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, 26 September 2018.

PRESENT: Mr M A C Balfour, Mrs P M Beresford, Ms S Hamilton and Mr K Pugh (Chairman)

ALSO PRESENT:

IN ATTENDANCE: Mr G Romagnuolo (Research Officer - Overview and Scrutiny), Mrs A Taylor (Scrutiny Research Officer) and Miss G Little (Democratic Services Officer)

UNRESTRICTED ITEMS

4. Andy Staniford (Senior Policy Advisor, Department for Digital, Culture, Media & Sport)
(Item 1)

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

Mr Staniford presented a series of slides which explored the opportunities and priorities involved in implementing a national strategy to tackle loneliness and welcomed questions from the Committee.

Tackling loneliness: exploring opportunities and priorities for the national strategy: https://democracy.kent.gov.uk/documents/s86397/Andy%20Staniford%20presentation.pdf

Q – Please introduced yourself and offer an outline of the DCMS Tackling Loneliness Team and its main objectives?

Mr A Staniford, Senior Policy Advisor, Tackling Loneliness Team, Department for Digital, Culture, Media and Sport (DCMS) joined the team in April 2018. He said that he had previously worked in local government, spending the majority of his career at the Brighton and Hove City Council as the Housing Strategy Manager. During that time, he was responsible for the Housing Strategy and worked on a number of cross-cutting themes with health and social care such as, the Health and Wellbeing Strategy, Rough Sleeping, Travellers and Supporting People. Mr Staniford said he was a Fellow of the Chartered Institute of Housing and a Board Member for the South East Region, and Chair of the CIHSE International Housing Group. To deliver a strategy that cuts across government, the Tackling Loneliness Team it is comprised of staff on secondment from 9 government

departments. The DCMS team worked in conjunction with Tracey Crouch (Minister for Sport and Civil Society) who was appointed as the lead for cross-government work on loneliness and played an active role in supporting the delivery of the governments plan. Mr Staniford said that it was important to understand that tackling loneliness mattered to everyone, whether it be the individual, the employer, communities, educators, professionals. Loneliness was something that everyone could relate to, yet it is often something we find difficult to talk about when we are lonely.

Q – When is the secondment period for your staff coming to an end?

Mr Staniford said that Phase 1 with the initial 12-month secondment was primarily established to develop the strategy and ensuring that the lessons learned were built into future policies. Work was being done to identify ways to deliver phase 2 of the strategy and the work that would need to be incorporated post April 2019

Q – Is there a reason why someone who is lonely would prefer to complete a national survey online rather than complete a survey in person?

DCMS has been testing the draft loneliness measure both online and face-to-face to help understand how people react and respond to the questions. For adults, DCMS tested the questions online through the Community Life Survey which is used to track statistics on issues that were important to encouraging social action and empowering communities. This included volunteering, community engagement, wellbeing and loneliness. The reason why the surveys were carried out online for adults was because the set of questions used had been tested in a number of global surveys and research and were proven but DCMS wanted to see how they worked together. Less was known about how younger people would react to the questions so DCMS worked with the Office for National Statistics and Children's Society to carry out face-to-face interviews to understand how the respondent identified and engaged with questions relating to loneliness. Guidance on the preferred methods of questioning people about loneliness would be issued in November.

Q –Does the variable in age change the response you receive i.e. are those who are younger more likely to answer the survey more openly compared to those who are older?

Mr Staniford said that the questions had been tested on adults, however, they had not been trialled with younger persons. Issues were identified around the phrasing which caused some confusion, however, they were well engaged and recognised what loneliness was. Work has since been done to rectify the initial issues to ensure a more child-friendly approach. The survey for adults used a total of 4 questions, 3 of which were tested and approved by the University of California model and the questions proved to be successful in getting the correct evidence to measure loneliness in adulthood. The Children's Society employed very skilled and capable researches who specialised in understanding loneliness to carry out 45-minute, face-to-face interviews, with younger persons. As this was an area that had not been tested, the interview was used to capture a more detailed picture in terms of how a child recognised loneliness, how loneliness was

affecting a child's behaviour and then what methods that child used to manage their loneliness.

