LONELINESS & SOCIAL ISOLATION NEEDS ASSESSMENT

Warwickshire Joint Strategic Needs Assessment 2015
This document is only valid on the day it was printed.

Revision History

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Approvals

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Loneliness and Social Isolation Plan on a Page

**What**

‘Loneliness’ = psychological state. A subjective, negative feeling associated with lack or loss of companionship. If you feel lonely, you are lonely.

‘Social isolation’ = sociological category relating to imposed isolation from social networks. Can lead to loneliness and can be caused by loss of...

**Risk Factors**

Intrapersonal Factors (personality/cognitive, identity), Engagement (family, friends, neighbours), Life Stage (retirement, widowhood, sensory impairments, physical health), Social Environment (living arrangements, community, hobbies/interests, pets, housing, car, holidays/seasons, technology), Social Structures (poverty, quality of care, ageism, transport, crime, population turnover, demographics).

**Why**

Over-eating, smoking, alcohol, stress, self-imposed isolation, immune system, cardiovascular systems, impact on metabolic, neural and hormonal regulations, physical health, depression, blood pressure, sleep, immune stress responses, cognition, cardiovascular disease, diabetes, stroke...

**Recommendations**

Ensure tackling loneliness & social isolation is considered in all relevant policy areas.

Support local organisations and partnerships to raise awareness of and tackle loneliness and social isolation.

Target interventions at a range of vulnerable groups in the community, particularly older people, including:

- older people with other issues including alcohol issues & mental health problems
  - carers
  - ethnic minorities
  - LGBT groups

Provide frontline staff within relevant organisations with the skills and knowledge to identify potentially lonely and socially isolated individuals and the confidence and tools to offer solutions.

Develop and support effective loneliness evidence based interventions, including an evaluation component in all proposals for local interventions.

**How**

1. Needs Assessment & Index development
2. Warwickshire Cares Better Together programme integration
3. Stakeholder & public engagement
4. Upskilling organisations & frontline staff
5. Develop projects aimed at tackling loneliness & social isolation

**Outcome s/Outputs**

Increased numbers in people reporting they feel that they belong to their immediate neighbourhood.

% of adult social care users and adult carers who have as much social contact as they would like.

Health related quality of life for older people.

Increase in WEMWBS score.

**Links to corporate plans**

One Organisational Plan:

- Our communities and individuals are safe and protected from harm and able to remain independent for longer.
- ‘The health and wellbeing of all in Warwickshire is protected.’

Health and Wellbeing Strategy

- Promoting Independence
- Community Resilience
- Integration & Working Together
Rationale
This document is intended to set out the evidence base around loneliness and social isolation in relation to causes, risk factors, distribution across Warwickshire and the effectiveness of interventions. The document also serves to set the context for the emerging loneliness and social isolation workstream, setting the direction of travel for the county council, and raising awareness of some of the key issues of the topic.

It is hoped that partner organisations across the county will be able to utilise this report to inform the commissioning of initiatives and to support and inform funding bids for projects that aim to tackle loneliness and social isolation.

The mapping work undertaken as part of this report seeks to highlight small areas that house individuals who are at an increased risk of being or becoming lonely or socially isolated; this should allow more informed planning and targeting of interventions.

A summary version of this document is also available, as are a range of different versions of the loneliness and social isolation risk maps. These can be accessed on the Public Health Warwickshire website: http://publichealth.warwickshire.gov.uk/loneliness-and-social-isolation/
Executive Summary

Loneliness and social isolation is now more recognised as being a public health issue. It is associated with harm to mental and physical health, as well as having broader social, financial and community implications. Because of this, there has been a local, national and international consensus that support needs to be provided to individuals and communities in order to tackle loneliness and social isolation.

Whilst loneliness and social isolation is a problem present across all age groups in society, it is a significant and growing issue for older people in particular. It is estimated that approximately 25% of the population will be aged 60 or above within the next 20 to 40 years, so it is important that we intervene now in order to address loneliness and social isolation.

Almost half of adults in England say they experience feelings of loneliness. On average, 10% of the population aged over 65 are often or always lonely. Furthermore, Help the Aged’s Spotlight on Older People in the UK 2007 showed that the percentage of over 65s who said that they are often or always lonely was increasing dramatically. The reasons for this are complex, to do with changing family relationships, people living at greater distances from their relatives, and often an altogether less strong desire to be the mainstay of frail older relatives.

The 2014 Living in Warwickshire survey revealed that in Warwickshire, when compared to the population as a whole, those aged 65+ are:

- more likely to know people in their immediate neighbourhood
- more likely to feel that they ‘belong’ to their immediate neighbourhood
- slightly more likely to volunteer
- less likely to report ‘very good’ or ‘good’ health and much more likely to report ‘fair’ health

This suggests a real difference in perceptions of community, community perception and health across the life course.

Loneliness and social isolation harm physical and mental health by increasing the risk of depression, high blood pressure, sleep problems, reduced immunity and dementia. It has a greater impact than other risk factors such as physical inactivity and obesity. A recent study found that loneliness and social isolation has an equivalent risk factor for early mortality to smoking 15 cigarettes per day.

On a positive front, people are able to ‘recover’ from loneliness, which means that there is scope for interventions to improve the situation for individuals. Loneliness is responsive to a number of effective interventions, which are often low cost, particularly when voluntary effort is harnessed and taking action to address loneliness can reduce the need for health and care services in future.

Interventions to tackle loneliness include one-to-one interventions, such as befriending, Community Navigators and mentoring; and also social group schemes (e.g. art, discussion or writing groups); and wider community engagement. There is evidence that all of these schemes can help to reduce loneliness and improve health and wellbeing. It would appear that overall, group interventions are more effective than one-to-one support.

With reducing budgets and projected increasing demand for services, identifying successful and cost effective early interventions, particularly involving sustainable community and volunteering approaches and initiatives, will present good opportunities for improved outcomes to combat loneliness and social isolation in the future.

Whilst the terms ‘loneliness’ and ‘social isolation’ are often used interchangeably, it is important to bear in mind that they are different concepts and as such may need to be tackled using different approaches.
What are we going to do?
An action plan outlining how Warwickshire County Council will tackle loneliness and social isolation in the county has been developed, to be delivered via the Loneliness and Social Isolation Working Group, and can be found on the Public Health website.

However, to effectively tackle loneliness and social isolation, an integrated approach to working must be adopted by all partners in Warwickshire, delivering on the following:

1. Develop and support effective loneliness evidence based interventions, including an evaluation component in all proposals for local interventions;
2. Target interventions at a range of vulnerable groups in the community, particularly older people
3. Ensure that tackling loneliness is a consideration in all relevant policy areas;
4. Support local organisations and partnerships to raise awareness of and tackle loneliness and social isolation;
5. Provide frontline staff within relevant organisations with the skills and knowledge to identify potentially lonely and socially isolated individuals and the confidence and tools to offer solutions.
1.0 Introduction
Reducing loneliness and social isolation is challenging but much needed as the number of one-person households increases. In 1991 26.3% of households contained one person, rising to 31% in 2011, a trend that continues. However, loneliness and social isolation concern more than just those living alone. Loneliness and social isolation encompass social, political, cultural and economic dimensions and have different impacts at different stages in a person’s life.

Loneliness and social isolation impact on health: social networks and social participation act as protective factors against dementia or cognitive decline over the age of 65. Individuals who are lonely or socially isolated are between two and five times more likely than those who have strong social ties to die prematurely. Social networks have a larger impact on the risk of mortality than on the risk of developing disease; it is not so much that social networks prevent an individual from becoming ill, but they help recovery when an individual is post-illness.

2.0 What is Loneliness and Social Isolation?
The terms ‘loneliness’ and ‘social isolation’ (as defined in box 1) are often used interchangeably, and whilst there are clear links between the two experiences they are distinct concepts. People can be socially isolated without feeling lonely, or feel lonely whilst being amongst others. The literature stresses the distinction between loneliness and isolation, not least because the appropriate response to designing and measuring interventions will be different for each. Although the terms have slightly different meanings, the experience of both is generally negative and the resulting impacts are undesirable at the individual, community and societal levels.

‘Loneliness’ is a psychological state. It is a subjective, negative feeling associated with lack or loss of companionship. If you feel lonely, you are lonely.

‘Social isolation’ is a sociological category relating to imposed isolation from normal social networks. This can lead to loneliness and can be caused by loss of mobility or deteriorating health.

