experienced loneliness were more likely to have difficulties earlier on in their life compared to someone who was not lonely. Dr Payne said that through reducing loneliness, it could boost independence and therefore reduce reliance on the Health Care system meaning fewer inappropriate admissions, less reliance on medication and fewer admissions to care homes, all of which increase a person's ability to actively contribute to society, sharing their skills, knowledge and experience instead of living in an isolated state.

Q – What interventions and strategies are working particularly well to prevent or reduce the negative impacts of loneliness and social isolation on older people?

The report *'Promising Approaches to reducing loneliness and isolation in later life'* included a framework that looked at all aspects of loneliness and how to tackle this in later life. In terms of systematic interventions, this included a number of approaches such as transport, technology and community-based approaches, however direct intervention also played a crucial role in tackling social isolation. Dr Payne said that there were two main types of direct intervention; the first being to create new connections which looked at connecting people on a one-to-one basis and the other was group activity. The cognitive discrepancy theory looked at the definition of loneliness, helping to identify the ways in which an individuals' sense of self-worth affects the level of loneliness that a person experiences. Research suggests that if a person could manage their expectations in terms of their relationships and re-frame the way they think i.e. realising that three good friends are better than having 20 acquaintances, this could have a positive impact and reduce the feeling of loneliness. Another promising approach was social prescribing, Dr Payne acknowledged that this was not currently commissioned within Kent, however, evidence showed that commissioned social prescribing through referral services into Community teams was an effective intervention. A Community Connector was a specialist person who would have access to a person's medical records and would have the space and time to identify the appropriate pathway for that person suffering with loneliness. Dr Payne reminded the committee that there was not a 'one size fits all' approach to tackling social isolation, people could be lonely for a number of reasons, and if the root cause of that loneliness could be identified earlier on, that person would have an increased chance of recovering. Dr Payne said that the Clinical Commissioning Groups (CCG's) were investing in the social prescribing programmes and it was now a prominent part of the transformation plans; work continued to be done to scope further research opportunities.

https://www.campaigntoendloneliness.org/wp-content/uploads/Promising-approaches-to-reducing-loneliness-and-isolation-in-later-life.pdf

Q – In your view, what are the challenges associated with preventing or reducing social isolation amongst older residents?

Dr Payne advised the Committee that it was important to have a strategic approach to loneliness. In terms of creating a strategy for your own Local Authority there were key elements that should be incorporated when doing this, such as mapping of local assets, highlighting gaps in the area and identifying strategies to help identify what a lonely person may look like. The Campaign to End Loneliness had produced online guidance which was available to Local Authorises and Commissioners and offered a step-by-step guide on how to set up a strategy. Dr Payne said that it was crucial to work across different departments as loneliness affected a number of areas including transportation, technology and environment. Current evidence showed that there was a digital divide as those over a certain age were less inclined to use social media to connect with family and friends, however the internet needed to be recognised as a powerful tool in helping people to connect and reconnect with friends and this needed to be encouraged. In terms of asset management, it was important to move away from looking at community deficits and instead look at what assets were available in a community and how these could be utilised to optimum effect.

Q – Are there any other issues, in relation to the review, that you wish to raise with the Committee?

Dr Payne said that there was not anything specific to raise and welcomed questions from the committee.

Q – Are there prediction forms available at GP surgeries for people to fill out?

Dr Payne said that there were loneliness measures which could be used, however, it was advised that these were not to be used as a predictive aid. The charity Age UK had created a risk map which identified the relative risk of loneliness based on the Census 2011 figures. Dr Payne said that prevention was the key aim of the campaign and this was the approach taken with public engagement work.

Q – Are we better to employ more social workers or put more money into community staff?

Dr Payne said that it was those providing the services that needed the funding. The charity sector spends a significant amount of time writing grant proposals and trying to get funding to keep those community services running.

Q – How do we get funding from the NHS budget to do this?

Dr Payne said that the community connector model had been well received and had been a successful model. The risk with the model was that whilst the NHS services were the first point of call, they often referred patients onto other community projects that were funded through third sector charity funds. The Community Connector model was not expensive to fund, the key concern would be getting GPs onboard and ensuring they made the referrals.

Q – Should there be a central organisation that is tackling this?

The Campaign to End Loneliness was established for this purpose. It was designed to pull knowledge from a range of sources and charities and then disseminate that information amongst those working within the community. The campaign did not work in direct contact or provide services for lonely people, it collated evidence for those organisations to improve their services for lonely people.

Q – do you think the Scottish or English government work better to tackle social isolation?

Dr Payne said that the English and Scottish Government were commissioned to create strategies, however, Westminster were better equipped to push the strategy forward. Scotland did not have a specialised team and therefore kept postponing it due to capacity.

Q - Are community connectors paid for by the NHS service

Dr Payne said that the Community Connectors were funded separately. Work was being done in conjunction with the London School of Economics to look at the cost effectiveness of intervention and how much money could be saved. There was an intervention calculator available online for Local authorities and Commissioners to use to identify cost savings.