Q – Would the national strategy focus on those over the age of 65 or would it be a global strategy for all?

Mr Staniford said that academic research and Office for National Statistics analysis showed that loneliness fluctuated over the life course, and certain life events could increase the risk. There was a number of trigger points that affect loneliness such as: leaving education, entering a period of poor health, being widowed (bereaved), becoming unemployed (or retiring), becoming a carer (or stooping a caring responsibility). The age range which had reported higher levels of loneliness was those between 16 and 24, the trend then dropped through middle age and peaked again at older age. Whilst previous work has focused on older age it was evident, following recent statistics, that the strategy needed to take a more balanced approach. If people were equipped with the ability to recognise and tackle loneliness at a younger age, the tools they required early on could potentially help them through life's journey into older age.

Q – Does prevention feature within the strategy?

Mr Staniford said that the most basic interventions could have the most significant impact. Evidence showed that volunteering for just 2 hours per week helped to reduce loneliness in older adults and widows. The most basic interventions started with engaging with people in the community and using social activities to help reduce feelings of isolation. Costa Coffee recently joined the initiative to tackle loneliness by launching a scheme called 'Chatty Cafe' providing people with the choice to sit at an allocated table and engage with others who feel equally isolated and encourage that social interaction. Further research needed to be done to look at the interventions required to tackle isolation. Social prescribing pilots were showing promise in helping to connect lonely people to the measures and interventions needed to help with isolation. Mr Staniford said that a recognised factor associated with high levels of loneliness relevant to local authorities was neighbourhood engagement, those who felt they did not identify or belong to their neighbourhood.

Q – As we move towards a modernised society, the face-to-face services we once had to physically access are moved online which restricts a person from having that social interaction, what is your view on how this affects loneliness?

Mr Staniford said that some retailors have adapted their spaces to include cafes and use these areas to promote group activities in support of helping to tackle social isolation. An energy company had also joined the initiative and trained it's call centre staff to identify dementia and recognise vulnerable callers. Whilst from a business point of view this may have been seen as quite disruptive, the company recognised the opportunity and arranged for staff to schedule in social calls to those vulnerable clients during the non-busy hours. This was not only beneficial for the staff member who may be in a very repetitive job but was also beneficial for the customer who retained that social interaction and also the

organisation which was able to retain the link with those customers. Corporate responsibility was something that needed to be considered by companies from the start. In terms of supporting customers through the transition from old to new modernised services, Mr Stanford said that there were a number of lottery funded charities the helped to support organisations to address the needs of vulnerable customers in the transition to a digitalised world. Government was working with companies to adopt this way of working as part of the loneliness strategy, good organisations however already had policies in place to support staff and customers and were happy to engage with the strategy's proposals.

Q – is there correlating evidence that suggests that those who experience loneliness at a younger age are more perceptible to experiencing loneliness at an older age?

Mr Staniford said that there was a significant gap in the evidence base as the concept and questions around loneliness were not available in existing longitudinal studies. In order to gather the evidence through a person's life this would require a new batch of volunteers to be studied for potentially 60+ years.

Q – In terms of social prescribing, Kent has a significant problem with getting GPs signed up to this, is there evidence of this elsewhere?

Mr Staniford said that GPs published their own manifesto on loneliness, so it was evident that loneliness in their patients was an issue for them. They highlighted that three out of four GPs say they see between 1 and 5 people a day who have come in mainly because they are lonely. If those GPs could direct people to an intervention, then this would increase their capacity to see other patients. The Department of Health and Social Care developed a number of pilots which provided good results. Mr Staniford agreed to relay the comments of the committee, concerning the GPs concerns of losing patients to interventions to the DCMS team and look at whether there was evidence in support of this.