It is possible to be lonely whilst not isolated, for example amongst those caring for a dependent spouse with little help. It is also possible to be socially isolated but not feel lonely.

Box 1: Definitions of loneliness and social isolation

As our population ages, loneliness and isolation in older age (and amongst other groups) is becoming a growing public health challenge. Research shows that loneliness and social isolation can be as harmful as smoking 15 cigarettes a day and increases the risk of conditions including dementia, high blood pressure and depression. Socially isolated older adults have longer stays in hospital, a greater number of GP visits and are more dependent on homecare services. Therefore, there is an economic as well as a health related case to be made for tackling social isolation.
2.1 Loneliness
Loneliness can be defined as a subjective, unwelcome feeling of lack or loss of companionship. It happens when we have a mismatch between the quantity and quality of social relationships that we have, and those that we want (Perlman and Peplau, 1981)

There are different types of loneliness:

- Emotional loneliness is felt when we miss the companionship of one particular person; often a spouse, sibling or best friend.
- Social loneliness is experienced when we lack a wider social network or group of friends.

Loneliness can be a transient feeling that comes and goes. It can be situational; for example only occurring at certain times like Sundays, bank holidays or Christmas. Loneliness can also be chronic; meaning that it is experienced all or most of the time.

2.2 Social Isolation
Loneliness is linked to social isolation but it is not the same thing. Isolation is an objective state whereby the number of social contacts or interactions a person has can be counted. One way of describing this distinction is that you can be lonely in a crowded room, but you will not be socially isolated.

3.0 Background

3.1 Policy

3.1.1 National
Loneliness and social isolation are emerging issues in the national health and social care agenda. In July 2012 there was an international “Loneliness Conference” where Minister for Care Services, Paul Burstow, launched an online toolkit for local health organisations and councils to address loneliness in older age. This 2012 research conference “What Do We Know About Loneliness?” (hosted by Age UK Oxfordshire and the Campaign to End Loneliness) highlighted that loneliness should be considered a major health issue and investigated the research that brings to light huge numbers of older people affected by loneliness in the UK.

Nationally and locally, a challenge has been in identifying those most at risk in order to better target resources and facilitate early intervention services. In November 2012 the Health Secretary announced a proposal to identify areas in the country where the issue is most prevalent; although at this stage no indication is available at what level this will be developed.

Nationally, 51% of Health and Wellbeing Boards are tackling loneliness as a priority area, highlighting the scale of the issue across the UK.

Marmot’s 2011 Review: Fair Society, Healthy Lives, included ‘improve[ing] community capital and reduce social isolation across the social gradient’ as a priority objective,
recommending ‘Support [to] locally developed and evidence based community regeneration programmes that emphasise reduce social isolation’.

Furthermore, the recent Care and Support White Paper recognises loneliness and social isolation as large problem for society as a whole.

3.1.2 Warwickshire
The Warwickshire Health and Wellbeing Strategy has specific outcome measures related to loneliness and social isolation, as follows:

‘In five years’ time, Warwickshire will have fewer people who feel lonely or socially isolated’

‘In five years’ time, Warwickshire will have strong social and community networks that are cohesive and connected, with less isolation’

Warwickshire’s Joint Strategic Needs Assessment (JSNA) has priorities around mental health, dementia, carers and maintaining independence, which are all issues and groups associated with being impacted by loneliness and social isolation.

Warwickshire Cares, Better Together incorporates Warwickshire’s Better Care Fund plans, including work streams around promoting independence and community resilience, which both have outcome measures around reducing loneliness and social isolation.

Warwickshire Cares, Better Together also covers work streams in relation to the Care Act; Warwickshire County Council has work streams focusing on prevention and wellbeing, in terms of preventing and delaying needs for care and support in vulnerable and older people.

3.2 Impact on health
The 2014 Living in Warwickshire Survey asked respondents to report on their health. Those aged 65+ were less likely to report that they were in ‘very good’ or ‘good’ health than the population as a whole, suggesting that, generally, experience of health worsens with age.

<table>
<thead>
<tr>
<th>In general how good would you say your health is?</th>
<th>Aged 65+</th>
<th>All ages</th>
<th>Percentage point difference</th>
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</thead>
<tbody>
<tr>
<td>Very good</td>
<td>13%</td>
<td>28%</td>
<td>15%</td>
</tr>
<tr>
<td>Good</td>
<td>43%</td>
<td>47%</td>
<td>3%</td>
</tr>
<tr>
<td>Fair</td>
<td>33%</td>
<td>19%</td>
<td>-14%</td>
</tr>
<tr>
<td>Poor</td>
<td>8%</td>
<td>4%</td>
<td>-4%</td>
</tr>
<tr>
<td>Very poor</td>
<td>2%</td>
<td>1%</td>
<td>-1%</td>
</tr>
</tbody>
</table>

Table 1: Self-reported health, age 65+ and the general population, the Living in Warwickshire Survey, 2014

For most people, feelings of loneliness are short lived but research carried out in 2008 identified 5 causal pathways through which chronic loneliness can adversely affect health:

- Increasing negative lifestyle habits (over-eating, smoking, increased alcohol consumption etc.);
- Increasing stress levels;
• Self-imposed isolation and failure to seek emotional support;
• The effect on immune and cardiovascular systems;
• Difficulty in sleeping, negative impact on metabolic, neural and hormonal regulations

A 2008 systematic review found that loneliness appears to have a significant impact on physical health, being linked detrimentally to higher blood pressure, worse sleep, immune stress responses and worse cognition over time in the elderly\(^1\). It is also suggested that loneliness (independent of age) is associated with the metabolic syndrome (cardiovascular disease, diabetes, stroke, and mortality) and as such increases risk of morbidity and mortality\(^2\). Marmot (2011) stated that social isolation can lead to increased risk of premature death. Links between loneliness and physical and mental health have been established by the work of Holt-Lunstad et al (2010) in the meta-analytic review of 148 studies of the influence of social relationships on the risk of mortality\(^2\). This work identified that there is a 50% increased likelihood of survival for people who had stronger social relationships compared to those who had weaker relationships. Other research has identified that the impact of social relationships on the risk of mortality is comparable with major established health risk factors such as smoking and alcohol and exceeds that of physical inactivity and obesity\(^13\). Research shows that loneliness and social isolation are harmful to our health: lacking social connections is a comparable risk factor for early death as smoking 15 cigarettes a day\(^2\).

The 2008 systematic review also found that loneliness has strong associations with depression and loneliness may in fact be an independent risk factor for depression\(^1\). Loneliness has been found to be linked to reduced day to day happiness and excitement experienced day to day by older people, which may enhance risks to physical and mental health\(^14\).

In addition to direct risks to mental and physical health, loneliness and social isolation have also been found to be independently associated with a greater risk of being inactive as well as a range of other negative health behaviours; social isolation is also associated with increased levels of smoking\(^15\). Therefore it is suggested that loneliness and social isolation may affect health through their effects on health behaviours.

3.2.1 Health: conclusions
The literature indicates that there is an inadequate base around interventions for loneliness and social isolation (this is explored further in section 4.4.1.2). This is despite loneliness and its associated detrimental consequences for mental and physical health being a common issue in older people. Further research around intervention strategies will determine whether treating loneliness can improve quality of life in older people.

3.3 Risk factors
The relationship between social isolation and loneliness is complex, and is subject to change over the life course. Research has identified a number of predictors of loneliness and social isolation 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, low socio-economic status and physical isolation\(^16\).
Loneliness and social isolation can be felt by people of all ages, but as we get older, risk factors that might lead to loneliness begin to increase and converge. Such risk factors are outlined in figure 1 (but are not limited to those cited in the diagram).17

![Figure 1: Risk factors for loneliness Source: Sullivan & Victor, 2012](image)

In addition to these tangible risk factors, the English Longitudinal Study of Aging (ELSA) has revealed a series of other more holistic risk factors. **Expectation of loneliness** can be a predictor of becoming lonely; ELSA found that people who expect to become lonely do go on to experience loneliness (and this has implications for the acceptance and effectiveness of interventions). **Seasons** can also have implications; whilst the common conception is that loneliness is experienced more during the winter, ELSA has indicated that the highest levels are in the spring and summer when the days are longer and family members may be on holiday. There are variations by **ethnicity**. All BME communities have been found to have a higher rating of self-reported loneliness than the White British ethnic group. This is with the exception of the Indian group who report similar levels of loneliness. **Depression** was also found to be a risk factor in loneliness. However, no correlation between limiting long term conditions and loneliness was found, when all other factors were taken into account. Several studies also suggest that **lesbians and gay men** suffer disproportionately from loneliness and isolation as they age.18,19 **Carers** are another group that at particular risk of loneliness and isolation, and the subsequent negative impact this has on health and wellbeing. Marmot (2011) outlined **multiple deprivation** amongst communities as a risk factor in social isolation.