Q – Do you have the statistics for inappropriate admission into care homes

Dr Payne agreed to circulate this to Members of the Committee.

Q – What is the balance of responsibility to take action – if you are in that state and you need to reach out?

Dr Payne said that when someone was lonely their confidence declined, so it was very difficult to say to someone to do something about it as they do not have that motivation to change. People do not tend to usually acknowledge they are lonely, they understand they feel bad, but they don't identify it as loneliness. The campaign aimed to raise awareness and help people to self-predict signs of loneliness.

Q – what are we doing to engage GPs?

The Campaign to End Loneliness was working with the Royal Council of GPs to promote social prescribing. In terms of the Royal Society of Doctors, the Campaign had received good engagement and work was on-going.

9. Olivia Field (Policy and Engagement Manager - Loneliness and Social Isolation, British Red Cross)

(Item 2)

Olivia Field (Policy and Engagement Manager – Loneliness and Social Isolation, British Red Cross) and Kat Radlett (Policy & Advocacy Officer, British Red Cross) were in attendance.

The Chair welcomed the guests to the Committee. Olivia began by explaining the British Red Cross (BRC)'s involvement with the Jo Cox Commission on Loneliness (JCC). The BRC was one of thirteen partners on the JCC. The BRC set up a Loneliness Action Group in partnership with the Co-op to follow up on the recommendations from the JCC. The action group included representatives from 50 organisation including businesses, charity, local government, Royal Colleges, NHS and Public Health England.

Olivia reported that through its work, the BRC, saw the impact of loneliness on the people it supported. She noted that the BRC was the largest provider of support to refugees and asylum seekers in the UK; it provided detention support, family reunions and an international family tracing service. The BRC also provided support to patients' leaving hospital to enable them to regain confidence and independence and prevent readmission into hospital. She also highlighted the BRC and Co-op's new Community Connector service which was in operation in Thanet. She stated that the Co-op was keen to work with the BRC to tackle loneliness as its staff were noticing people coming into its shops for social interaction.

Olivia proceeded to give a presentation, attached as a supplement, which covered national action to address loneliness and Community Connectors. She explained that the JCC was set up by Jo Cox prior to her murder in 2016 with Seema Kennedy MP as a cross party group. Thirteen organisations, which supported people who Jo Cox had identified at the risk of loneliness, came together through the JCC to start a national conversation about loneliness. The JCC work culminated in a call to action published in December 2017 which included a number of recommendations to government:

- UK wide strategy for loneliness (accepted by Government and due to be published in October 2018)

- Nominated lead Minister to drive action on loneliness across Government (accepted by Government with the appointment of Tracey Crouch as new ministerial lead for loneliness and the creation of a cross-government team of civil servants and cross-ministerial group)

- Development of the current Family Test to become a Family and Relationships Test (not accepted by Government)

- Development of a national indicator on loneliness and annual reporting (accepted by Government. A report from a technical group made up of the Office for National Statistics, academic and charity partners regarding a national indicator was expected in October. JCC to publish a report annually based on ONS data.)

- Easy-to-understand messages, similar to five pieces of fruit and vegetables a day, to help individuals connect with others and avoid loneliness (not accepted by Government)

- Government to create an innovation and spread fund (accepted by Government who announced £20 million of new investment).

With regards to Community Connectors, Olivia explained that the service provided one-to-one person centre support. She noted that the aim of the service was to support someone over a twelve-week period to access a service, support someone to participate in an activity or reconnect them with someone. She noted that people were able to self-refer or be referred into the service by a health or social care professional, job centre and other charities. She reported that the service began with a conversation to co-develop a personal goal such as leaving the house, getting access to a mobility aid or participating in an online course. She noted that the model of Community Connectors was a foundation service which linked people into other support. She stressed the importance of the whole system working together. She reported that a full evaluation of the service was expected within the next few weeks; an initial evaluation of the service using the UCLA loneliness scale had found that service users' scores increased by three points on the ten-point scale and almost half were no longer considered lonely.

Q – What support is available to service users after the 12 weeks of support from Community Connectors?

Olivia explained that the aim of the service was to avoid service users being alone at the end of the 12 weeks by creating a system of support; after the initial 12-week intervention, service users received phone calls to check up on them followed by a six-month visit. She noted the BRC's work to support in and out of hospital care and highlighted a recent BRC report which identified practical measures to mitigate risks around hospital readmission -https://www.redcross.org.uk/-/media/documents/about-us/research-publications/health-social-care-and-support/in-and-out-of-hospital-report.pdf.

Q – How many staff and volunteers support the Community Connectors?

Olivia reported that there were 40 Connectors nationally. Each Connector was supported by four volunteers and one support worker.

Q – How many people in Kent would benefit from a short-term mobility aid?