Q –Another part aspect of bereavement is when an older person experiences the loss of a pet which may be their only companion. Have you considered involving vets?

Mr Staniford agreed that this was an interesting aspect that may not have been considered and may prove to be an effective intervention method as part of Phase 2 of the national strategy. Mr Staniford agreed to relay the comments of the committee to the DCMS team to look at ways in which this could be incorporated as part of the cross-government conversations going forward.

Q – Can the statistic on cigarettes be removed from the strategy?

Mr Staniford said that the statistic had been removed in the latest briefing and replaced with "Loneliness is as harmful as smoking and obesity."

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

Mr Staniford said that a modern lifestyle was a contributing factor to loneliness. Due to the constant changes that one may experience in life, especially those within modern society whom move regularly in their jobs, move for study, move for marriage, move for divorce, it encourages people to rebuild their lives and networks a number of times. However, if a number of those transitions happened all at once, it can affect people's confidence and make reconnection more difficult which may lead to loneliness. This is particularly noticeable when combined with health issues.

Q – Is transports a significant issue within rural communities?

Mr Staniford said that work was being carried out with the Department for Environment, Food & Rural Affairs (DEFRA) to look at loneliness within rural communities and issues around transportation. Government was also reaching out to the wider communities to look at the available assets within a community and how these could be utilised to support loneliness.

Q – In your opinion, what more could be done, if anything, to prevent or reduce the impact of social isolation and loneliness?

Mr Staniford said that they key to reducing loneliness was removing the stigma around it and encouraging people to openly talk about it. If people could relate to it, then they could potentially start to see how they could make a difference. The networks were out there for people to use, the challenge was having the conversation with those who were lonely and supporting them to utilise the services available to them. Everybody arguably had a responsibility and a role to play in ensuring they recognised loneliness and offered a helping hand to those in their community who may be more vulnerable. The key aspect of the strategy was to promote that everybody had a part to play in reducing loneliness.

Q – does the evidence show that there is a difference between the north and the south of the country?

Mr Staniford said that the evidence to support this notion was not available. Loneliness was an issue that impacted on both rural and urban areas and work was being done in conjunction with councils and Heath Organisations to develop ways to identify that.

5. Public Health England - Nicky Saynor (Health & Wellbeing Programme Manager) & Terry Blair-Stevens (Public Health Consultant in Health & Wellbeing)
(Item 2)

1. The Chairman welcomed Nicky Saynor, Health and Wellbeing Programme Manager and Terry Blair-Stevens, Public Health Consultant in Health and Wellbeing, both from Public Health England (PHE). Both guests were invited to introduce themselves and gave a background to their work.

2. Terry explained the differences between the role of PHE and Government Ministers (the Select Committee had previously heard from Andy Staniford, Senior Policy Advisor, Department for Digital, Culture, Media and Sport). He explained that the Government was responsible for setting policy and PHE provided evidence to inform the Government's strategy and policy making. PHE accessed evidence available through existing public sources and international databases. There was a need to be clear about the questions being asked and the measures being looked at. The officers were trained to critically appraise the evidence.

3. Terry gave Members a presentation which is available online here and via this link: https://democracy.kent.gov.uk/documents/s86502/Tackling%20Social%20Isolation%20and%20Loneliness%20-%20Presentation.pdf

4. Terry explained that there was a difference between loneliness and isolation and the relationship between the two was complex and varied between individuals. Referring to impact on health and wellbeing there were links between loneliness and social isolation and dementia. Terry described a study which had looked at nuns, living long and healthy lives with high cognitive abilities. The nuns donated their brains to science and the scientists found that their brains had the same level of aging brain disease as those who were not nuns, therefore it was thought that the social connections of nuns living together was keeping their brains active.

5. Terry referred, briefly, to the "Men's Sheds" programme in Kent specifically designed to prevent suicide and loneliness in men.