This is not an exhaustive list - there will be other factors and groups of people for whom loneliness may also be an important issue, but with published evidence not always available. These would include young care-leavers, refugees, those with mental health problems,
homeless people, unemployed people, mothers with post-natal depression and people abusing drugs or alcohol.

A 2005 study that identified these risk, or vulnerability, factors, proposed three loneliness pathways in later life:

1. continuation of a long-established attribute;
2. late-onset loneliness; and
3. decreasing loneliness.

Confirmation of the different trajectories suggests that policies and interventions should reflect the variability of loneliness in later life, because undifferentiated responses may be neither appropriate nor effective.

4.0 Need: The Scale of the Issue

4.1 Measuring Loneliness and Social Isolation

Unlike other physical or mental health conditions, data on the prevalence and incidence of loneliness and social isolation are not routinely collected. Therefore, identifying individuals who are lonely or socially isolated, or are at risk of being so, is a challenge. A range of national and local surveys including questions around loneliness and social isolation have been carried out and the results can be used to give an indication of the incidence and prevalence locally, for example the ELSA (see box 2). Alternatively, a range of indicators and measures that are collected for other purposes can be combined and used to give a proxy indication of the situation locally (for example, using census data, Mosaic profiling, Quality and Outcomes Framework (QoF) data, Index of Multiple Deprivation (IMD), Public Health and/or Social Care Outcomes Framework data). Section 4.2 outlines this further and discusses a model that has been developed in Warwickshire.

4.1.1 The development of an Index

As previously mentioned, there is currently no specific dataset that is used nationally to measure the incidence or prevalence of loneliness and social isolation. Therefore, proxy indicators must be used in order to gain an approximate indication of the issue. Public Health Warwickshire have developed a ‘Loneliness and Social Isolation Index’ using Mosaic.
customer profiling data\(^1\), based on work already undertaken by Essex County Council. The aim of this Index is to ascertain an estimate of the number of households in Warwickshire that are at an above average risk of experiencing loneliness and social isolation, thus giving a prevalence estimate. Appendix 1 outlines the methodology used to develop the Index.

The index identified a number of existing groups who are at a higher than average risk of being lonely or socially isolated, as shown in table 2. These groups vary in age, ethnicity, and family and social status but all have a level of deprivation across various domains (e.g. income, housing, health, employment). The Index has allowed mapping of these groups at small area level (see section 4.2.3; a full range of maps is available on the Public Health Warwickshire website).

<table>
<thead>
<tr>
<th>Mosaic Type (group)</th>
<th>Key Feature 1</th>
<th>Key Feature 2</th>
<th>Key Feature 3</th>
<th>Key Feature 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>I38: Asian Heritage</td>
<td>Extended families</td>
<td>Areas with high South Asian population and tradition</td>
<td>Low property value</td>
<td>Never worked and long-term unemployed</td>
</tr>
<tr>
<td>L49: Disconnected Youth</td>
<td>Aged under 25, mostly living alone</td>
<td>Have lived at address less than 3 years</td>
<td>Limited employment options</td>
<td>Some lone parents</td>
</tr>
<tr>
<td>L50: Renting a Room</td>
<td>Singles and homesharers</td>
<td>Short term private renters in low rent accommodation</td>
<td>Low wage occupations</td>
<td>High index of Multiple Deprivation</td>
</tr>
<tr>
<td>M55: Families with Needs</td>
<td>Cohabiting couples and singles with kids</td>
<td>Areas with high unemployment</td>
<td>Pockets of social housing</td>
<td>Very low household income</td>
</tr>
<tr>
<td>N57: Seasoned Survivors</td>
<td>Very elderly</td>
<td>Most are living alone</td>
<td>Retired from routine / semi-skilled jobs</td>
<td>Claim support allowance</td>
</tr>
<tr>
<td>N60: Dependent Greys</td>
<td>Ageing singles</td>
<td>Vulnerable to poor health</td>
<td>Living on estates with some deprivation</td>
<td>Bad health</td>
</tr>
<tr>
<td>O62: Low Income Workers</td>
<td>Older households</td>
<td>Renting low cost semi and terraces</td>
<td>Areas with low levels of employment</td>
<td>Very low household income</td>
</tr>
<tr>
<td>O63: Streetwise Singles</td>
<td>Singles and sharers</td>
<td>Low cost social flats</td>
<td>Shortage of opportunities</td>
<td>High index of Multiple Deprivation</td>
</tr>
<tr>
<td>O64: High Rise Residents</td>
<td>Singles and sharers</td>
<td>High rise social flats</td>
<td>Very low household income</td>
<td>Least likely to own a car</td>
</tr>
</tbody>
</table>

\(^1\) Mosaic UK is Experian’s system for classification of UK households. It is one of a number of commercially available geodemographic segmentation systems, applying the principles of geodemography to consumer household and individual data collated from a number of governmental and commercial sources.
4.2 Prevalence and incidence

4.2.1 National

Nationally available data is almost exclusively prevalence data, i.e. reporting on existing cases of loneliness and social isolation.

Loneliness is a common experience, with a ‘U’ shaped population distribution; those aged under 25 years and those aged over 55 years demonstrate the highest levels of loneliness\(^{27}\). The focus of this report is on the experience of loneliness and social isolation in older people.

In a national study (Victor et al, 2005) examining the prevalence of loneliness amongst older people in Great Britain, loneliness was measured using a self-rating scale, and measures of socio-demographic status and health/social resources were included. Interviews were undertaken with 999 people aged 65 or more years living in their own homes, and the sample was broadly representative of the population in 2001. The study found the following:

- 61% of people aged 65 and over reported ‘never’ being lonely
- 31% rated themselves as being ‘sometimes’ lonely
- 7% reported feeling lonely ‘often’ or ‘always’\(^{21}\)

Applying these percentages to ONS population data, it can be suggested that in 2001 there may have been 2,329,650 people living in England who would rate themselves as being ‘sometimes’ lonely and 526,050 people who reported being lonely ‘often’ or ‘always’.

Living alone is one of the factors contributing to a sense of social isolation, which is characterised by a lack of contacts or ties with other people. Isolation is also linked to a more subjective sense of loneliness. ONS data released in 2012 shows a higher number of people aged 45 – 65 are living alone than ever before. In England as a whole, 53% of all households with people age 65 and over were one person household. The older people get the more likely they are to live within one person household:

- 37% for people age 65-74
- 66% for people age 75-84
- 72% among those age 85+

Furthermore, some British studies suggest that loneliness rates tend to be higher amongst older people who live in socially disadvantaged urban communities. A study of deprived

<table>
<thead>
<tr>
<th>O65: Crowded Kaleidoscope</th>
<th>Many lone parents with multiple children</th>
<th>Non-nuclear household composition</th>
<th>Socially rented, overcrowded households</th>
<th>Significant proportion of adults not born in the UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>O66: Inner City Stalwarts</td>
<td>Mostly single adults Aged 56+</td>
<td>Health problem or disability limits activities/work</td>
<td>Renting from social landlord</td>
<td>Never worked and long-term unemployed</td>
</tr>
</tbody>
</table>

Table 2: Mosaic groups at a higher than average risk of being lonely or socially isolated
neighbourhoods of three English cities identified 16% of older people as being severely lonely (Scharf et al., 2002)\textsuperscript{22}.

4.2.2 Warwickshire

According to Warwickshire’s JSNA\textsuperscript{23} the highest rates of projected population growth in Warwickshire are in the groups aged 65 years and over. The rate of growth increases with age, with the oldest age group, those aged 85 and over, projected to increase by more than 40% between 2011 and 2021. Population projections help inform the planning of services and decisions about the future allocation of resources. An ageing population in particular, has implications for the future provision of many health and social services linked to older age groups.