Kat noted that one of the services the BRC provided was short-term mobility aids. She highlighted that there was no statutory duty to provide short-term mobility aids such as wheelchairs which were required for six months or less. She highlighted a recent report which had stated that 4.2 million people in the UK would benefit from a short-term mobility aids - https://www.redcross.org.uk/-/media/documents/about-us/research-publications/health-social-care-and-support/maintaining-mobility-full-report.pdf. She committed to looking at the Kent data and emailing the Committee.

Q - Do Community Connectors link in with patients discharged from hospital?

Olivia stated that they did in areas where Community Connectors were in operation.

Q - Was the Royal College of GPs one of the original 13 organisations in the JCC?

Olivia confirmed that the original 13 organisations in the JCC were charities.

Q – With regards to the statistic in your presentation which states that socially isolated people were 3.5 times more likely to enter local authority funded residential care, what is the number of people entering residential care?

Olivia explained that she was not able to provide that statistic but committed to raising it an upcoming Loneliness Lab and emailing the Committee.

Q – Are Community Connectors integrated with other organisations?

Olivia stated that the integrated working was key for the service. It was important that Community Connectors were able to link in with community activities and initiatives such as a community garden. She noted that they also worked with businesses who were able to provide space for community groups to meet in the evening.

Q – How do you engage with people who are difficult to engage with?

Olivia highlighted a range of initiatives that Community Connectors used to engage with the disengaged such as door knocking; library sessions; linking in with taxi drivers, postmen and women, utilities and the fire service. She noted a scheme in Gloucestershire in which the Royal Mail identified areas in need of outreach. She highlighted the importance of Community Connectors linking with health and social care with measures ranging from attending team meetings through to colocation in the same office.

Q – Who provides training for Community Connectors and would it be available to share with the Committee?

Olivia stated that the BRC provided inhouse training. She noted that Community Connectors were often from a police or caring background and had useful links within their communities. She committed to sharing the training programme with the Committee. Kat noted that Community Connectors had often experienced loneliness themselves so were able to understand the issue and empathise with the individual.

Q – What is the caseload of each Community Connector and who supports and supervises them?

Olivia explained that there was a variation in caseload. The main determinant of case load was the links each Connector had within the community. She stated that senior

managers within the Health & Social Care team at the BRC supported and supervised the Community Connectors.

Q – Do Community Connectors interact with faith groups?

Olivia confirmed that Community Connectors did interact with faith groups. She noted that the Loneliness Action Group contained representatives from a number of faith groups including Muslims, Christians, Jews and Humanists. She recognised the ability of faith groups to reach people.

Q – What more can KCC do more to tackle social isolation and loneliness?

Olivia commended KCC for a having a Committee to look at this issue. She stressed the importance of prevention in building resilience, identifying those most risks and looking at the pathways available. She also noted the importance of raising awareness of social isolation and loneliness.

Q – What is your view on social prescribing?

Olivia explained that she was an advocate of social prescribing. She noted the importance of Community Connectors or support workers in providing person-centred support as loneliness was subjective and was only able to be solved if the professional understood the individual.

Q – Do you work with organisations such as the Samaritans and Alcoholics Anonymous?

Olivia confirmed that BRC did work together with Samaritans and Alcoholics Anonymous. She noted that the BRC had a good relationship with Silverline. Gaetano noted that the Committee would be receiving evidence from most of those organisations.

Q – What is your view on technology being used to tackle social isolation and loneliness?

Olivia acknowledged that for some people, technology can transform their situation by using Skype to connect with people or participate in an online course. However, the use of social media could have a negative impact on younger people especially if it replaced face to face communication.
In response to a comment about a community Facebook page which shared old photos of its local area, Olivia noted that it was a way of connecting people from different generations.

Q – How is loneliness measured?

Olivia explained that a report from a technical group regarding a new national indicator to measure loneliness was expected in October. She noted that at present a wellbeing measure and UCLA loneliness scale was used. She noted training to use the UCLA scale was required due to the use of negative wording.

Q – What aspects of prevention do you focus on?

Olivia stated the primary focus should be to prevent deterioration, the secondary focus would be to target those at risk of loneliness and the tertiary focus would be on those who have lonely a long time and are disconnected.

Q – Can a life-changing event such as going to university cause loneliness?

Olivia stated that the research in this area was least advance. There was a potential impact on both the parent and young person.

The session concluded by Olivia sharing the learning summary of the Connecting communities to tackle loneliness and social isolation and the In & Out Hospital Report.

Connecting communities to tackle loneliness and social isolation: learning summary - https://www.redcross.org.uk/-/media/documents/about-us/research-publications/health-social-care-and-support/connecting-communities-learning-summary.pdf

Connecting communities to tackle loneliness and social isolation: full report - https://www.redcross.org.uk/-/media/documents/about-us/research-publications/health-social-care-and-support/connecting-communities-learning-report.pdf

10. Appendix

(Item 3)