6. Terry explained that research suggested that those aged 16-24 were significantly more likely to feel lonely often/always than the other age groups, it was considered that the key to reducing this was to build personal resilience. A Member asked if there was any correlation with the use of social media in that age group? Terry stated that there was evidence around how it affected their self esteem and how well liked they were. Nicky commented on the pressure and pervasiveness of social media. There had been limited research on social relationships and the ways in which people interact online as opposed to on social media. A Member asked if research had been done on different cohorts of young people, such as those in boarding school which was another environment which was 24/7 as it was considered social media was?

7. In response to a query about whether studies had been undertaken on children under the age of 16 years Terry explained that there were studies available, however these were affected by the way in which questions were asked. The term 'loneliness' could be stigmatising for all age groups. It was recommended that alternative language was used that enabled people to feel more open and confident about discussing their experience of loneliness.

8. Evidence suggested that there was a significant correlation between low socioeconomic status and social isolation. Terry explained that there was strong evidence that people from disadvantaged backgrounds experience more social isolation and loneliness. However, it should be remembered that that experience could happen to anyone.

9. Referring to physical disconnection Terry explained that there had been a study in Belfast with older people in a community who were offered an area of green space, but they did not want it because of the fear that young people would congregate in it. Members discussed the benefits of locating cafes in local parks which then could become community hubs for example.

10. Nicky stated that it was important to recognise that more was needed than the bricks and mortar of cafés; they were important to facilitate intergenerational cohesion. Terry also pointed out that often there was no additional cost to the local authority of because the cafes could be rented out. It was important to look at how space was managed for the benefit of the community. There were also opportunities for schools and other groups to be involved.

11. Terry explained that male care givers were likely to be more isolated because females tended to have more contacts.

12. It was considered that there had not been enough research on the oldest old (85+). There were numerous factors to consider such as being in residential care settings, in which residents reported that they didn't feel sufficiently close to family and that they felt disconnected from communities. There was strong evidence that focussing Public Health intervention on those most at risk had the greatest impact. Efforts were concentrated on those who lived alone, had poorer health, and were recently bereaved or were carers, rather than all older people. There was a focus on positive mental health promotion this was more likely to reduce feelings of social isolation and loneliness and included helping people to realise their mobilities and feel a sense of belonging and worth.

13. A Member questioned the statistic set out in the presentation which stated that "57% of 85-year olds reported 'never' feeling lonely" and whether it was a surprise.

14. A Member asked if there was a correlation between those who were clinically depressed and those who were lonely. Terry explained that there most definitely was. If you were depressed you might not have the confidence or energy to connect with your partner and children let alone with the wider population.

15. Terry and Nicky explained that group interventions were much more beneficial than one to one (with the exception of the recently bereaved or those who were recently discharged from hospital). Work was targeted in particular circumstances. Nicky stated that there was evidence that with certain groups 1 to 1 intervention worked well in specific situations. Targeted 1 to 1 was good but the general approach to befriending was worth questioning.

16. The Select Committee discussed social isolation across the life course. It was considered that being in work was a positive health outcome and related to better health. In relation to retirement and later life it was important to promote good quality work.

17. In relation to wider public health interventions; there were issues around supporting older people such as ensuring there were accessible public toilets and seats.

18. Terry also raised the promotion of physical activity for the over 50s and tackling drugs and alcohol. It was important to look out for signs and symptoms and there were opportunities to identify lonely people through health screening.

19. In conclusion there were cross cutting opportunities between public services and with the private sector and community and voluntary sectors. There were clear opportunities for the local authority to work with the NHS.

20. A Member asked whether there was any research linking eating disorders to social isolation and loneliness and with the ex-forces and their needs? Terry explained that some groups did experience more social isolation and loneliness than other groups.

21. One Member commented that the act of volunteering was perhaps one of the best ways of preventing social isolation and loneliness. At certain points in life society could pick a person up and encourage them to spend two days a week volunteering with meals on wheels for example. Terry and Nicky agreed and thought that this could be more ambitious. Information would be shared through KCC's public health team as this was the most direct link.