<table>
<thead>
<tr>
<th>District</th>
<th>% increase 2012 to 2037</th>
<th>65+ population as % of total (2037)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warwickshire</td>
<td>66.7%</td>
<td>27.9%</td>
</tr>
<tr>
<td>North Warwickshire</td>
<td>65.5%</td>
<td>29.2%</td>
</tr>
<tr>
<td>Nuneaton and Bedworth</td>
<td>65.0%</td>
<td>25.5%</td>
</tr>
<tr>
<td>Rugby</td>
<td>73.8%</td>
<td>26.5%</td>
</tr>
<tr>
<td>Stratford-on-Avon</td>
<td>69.9%</td>
<td>35.6%</td>
</tr>
<tr>
<td>Warwick</td>
<td>61.1%</td>
<td>24.1%</td>
</tr>
<tr>
<td>England</td>
<td>65.1%</td>
<td>24.0%</td>
</tr>
</tbody>
</table>

Table 3: Percentage increase in population and percentage of population aged 65+, Warwickshire. Source: ONS

Table 3 shows the projected population increase for those aged 65+ over the next 22 years. In the majority of districts and boroughs in Warwickshire, the population is projected to rise at the same level or higher than the England figure. The table also shows the proportion of the population that will be aged 65+ in 2037; the proportions for each of the districts and boroughs in Warwickshire are higher than the proportion for England as a whole, highlighting the scale of the issue for Warwickshire. The table also shows inequalities between the districts and boroughs; Rugby Borough is projected to see the largest percentage increase in the population aged 65+ and in 2037 is projected to have the largest proportion of the population who are aged 65+, at 35.6%.

In terms of the proportion of the population who are at risk of being lonely or socially isolated, using the figures indicated in Victor’s 2005 survey, mentioned above, the figures in table 4 could be suggested for the scale of the issue in Warwickshire:

<table>
<thead>
<tr>
<th>District</th>
<th>Total population aged 65+</th>
<th>Lonely ‘all of the time’ or ‘often’</th>
<th>Lonely ‘some of the time’</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Warwickshire</td>
<td>9,000</td>
<td>630</td>
<td>2,790</td>
</tr>
<tr>
<td>Nuneaton &amp; Bedworth</td>
<td>17,200</td>
<td>1,204</td>
<td>5,332</td>
</tr>
<tr>
<td>Rugby</td>
<td>13,500</td>
<td>945</td>
<td>4,185</td>
</tr>
<tr>
<td>Stratford-on-Avon</td>
<td>19,300</td>
<td>1,351</td>
<td>5,983</td>
</tr>
<tr>
<td>Warwick</td>
<td>19,700</td>
<td>1,379</td>
<td>6,107</td>
</tr>
<tr>
<td><strong>Warwickshire</strong></td>
<td><strong>78,900</strong></td>
<td><strong>5,523</strong></td>
<td><strong>24,459</strong></td>
</tr>
</tbody>
</table>

Table 4: Varying degrees of loneliness, Warwickshire
### 4.2.2.1 Living in Warwickshire survey data

The 2014 Living in Warwickshire survey revealed that in Warwickshire, when compared to the population as a whole, those aged 65+ are:

- more likely to know people in their immediate neighbourhood
- more likely to feel that they ‘belong’ to their immediate neighbourhood
- slightly more likely to volunteer

This suggests higher level of self-reported community involvement amongst older people, which is associated with lower levels of loneliness and social isolation.

The survey asked respondents to rate their wellbeing, using the WEMWBS\(^2\) scale, as shown in table 5. Responses to the questions can give an indication about individual mental wellbeing and resilience, both of which are factors to consider when thinking about loneliness and social isolation.

The survey responses have been disaggregated by age to show some of the differences in response between the general population and those aged 65+, with percentage point differences of 5% highlighted in red to show where responses differ most. Those aged 65+ were notably less likely to respond ‘often’ to the majority of the questions, suggesting relatively lower levels of mental wellbeing amongst people of this age.

One of the WEMWBS questions asks respondents to report how often they have been ‘feeling close to other people’, which, within the question set, is the strongest indicator of loneliness. The responses to this question were relatively similar in terms of percentages falling into each category, for those aged 65+ and for the general population. This suggests that feeling close to people, or not, is experienced at a relatively consistent level across the life course.

<table>
<thead>
<tr>
<th></th>
<th>None of the time</th>
<th>Rarely</th>
<th>Some of the time</th>
<th>Often</th>
<th>All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>I've been feeling optimistic about my future</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 65+</td>
<td>9%</td>
<td>14%</td>
<td>41%</td>
<td>27%</td>
<td>10%</td>
</tr>
<tr>
<td>All age</td>
<td>4%</td>
<td>11%</td>
<td>37%</td>
<td>38%</td>
<td>11%</td>
</tr>
<tr>
<td>% diff</td>
<td>-4%</td>
<td>-3%</td>
<td>-4%</td>
<td>11%</td>
<td>1%</td>
</tr>
<tr>
<td>I've been feeling useful</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 65+</td>
<td>4%</td>
<td>9%</td>
<td>39%</td>
<td>34%</td>
<td>13%</td>
</tr>
<tr>
<td>All age</td>
<td>3%</td>
<td>7%</td>
<td>34%</td>
<td>44%</td>
<td>13%</td>
</tr>
<tr>
<td>% diff</td>
<td>-2%</td>
<td>-2%</td>
<td>-5%</td>
<td>10%</td>
<td>-1%</td>
</tr>
<tr>
<td>I've been feeling relaxed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 65+</td>
<td>3%</td>
<td>8%</td>
<td>40%</td>
<td>39%</td>
<td>11%</td>
</tr>
<tr>
<td>All age</td>
<td>3%</td>
<td>14%</td>
<td>42%</td>
<td>34%</td>
<td>6%</td>
</tr>
</tbody>
</table>
| % diff               | 0%               | 7%     | 2%               | -5%   | -5%             

---

\(^2\) The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) is a scale of 14 positively worded items, with five response categories, for assessing a population’s mental wellbeing. See: [http://www.healthscotland.com/scotlands-health/population/Measuring-positive-mental-health.aspx](http://www.healthscotland.com/scotlands-health/population/Measuring-positive-mental-health.aspx)
I've been dealing with problems well

<table>
<thead>
<tr>
<th></th>
<th>Age 65+</th>
<th>All age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>% diff</td>
<td>-1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

I've been thinking clearly

<table>
<thead>
<tr>
<th></th>
<th>Age 65+</th>
<th>All age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>% diff</td>
<td>0%</td>
<td>1%</td>
</tr>
</tbody>
</table>

I've been feeling close to other people

<table>
<thead>
<tr>
<th></th>
<th>Age 65+</th>
<th>All age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2%</td>
<td>7%</td>
</tr>
<tr>
<td>% diff</td>
<td>0%</td>
<td>1%</td>
</tr>
</tbody>
</table>

I've been able to make my mind up about things

<table>
<thead>
<tr>
<th></th>
<th>Age 65+</th>
<th>All age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>% diff</td>
<td>-1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Table 5: WEMWBS responses from the Living in Warwickshire Survey 2014, for those aged 65+ and for the population as a whole

4.2.3 Data limitations

The national and local data cited in this report is almost exclusively prevalence data (i.e. reporting on existing cases of loneliness and social isolation). The lack of available incidence data, which would allow identification of ‘new’ cases, indicates a data gap. The benefits of obtaining incidence data would include validating the risk factors analysis carried out so far and aid further understanding of the topic. This will be addressed in the action plan.

The ELSA goes some way to address this data gap by using its longitudinal design to identify new cases of loneliness and social isolation amongst its cohorts alongside identified risk factors.

4.2.4 The Index of Loneliness and Social Isolation

The index has allowed the identification of small areas of Warwickshire where individuals are at a higher than average risk of being lonely or socially isolated (see Maps 1 to 7).

The mapping suggests that there are higher numbers of households at an increased risk in urban areas, which is what would be expected given the higher density of housing in these areas. However, some more rural areas have been identified.

The following sections consist of brief analysis of the mapping; more detailed analysis is available in appendix 2.
Map 1: Number of households at risk of loneliness and social isolation, Warwickshire

Each square is 2.5km by 2.5km. The map shows the number of households at risk of loneliness in these areas.

Number of households at risk of loneliness and social isolation (all identified residents)

- Green: 1 - 200
- Light Green: 201 - 400
- Yellow: 401 - 600
- Light Orange: 601 - 800
- Orange: 801 - 1000
- Red: >1001

Warwickshire District / Borough Boundaries

We are happy for you to use these maps, but please adequately reference "Public Health Warwickshire". For more information, contact publichealthintelligence@warwickshire.gov.uk

Map 1: Number of households at risk of loneliness and social isolation, Warwickshire
Map 2: Percentage of households at risk of loneliness and social isolation, Warwickshire.
4.2.4.1 Warwickshire
Map 1 shows that, in terms of gross numbers, households at 'above average' (Level 1-2) or 'high' (Level 3-4) risk of loneliness and social isolation according to the Mosaic Types are clustered around the more densely populated urbanised areas of the county. The greatest number of households at risk of loneliness are located in Nuneaton and Rugby, with significant numbers also seen in Warwick, Leamington and Bedworth. There are also clusters in Stratford-on-Avon, Polesworth, Atherstone, Coleshill, Studley, Alcester, Kenilworth and Henley-in-Arden. The distribution is similar for those at above average risk and high risk.

Map 2, which demonstrates that households at risk as a percentage of the total number of households within an area again shows broadly the same sort of distribution, favouring the larger towns. It particularly highlights that the households at risk are far more concentrated in these areas than in other areas, suggesting that these areas are the ones most likely to benefit from intervention.

4.2.4.2 North Warwickshire
Map 3 for North Warwickshire Borough highlights a hotspot of households at risk of loneliness and social isolation in Atherstone South Mancetter Ward, where there is one small area in which 47-56% of households are at risk. The neighbouring areas of the Atherstone North and Atherstone Central Wards also appear as being high risk, although the percentage of households at risk in these areas is lower, ranging from 1-18% or 19-28%. There is also an area in the south-east of Arley and Whitacre Ward in which 38-46% of households are at risk of loneliness and social isolation, with some of the neighbouring areas in this ward containing households of which 1-18% are at risk.
Map 3: Number of households at risk of loneliness and social isolation, North Warwickshire

Each square is 2.5km by 2.5km. The map shows the number of households at risk of loneliness in these areas.

**Percentage of households ‘at risk’ of loneliness and social isolation (all identified residents) in North Warwickshire**

- **1% - 18%**
- **19% - 29%**
- **30% - 37%**
- **38% - 46%**
- **47% - 56%**

1. Newton Regis and Warton Ward
2. Polesworth East Ward
3. Polesworth West Ward
4. Baddesley and Grendon Ward
5. Dordon Ward
6. Atherstone North Ward
7. Atherstone Central Ward
8. Atherstone South Mancetter Ward
9. Hartshill Ward
10. Arley and Whitacre Ward
11. Fillongley Ward
12. Coleshill South Ward
13. Coleshill North Ward
14. Water Orton Ward
15. Curbworth Ward
16. Kingsbury Ward
17. Hurley and Wood End Ward

We are happy for you to use these maps, but please adequately reference ‘Public Health Warwickshire’. For more information, contact public.healthintelligence@warwickshire.gov.uk
4.2.4.3 Nuneaton and Bedworth Borough

There are several main areas of high risk of loneliness and social isolation in Nuneaton and Bedworth Borough (see map 4). In particular, there are two neighbouring areas where the percentage of households at risk is 47-56% which lie largely in the Camp Hill Ward but also overlap slightly into the Bar Pool and Galley Common Wards. There is also another high density area that straddles the Wards of Abbey, Wem Brook, Attleborough and St Nickolas. In addition, there are areas other areas within Abbey, Camp Hill, Bar Pool and Wem Brook Wards in which 38-46% of households are at risk. This large combined area all seems to fall in and the most densely populated area of the borough. Whilst it is unsurprising that Nuneaton Town and its immediate surroundings rank highly in terms of gross numbers of households at risk of loneliness and social isolation (given that it is the most densely populated area in the borough and therefore the areas highlighted will have a higher number of households within them than other areas), it is interesting to see that these areas remain as hotspots for risk of loneliness and social isolation when the proportion of households at risk within these areas is considered. One might have thought that living in a well-populated area with close access to amenities and public services might have reduced the risk, however this may not be the case or there may be other factors that outweigh this. There are numerous other areas throughout the borough that have areas containing households at risk of loneliness and social isolation ranging in proportion from 1-18% through to 29-37%.

4.2.4.4 Rugby Borough

The areas at highest risk of loneliness and social isolation in Rugby Borough are largely centred around the most densely populated area of the borough (see map 5). Most prominent is Benn Ward, which is largely taken up by an area in which 47-56% of households are at risk of loneliness and social isolation. There are two areas neighbouring on either side that lie partially within Benn Ward but also in New Bilton Ward to the west and Eastlands Ward to the east where the proportion of households at risk is 38-46%. Other wards in and immediately surrounding Rugby mostly contain areas where 1-18% of households are at risk of loneliness and social isolation, with a few areas where 19-28% of households are at risk. These wards include Newbold and Brownsover Ward, Coton and Boughton Ward, Rokeby and Overslade Ward, Bilton Ward, Paddox Ward, Hillmorton Ward, Admirals and Cawston Ward and Wolston and the Lawfords Ward. Wolston and the Lawfords Ward also contains two neighbouring areas further to the west in which 1-18% of households are at risk of loneliness and social isolation, and Dunsmore Ward, to the south, also contains one such area. Once again, the main areas at risk of loneliness and social isolation are within the most urbanised parts of the borough.
Map 4: Number of households at risk of loneliness and social isolation, Nuneaton and Bedworth
Each square is 2.5km by 2.5km. The map shows the percentage of households at risk of loneliness in these areas.

**Percentage of households at risk of loneliness and social isolation (all identified residents) in Rugby**

- **1% - 18%**
- **19% - 28%**
- **29% - 37%**
- **38% - 46%**
- **47% - 56%**

1. Wolvey and Shilton Ward
2. Revel and Binley Woods Ward
3. Clifton, Newton and Churchover Ward
4. Coton and Boughton Ward
5. Hillmorton Ward
6. Paddock Ward
7. Eastlands Ward
8. Benn Ward
9. Newbold and Brownsover Ward
10. New Bilton Ward
11. Rokeby and Overslade Ward
12. Bilton Ward
13. Leam Valley Ward
14. Dunsmore Ward
15. Admirals and Cawston Ward
16. Wolston and the Lawfords Ward

Map 5: Number of households at risk of loneliness and social isolation, Rugby
4.2.4.5 Stratford-on-Avon District
As shown in map 6, Stratford-on-Avon District contains the fewest areas containing households at risk of loneliness and social isolation of any of the boroughs in Warwickshire. This seems to be in keeping with the general pattern in that this borough is comprised of smaller towns and villages compared to other boroughs, where risk of loneliness and social isolations is mainly centred around the larger towns. There are small areas of high risk in the towns of Stratford (Stratford Guild and Hathaway, Stratford Avenue and New Town Wards), Alcester (Kinwarton and Alcester Wards), Studley (Sambourne and Studley Wards) and Henley-in-Arden (Henley Ward) where 1-18% of households are at risk. There are other isolated areas throughout the borough containing households of which 1-18% of households are at risk; these are in Claverdon Ward, Bidford and Salford Ward, Wellesbourne Ward, Kineton Ward and Southam Ward. There are no areas in which the households are at the ‘higher risk’ of loneliness and social isolation. However, when compared to the other districts/boroughs, the identified areas are more spread out, indicating a more disparate population which could present challenges for interventions.

4.2.4.6 Warwick District
The risk of loneliness and social isolation Warwick District (see map 7) lies in and around the town areas of Warwick and Leamington Spa, which once again are the more densely populated areas of the district. There are areas in which 1-18% of households are at risk in Clarendon, Crown, Manor, Milverton, Willes, Brunswick, Warwick South, Warwick West and Warwick North Wards. All of these lie either in or close to the towns of Warwick and Leamington Spa. There are also neighbouring areas slightly towards the east of Leamington Spa where there is a slightly higher risk of loneliness and social isolation, with 19-28% of households being at risk. In addition, there is also an area in Bishop’s Tachbrook Ward where 1-18% of households are at risk, along with another area in Park Hill Ward that overlaps slightly into Abbey Ward (this area lies in the town of Kenilworth). Finally, there are neighbouring areas in the north part of Stoneleigh Ward that represent a section of the southern border of Coventry with Warwickshire where 1-18% of households are at risk of loneliness and social isolation.
Map 6: Number of households at risk of loneliness and social isolation, Stratford-on-Avon

Each square is 2.5km by 2.5km. The map shows the percentage of households at risk of loneliness in these areas.