22. Referring to social prescribing Nicky stated that by 2020 it was expected that there would be social prescribing in every GP practice. There was a need for specialists, who have an idea of what the community needs, to advise people who visit their GP with concerns around loneliness. The Chairman concurred with this view, that trained people were needed to ensure that GPs felt confident that the residents would be helped and sent to the right place.

23. The Chairman thanked the guests for attending the Select Committee hearing and for answering Members' questions.

6. Kent Fire and Rescue Service - Ian Thomson (Assistant Director for Community Safety) and Richard Stanford-Beale (Research & Development Manager - Community Safety)
(Item 3)

1. The Chairman welcomed Ian Thomson, Assistant Director for Community Safety and Richard Stanford-Beale, Research & Development Manager – Community Safety, both from Kent Fire and Rescue Service (KFRS). Both guests were invited to introduce themselves and gave a background to their work.

2. Ian explained that KFRS was involved in loneliness and social isolation because of the correlation between health issues and fire fatalities and injuries. The root causes of loneliness and isolation were often the issues which put people at greater risk from fire. Social Isolation also meant people might not access services such as Safe & Well visits.

3. KFRS also aimed to make every contact count by encouraging healthy choices and making appropriate referrals into other services - for example by referring people to stop smoking services. There was a correlation between health issues, fire fatalities and injuries, and injuries were higher in single occupancy homes.

4. Older people are at greater risk from fire and KFRS targeted people over 70 years. NHS provide anonymised data to identify addresses of people over 65 years old. Richard explained that although age was a risk factor it was a fairly 'blunt instrument' and KFRS was continuing to develop methodologies to ensure it prioritised the highest risk individuals.

5. Ian and Richard gave the Select Committee a presentation which is available online here or via this link: https://democracy.kent.gov.uk/documents/s86433/KFRS%20-%20presentation.pdf

6. The presentation set out a number of issues which might impact on people's health, social circumstances were a significant factor.

7. Referring to the impacts of loneliness on health, there was a clear link between a high use of medication and falls risk. Medication could also put people at risk from fire, for example, by impeding their decision making or reaction times if they have a fire. Loneliness had been identified as having a significant cost to the emergency services.

8. Ian explained to Members that KFRS was also co-responding with the Ambulance Service. Officers were able to respond to certain category calls including cardiac arrest and many staff had also received mental health first aid training.

9. For KFRS prevention was key, over 50% of people who died in a fire had probably done so before the first phone call was made to the emergency

services. There was a strong recognition that all the workforce could have an impact in terms of people's health. KFRS were an additional public health workforce to work with other public services to help meet the challenge set out in the NHS's Five Year Forward View.

10. Referring to making every contact count, KFRS would take every opportunity to talk to someone and have a short conversation about health issues. There were good examples of where KFRS was working with Public Health, work was being done to support the delivery of local plans and KFRS would like to be more involved. In relation to making a referral KFRS would usually ask for consent except where there is an immediate risk or a safeguarding issue.

11. Richard explained that a trial had been run in Medway, this involved KFRS identifying whether people might be socially isolated and making them aware of local groups they might be interested in attending. KFRS had its own volunteers who would visit an individual 2 or 3 times but that wasn't sufficient. If an individual was really socially isolated time was needed to build confidence to join a group.

12. A Member asked how much contact KFRS had with the community warden scheme. Ian explained that they worked within the Kent Community Safety Team and issues could be referred between the teams. It was considered that there could be better communication on the ground. There was a greater need to understand the role of each agency.

13. One of the key points around KFRS was that it was a trusted brand, it was able to access homes where other services were not able to. Richard explained to Members that KFRS had the capacity to do more. They had been very successful at reducing the number of fires and incidents had dropped by about 50% in ten years. Discussions were continuing between the NHS and KFRS about how they could work together to continue promoting preventative measures.