Percentage of households at risk of loneliness and social isolation (all identified residents) in Stratford-on-Avon

1% - 16%
19% - 28%
29% - 37%
38% - 46%
47% - 56%

1 Tanworth Ward
2 Sambourne Ward
3 Studley Ward
4 Henley Ward
5 Claverdon Ward
6 Aston Cantlow Ward
7 Kinwarton Ward
8 Acoaster Ward
9 Bidford and Salford Ward
10 Bardon Ward
11 Stratford Guild and Hathaway Ward
12 Stratford Avenue and New Town Ward
13 Snitterfield Ward
14 Stratford Alveston Ward
15 Welford Ward
16 Welford Ward
17 Quinton Ward
18 Ettington Ward
19 Wellesbourne Ward
20 Kinerton Ward
21 Harbury Ward
22 Southam Ward
23 Stockton and Napton Ward
24 Fenny Compton Ward
25 Burton Dassett Ward
26 Vale of the Red Horse Ward
27 Brailles Ward
28 Long Compton Ward
29 Shipston Ward
30 Tredington Ward

We are happy for you to use these maps, but please adequately reference “Public Health Warwickshire”. For more information, contact publichealth.intelligence@warwickshire.gov.uk
Each square is 2.5km by 2.5km. The map shows the percentage of households at risk of loneliness in these areas.

Percentage of households at risk of loneliness and social isolation (all identified residents) in Warwick

- 1% - 18%
- 19% - 28%
- 29% - 37%
- 38% - 46%
- 47% - 56%

1 Lapworth Ward
2 Leek Wootton Ward
3 Abbey Ward
4 St John's Ward
5 Park Hill Ward
6 Stoneleigh Ward
7 Cubbington Ward
8 Radford Semele Ward
9 Clarendon Ward
10 Crown Ward
11 Manor Ward
12 Milverton Ward
13 Willes Ward
14 Brunswick Ward
15 Whitnash Ward
16 Bishop's Tachbrook Ward
17 Warwick South Ward
18 Warwick West Ward
19 Warwick North Ward
20 Budbrooke Ward

Map 7: Number of households at risk of loneliness and social isolation, Warwick
4.3 Trends over time
Over the next 10 years, the number of people aged over 65 in England is expected to increase by 18%. This is reflective of the situation in Warwickshire, where the number of residents aged over 65 is projected to rise by 18% or approximately 25,400 people between 2015 to 2025\(^24\). This therefore suggests that the number of people experiencing loneliness and social isolation both locally and nationally will increase.

However, a 2005 study\(^20\) found that the proportion of people in the population who experience loneliness and social isolation has remained relatively unchanged over the last 60 years. The study examined the prevalence of self-reported loneliness amongst older people in Great Britain, and made comparisons with the findings of studies undertaken during the last five decades. Table 6 shows the variation in self-reported loneliness over time; the proportion experiencing loneliness ‘always/often’ showing little change.

<table>
<thead>
<tr>
<th></th>
<th>Sheldon 1948</th>
<th>Townsend 1954</th>
<th>Victor 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always/often</td>
<td>8</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Sometimes</td>
<td>13</td>
<td>25</td>
<td>32</td>
</tr>
<tr>
<td>Never</td>
<td>79</td>
<td>66</td>
<td>61</td>
</tr>
</tbody>
</table>

Table 6: Self-reported loneliness over time. Source: Victor et al, 2009

4.4 Interventions/Effective Interventions
Historically, the evidence base around interventions designed to tackle and/or prevent loneliness and social isolation has been relatively limited. This has meant that the effectiveness of many interventions has been questioned due to a lack of supporting evidence. For example, a 2003 study that considered interventions designed to tackle loneliness and social isolation. The results reveal that although numerous such interventions have been implemented worldwide, there was very little evidence to show that they work. It concluded that future intervention programmes aimed at reducing social isolation should have evaluation built into them at inception, and that the results of the evaluation studies, whether positive or negative, should be widely disseminated\(^25\).

However, over the past few years a number of reports and systematic reviews have been published which is helping to establish a bank of knowledge around what works in tackling loneliness and social isolation. The commentary that follows in this section focuses on the effectiveness and cost-effectiveness of services aimed at preventing loneliness and social isolation.

Prevention is broadly defined to include a wide range of services that:

- promote independence
- prevent or delay the deterioration of wellbeing resulting from ageing, illness or disability
- delay the need for more costly and intensive services.
Preventive services represent a continuum of support ranging from the most intensive, 'tertiary services' such as intermediate care or reablement, down to 'secondary' or early intervention, and finally, 'primary prevention' aimed at promoting wellbeing. Primary prevention is generally designed for people with few social care needs or symptoms of illness. The focus therefore is on maintaining independence and good health and promoting wellbeing. The range of these 'wellbeing' interventions includes activities to reduce social isolation, practical help with tasks like shopping or gardening, healthy living advice, intergenerational activities and transport, and other ways of helping people get out and about. All of these interventions can help alleviate loneliness and social isolation.

Loneliness and social isolation are complex issues and practical steps to tackle the problem need to be taken at different levels:

- **Strategic** level across the authority;
- **Neighbourhood** action; and
- **Individual** intervention.

Marmot suggested four pathways which reflect the levels at which it is suggested loneliness and social isolation be tackled at\(^3\). These four pathways suggest the interventions and policies that could reduce social isolation and exclusion:

1. Firstly, identifying the population at risk requires better information from communities. In theory this can lead to health improvements and reduced health inequalities through an increased uptake of more effective services, particularly preventative services, and/or more effective interventions. **Neighbourhood**.

2. Second, improving governance and guardianship and promoting and supporting communities to participate in directing and controlling local services and/or interventions. This will help to improve the appropriateness and accessibility of services and interventions, increase uptake and effectiveness and influence health outcomes. **Strategic**.

3. A third way to reduce social isolation is to develop social capital by enhancing community empowerment. This helps to develop relationships of trust, reciprocity and exchange within communities, strengthening social capital. **Neighbourhood**.

4. Lastly, increasing control and community empowerment may result in communities acting to change their social, material and political environments. Including communities and individuals in designing interventions to address social isolation will help improve their effectiveness. **Individual**.

### 4.4.1 Effectiveness of Interventions

A wide variety of interventions can be and are being used to tackle loneliness and social isolation. These can be grouped according to the levels mentioned above. In the following section, interventions are assessed according to their effectiveness in reducing loneliness, improving mental and physical health and wellbeing and reducing usage or demand on health services. Measuring interventions against these three factors presents challenges, as some interventions are found to be effective in addressing some issues but not others. For
example, the Washington Choir\textsuperscript{iii} was found to be effective in improving health outcomes and reducing falls, but was found to yield no statistically significant reduction in loneliness and social isolation\textsuperscript{26}.

Furthermore, there is a suggestion that some interventions may be delivering on their aims of reducing loneliness and social isolation, there is little robust evidence to demonstrate this. For example, a mentoring intervention cited in table 7, found that the intervention group had poorer outcomes. However, this could be due to biases introduced by a small sample size, the methods selected, a lack of randomisation and a lack of similar studies to compare against.

A further challenge in evaluating the effectiveness of interventions tackling loneliness and social isolation in older people is in collecting valid user feedback; few older people feel able to risk negative comment when they rely on a service\textsuperscript{26}.

In the subsequent sections, the following interventions are assessed:

- befriending
- volunteering
- mentoring
- navigators
- group schemes
- wider community engagement
- internet access
- informal interventions
- social prescribing

The following review of evidence is based largely on evidence around interventions designed to tackle loneliness and social isolation in older people, with a focus on studies conducted since 2000. Searches terms included ‘loneliness’, ‘social isolation’, ‘interventions’ and ‘review’. Extensive usage was made of the SCIE research briefing\textsuperscript{26}, as well as a rapid evidence review carried out by the Liverpool Public Health Observatory\textsuperscript{27} and the Essex County Council JSNA special topic paper\textsuperscript{28} on loneliness and social isolation.

\textsuperscript{iii} A group activity focused toward wider community engagement
### 4.4.1.2 Evaluation of specific interventions

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Description</th>
<th>Level</th>
<th>Evidence/evaluation</th>
<th>Case Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Befriending Schemes</td>
<td>An intervention that introduces the client to one or more individuals, whose main aim is to provide the client with additional social support through the development of an affirming, emotion-focused relationship over time. It can offer support during transitional periods in a person’s life including, leaving hospital after an illness or periods of mental or physical ill-health, including long term conditions. Befriending is an activity which involves the development of relationships in which one individual, usually a trained volunteer gives time to provide informal support and encouragement to another. Befriending can be used to maintain independence, promote good health and well-being, provide opportunities to engage in social activities, increase social networks and provide people with information about other services and support available.</td>
<td>Individual</td>
<td>Befriending can help complement and enhance the practical support provided by existing reablement services by helping to ensure that all individuals have meaningful social ties, participate in activities and are able to access social networks for additional support and information. This is particularly important for those with existing mental health and wellbeing issues. In a report on commissioning of Befriending Services by the Association of Directors of Adult Social Services it was concluded that investment in befriending services as part of a wider package of integrated social care can help commissioners address the social needs of vulnerable individuals living within local communities who may be susceptible to the negative impacts of social isolation. Evaluation of a national befriending scheme considered the impact of telephone-based befriending services on older people’s health and wellbeing. It concluded that these schemes provide a low-cost means for socially isolated people to become more confident and independent and develop a sense of self-respect.</td>
<td>“Only the Lonely” Project&lt;sup&gt;32&lt;/sup&gt; In 2013, Trinity College Dublin set up a visiting scheme for older people living alone in Ireland, to try and better understand how to alleviate loneliness. The scheme consisted of 10 home visits from a volunteer, who themselves was older or retired, who supported the participants to join a new activity or make a new social connection. They then evaluated the impact of the scheme on the older people and the volunteers who took part with a Randomised Control Trial. Three months after the scheme finished, those who had taken part were less lonely than those who hadn’t. 30 of the participants said they had made a new social connection since the start of the scheme. 25 people still received visits from their volunteer, and 7 people had been referred to a local befriending. The research found that the scheme was low-cost and effective. Read more about the befriending scheme in Campaign to End Loneliness Research Bulletin 12 <a href="#">here</a>.</td>
</tr>
<tr>
<td>One-to-one Befriending</td>
<td>Provides face-to-face contact to those who have become, or are at risk of becoming socially isolated. One-to-one befriending can play a preventative role in helping those at risk to create new or sustain existing social links, access local services and facilities, meet like-minded people through clubs and groups and meet people with similar needs to provide</td>
<td>Individual</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Telephone Befriending | Provides regular one-to-one or social group support to a service user or group of users in their own home via a telephone link. | Individual | Further research determined that outcomes of befriending schemes are positive and supported the case for more befriending services, particularly in those with personal budgets. It also suggested that such services can lead to cost saving benefits for the NHS through early intervention and prevention of complicated health issues.  
A systematic review on the effectiveness of befriending found improvements in wellbeing outcomes including a reduction in depression, finding that befriending had a modest but significant effect on depressive symptoms in the short and long term when compared with usual care or no treatment. Individuals involved in befriending interventions reported that they felt less depressed following the intervention. However, the statistical significance of the change did not meet National Institute for Health and Clinical Excellence (NICE) guidelines. Nevertheless, as the authors argue, these ‘effect sizes of befriending in the short and longer term are not substantively different to those associated with conventional treatments in primary care such as collaborative care and counselling’. |
| Silver Line Friends | The Silver Line is a national helpline and befriending service for older people, offering information, and someone to talk to on a 24/7 basis. Alongside their helpline, they run a befriending scheme called Silver Line Friends where volunteers call an older person once a week and sometimes exchange letters. They aim to match older people to like-minded volunteers.  
The Silver Line was initially piloted in November 2012 in the North West of England and the Isle of Man and evaluated by the Centre for Social Justice. A number of outcomes started to emerge three months after the helpline and telephone befriending service was launched. They found that 24% of callers got in touch because they wanted a Silver Line Friend and a further 12% phoned to speak about general loneliness and health. |
<p>| Group Befriending | Provides individuals with a shared interest or similar concern, the opportunity to meet with each other on a regular basis in an informal environment. Group befriending is often facilitated by volunteers and usually takes place on a weekly basis. It also provides an environment where new friendships can be established outside of the group. | Individual | The West End Befrienders Care Homes project concluded that group befriending was as valuable as individual befriending in a care home setting, in a qualitative review. Group befriending was thought to tackle many of the issues associated with loneliness and social isolation, improving the lives of older people. |</p>
<table>
<thead>
<tr>
<th>Inter-generational Befriending</th>
<th>Brings older and younger people together to share a two-way learning experience by building trust and respect between generations. Intergenerational activities can often create opportunities for older members of a community to remain physically active and emotionally stimulated through active participation.</th>
<th>Individual</th>
<th>information or health needs assessment. This suggests that effectiveness of home visiting and befriending schemes remains unclear.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volunteering</td>
<td>Volunteering is a form of participation and an important part of the social fabric in England, occurring across most of the wider determinants of health including: sport and exercise, education, justice, arts and culture, children and young people, older people, neighbourhood and citizens groups, conservation, environment and heritage, as well as health and care.</td>
<td>Individual Community</td>
<td>National Institute for Health and Care Excellence (NICE) guidance endorses community engagement as a strategy for health improvement. There is a substantial body of evidence on community participation and empowerment and on the health benefits of volunteering. Cost-effectiveness evidence is still limited; nevertheless research indicates that community capacity building and volunteering bring a positive return on investment. Experimental and cohort studies show participation in volunteering is strongly associated with better health, lower mortality, better functioning, life satisfaction and decrease in depression. For volunteers, outcomes include increased knowledge and awareness, skills, self-confidence, quality of life and improved mental health. Volunteering in a health role can also be a pathway to education, employment or other volunteer roles. Outcomes for recipients depend on</td>
</tr>
</tbody>
</table>
| Touchstones – Yorkshire | Touchstones was set up to support bereaved older people to access and learn new practical skills for day-to-day living, and to provide opportunities for older people to get involved in their community through volunteering. Touchstones provided practical skills sessions across rural and small urban communities for bereaved older people provided by people in similar situations. The project set out to offer skills support to 200 beneficiaries over 18 months, delivered by 49 staff and volunteers. Over time 21 beneficiaries became volunteers for Touchstones, supporting skills sessions. Beneficiary feedback showed:  

- 91 per cent felt more involved or connected with their community as a result of Touchstones;  
- 86 per cent felt they now had more confidence to get out and meet people. |
focus of intervention but can include health behaviour change, increased social support, improved access to services and better management of health conditions. Service outcomes can include better reach and uptake, increased workforce capacity and changes in service use.

Analysis of the European Social Survey shows a weak but significant association between participation in civil society through voluntary groups and quality of life, in terms of better physical and emotional health, increased wellbeing, self-confidence, self-esteem and social relationships.

However, there are also some negative effects reported, including burnout with high time spent volunteering and stress from responsibilities; a review of volunteering, mental health and social exclusion found that volunteering does not ‘guarantee’ social inclusion.

| Mentoring | Mentors are trained volunteers working with individuals to achieve agreed goals. These goals are the primary focus and any social relationship if achieved is incidental to the process. A key element of this is to provide skills that will enable the mentee to sustain improvements achieved following removal of the support. | Individual/ Community | Two mentoring initiatives found divergent outcomes. A non-randomised observational study reported that improvements in individual depressive symptomology were maintained at 12 months follow-up. However, a case controlled trial exploring the same community mentoring intervention – working with socially isolated people for up to 12 weeks to restore older people’s self-confidence, self-esteem and social relationships, Case studies considered as part of a systematic review have indicated that for individuals with more severe health problems or disabilities there was a request for greater mentor support – a need for the mentor to be available longer than the 12-week limit or to visit more often within the existing timeframe. Users also reported the importance of a ‘skilled’ mentor. If mentors were unable to encourage users in the ‘right way’, users felt disempowered and less |
| Community Navigators/ Wayfinders/ Village Agents | identity – found there were no robust improvements in depressive symptoms, physical health, social activities, social support or morbidity. This same trial reported that the intervention group demonstrated poorer outcomes, reporting significantly less improvement in health status than the control group. However, users of a short-term mentoring outreach service reported that they had increased their social interaction and community involvement, taking up or going back to hobbies or wider community activities. They also said that their self-esteem had improved and that they felt physically and mentally better. They had increased their physical activity, were sleeping better and had reduced their medication.

Confident, feeling ‘blamed’ for their lack of progress. A final barrier to full use of interventions was that of transport. Users reported that lack of available transport limited those activities that could be attended or any meetings with each other outside the intervention. To overcome these difficulties, some pilot programmes provided transport to the venue by minibus. Unfortunately, it is likely that cost would prohibit such arrangements if an intervention was rolled out across a wider locality.

| Participants in ‘community navigator’ schemes are usually volunteers who provide ‘hard to reach’ or vulnerable individuals with emotional, practical and social support. They can act as ‘navigators’ or an interface between the community and public services, facilitating access to services. Depending on the dependency or frailty of the individual seeking support this can either be by face-to-face visit or through telephone support.