14. The Select Committee discussed Safe and Well visits. KFRS aimed to complete 20,000 visits this year and hoped to increase this further in future years. These visits looked at behaviour of the individuals in the home as well as environmental factors, for example housing quality, clutter, electrical safety, trip hazards etc. KFRS would offer to remove rugs for example if they were a trip hazard and re-route cables etc.

15. Richard explained that the Exeter data was used to identify addresses housing someone over 70 years to offer them a Safe and Well visit. KFRS were keen not to blanket visit everyone, this was not considered to be a good use of resources. Those who were entitled to a Safe and Well visit were:

a. Anyone 70 or over;
b. Anyone 5 or under;
c. Anyone smoking in or around the home;
d. Anyone with a disability;
e. Anyone who had any other reason to feel unsafe at home;

f. Referred by a partner agency.

16. A Member praised the fantastically efficient work of KFRS at an incident near his home, however it was considered that the age for a Safe and Well visit should be reduced. Ian explained that this age was set because those under 70 were more likely to be mobile so less likely to be killed or injured in a fire. Residents might be younger than that but fit into another category and therefore eligible for this service – para 15 refers. KFRS engaged with 7000 high rise residents last year following the fire at Grenfell.

17. A Member asked what more KCC could do to help? Ian explained that KFRS would like to be able to get to more people needing the service and would like to get more referrals. Those residents at highest risk were usually known to other agencies, if they were housebound there would be additional risk in case there was a fire. KCC commissioned telecare services and KFRS had offered to contribute towards the cost of smoke alarms being fitted as part of the telecare systems funded by KCC when a Safe & Well visit was also completed. This offer had so far been declined.

18. Ian explained that KFRS were also working with KCC on the Growth and Infrastructure Framework.

19. In response to a question from a Member about why KFRS focussed on the elderly Ian explained that fatalities and casualties increased sharply from the age of 70. Around 80% of the fire fatalities in Kent over recent years involved someone over 70 and people over 80 were 4 times more likely to be killed or seriously injured in a fire. Falls were also a big issue for this age group.

20. Hoarding was considered to be a big fire risk and this was almost always a social isolation issue as well. All agencies should be informed that any hoarders should be referred to KFRS. KFRS were working with the Kent & Medway Adult Safeguarding Board to strengthen the Self Neglect Policy to fully incorporate hoarding.

21. The Select Committee discussed the 'Haircare Network'. In this initiative KFRS engaged with local hairdressers (because hairdressers were well placed to have conversations with people who might be socially isolated). This scheme got a lot of people interested but didn't get enough leads and it was not possible to maintain the scheme. This may have been because KFRS wasn't as selective as it could have been. A similar scheme could be developed with the support of other agencies.

22. There was also an initiative called 'show you care' with Cheryl Baker, which encouraged people to build social networks or enjoy a cup of tea once a week with someone who might be lonely or socially isolated.

23. KFRS also provided winter warmth packs for residents with heating issues etc. It had a range of volunteers who assisted with giving safety advice and going out on incidents with fire fighters if required.

24. A pilot was underway with Maidstone hospital and Pembury hospital to promote Safe & Well visits to targeted groups e.g. in maternity, frailty units, older people, smokers etc.

25. In relation to attended cases of stroke a Member asked how many KFRS attended for category 1 and 2 and whether this information could be circulated? POST MEETING NOTE: This information has been circulated to Members.

26. In response to a question about what more could be done to reduce social isolation and loneliness Richard explained that it was a complex issue, the positive branding of KFRS had resulted in a good take up of social media which was useful for sharing information. In relation to the Haircare Network it might be possible to replicate this with other services such as vets for example. There were thoughts that these initiatives would be more effective if they were run together as partnership.

27. There were views that loneliness and social isolation was a societal issue which was difficult to change. KFRS did not have all the answers but was willing to provide assistance. Another Member considered that a cultural change could happen quickly, because of the need for it to do so.

28. The Chairman thanked the guests for attending the Select Committee hearing and for answering Members' questions.