The Village Agents provide a face-to-face signposting and outreach service for rural residents. The agents put people in direct contact with representatives or agencies. | Community People who have used Befriending or Community Navigator services have reported that they were less lonely and socially isolated.

| Springboard, Cheshire combines the twin assets of sophisticated data on the local population and a trusted brand to reach isolated and vulnerable older people in their own homes. Springboard is a partnership between Age UK Cheshire and Cheshire Fire and Rescue Services (CFRS), which delivers targeted home visits to adults throughout the county. It pools the resources of CFRS dedicated to improving home safety with support from both local councils’ adult social care directorates. Key outcomes include:

- increase in the number of older... |
who are able to provide appropriate help, advice and support. This service is particularly helpful for those isolated due to disability or public transport issues.

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**Group Schemes/Services**

Supportive interventions that fall within group services include day centre-type services (such as lunch clubs), and social group schemes which aim to help people widen their social circles.

The number and extent of services and schemes is broad. Those interventions within ‘social group schemes’ incorporate self-help and self-support groups that cover a number of areas (e.g. bereavement, friendship, creative and social activities, health promotion). Their structure and way of working depend on

**Community**

Where longitudinal studies recorded survival rates, older people who were part of a social group intervention had a greater chance of survival than those who had not received such a service. Users report high satisfaction with services benefiting from such interventions by increasing their social interaction and community involvement, taking up or going back to hobbies and participating in wider community activities.

Two systematic reviews identified

- **Men’s Sheds**[^36] is an effective mutual aid intervention, aimed at improving the wellbeing and social connectedness of men at risk of social isolation. A systematic review indicated that the beneficial effects of Men’s Sheds are likely to be mediated through reductions in social inclusion and isolation, with voluntary participation leading to the building of friendships, strengthening of social networks and providing a sense of purpose and identity[^38].

[^36]: Brendoncare, which runs 70 friendship

- **over £7.5 million in unclaimed benefits identified**
- **decrease in the number of accidental house fires or incidents**
- **increase in the number of people volunteering and helping other older people**
- **increase in the number of older people who now have some form of contact within their communities**
- **increase in referrals to healthy living resources, including falls prevention services.**
the needs of the population. For example, a group focused on social activities can be ‘open’ to all, while another wishing to build self-efficacy and independence for older socially isolated women would be restricted to specific individuals. Facilitation of groups can be peer-led or carried out by specialist staff within health and social care. This can also be referred to as following a ‘social network approach’.36

Facilitation of groups can be peer-led or carried out by specialist staff within health and social care. This can also be referred to as following a ‘social network approach’.36

closed self-help or support groups as effective in reducing loneliness and social isolation. The single studies provided helpful wider descriptions of the structures and processes of such groups, although differential outcomes were reported. A 12-week ‘closed’ group that aimed to develop ‘self-efficacy’ in terms of social integration, and focused each week on different topics relating to friendship, found no change in loneliness. Nevertheless, a further ‘closed’ model that included social group activities (‘art and inspiring activities’, ‘group exercise and discussion’ and ‘therapeutic writing and group therapy’) reported that 95% of the participants felt that their feelings of loneliness had been alleviated during the intervention.26

Evidence also suggests that involvement in group interventions can reduce usage of health services. Two studies reported decreased usage of GP, hospital bed days and outpatient appointments following group intervention.26

A 2005 systematic review found that nine of the 10 effective interventions (out of 31 included in the review) identified were group activities with educational or support input; thus, the review suggests that educational and social activity group interventions targeting specific groups can alleviate social isolation and loneliness among and wellbeing clubs for older people in the South of England, has used EQ-5D and a social return on investment approach (SROI) to demonstrate that people who have been members of its clubs for a longer period of time are in significantly better health that those who have only recently joined. It says that NICE would value the improvement in health as the equivalent of over £2m and suggests that for every £1 invested in the service, £1.40 in value is delivered back.39
| Schemes within this category are designed to support individuals to increase their participation in existing activities such as sport, libraries and museums from within their existing communities. This can also involve encouraging individuals to use and join outreach programmes. ‘Time Banks’ are also examples of community engagement at a local level whereby the type of support volunteers undertake depends on their own skills as well as the needs of the wider community. | Where longitudinal studies recorded survival rates, older people who were part of a social group intervention had a greater chance of survival than those who had not received such a service. Users report high satisfaction with services benefiting from such interventions by increasing their social interaction and community involvement, taking up or going back to hobbies and participating in wider community activities. It is clear from the various evaluations of schemes that there is a real need to be aware of existing community resources and to build community capacity. Schemes where older people have been involved in planning, implementation and evaluation have proved particularly effective; significantly strong partnership arrangements need to be in place between organisations to ensure that developed services can be maintained. | The Neighbourhood Approaches to Loneliness 3 year programme undertaken by Joseph Rowntree looks to find out what extent and in what ways different neighbourhoods and community activities can change a person’s experience of loneliness. Their scheme at Hartrigg Oaks is a retirement village enabling people aged 60 plus to remain independent and live life to the full in a “vibrant and socially active community”. It was reviewed in 2003 to understand what benefits of neighbourliness in communities had arisen from this closed community approach. Residents reported that neighbourliness of their community made a real difference to their lives. The report found that 83% of residents were very or quite satisfied with living there, and that they valued their social life and independence. The Craft Café, a programme run by Impact Arts in partnership with two housing associations, is designed to offer a safe, social and creative environment where older people can learn new skills, renew social networks, and reconnect with their communities. It is currently being piloted in Castlemilk and Govan in Glasgow. These are areas of multiple deprivation in which a high percentage of older tenants live alone and face exclusion from social and cultural life. |
An evaluation of the Craft Café has found that it reduces levels of anxiety and depression, encouraging participants to take greater notice of their health. As a result of participation they took more regular and vigorous exercise, reducing harmful behaviours (e.g. smoking, drinking, and poor diet) and also becoming more independent and more active in the community. The evaluation shows that overall the Craft Café pilots have created between £4.86 and £9.57 of social value for every pound of investment. Based on rigorous research and best assumptions, the report estimates a Social Return on Investment (SROI) of £8.27: £1\textsuperscript{39}.

**Internet Access and Training**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
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<tbody>
<tr>
<td>It has been argued that the Internet and social media may be part of the cause of loneliness but also part of the solution.</td>
<td>Individual</td>
</tr>
<tr>
<td>Generally the conclusion of studies undertaken has been that there is no empirical evidence that computer and/or internet usage impacts on loneliness, physical or psychological outcomes. There is, as yet, no conclusive empirical evidence that computer and/or internet usage impacts on loneliness, physical or psychological outcomes. Some evaluations, either singly reported or incorporated within systematic reviews, have argued that such interventions are effective in reducing loneliness. However, small samples and inadequate matching of comparison or control groups have led to unreliable outcomes. For example, in one study that provided computer and follow-up internet training to older</td>
<td></td>
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<tr>
<td>The Campaign to End Loneliness cite a number of technology-related interventions\textsuperscript{42}:</td>
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</tr>
<tr>
<td><strong>Internet Buttons</strong>: Created by We Are What We Do in partnership with Race Online 2012 and Age UK, this is a webtool that makes using the internet easier by creating an homepage of personalised buttons for chosen sites and services. In their own words: “9.2 million people in the UK alone are offline, and 6.4 million of them are over 65. Yet 90% of communication between 11-18 years olds is digital. Internet Buttons aims to overcome this growing divide.”</td>
<td></td>
</tr>
<tr>
<td><strong>FinerDay</strong>: Designed and run by the same creative people who run the excellent ‘Adopt a Care Home’ scheme, Finerday is an accessible family and</td>
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people the authors stated: "We cannot conclude that the reduction in loneliness observed among the participants could be attributed to the intervention." However, survey by AGE UK reported that over a quarter (28%) of people aged 65+ who admitted to feeling lonely said that keeping in contact with family and friends via the web helped relieve feelings of isolation. Despite this, only 46% of over 65's have internet connection.

Furthermore, a recent study found that Facebook use is only beneficial in terms of reducing peer-related loneliness over time if it is used with the intention of making new friends. A small scale study and a review reported that computer/internet usage helps to alleviate loneliness. The Policy Exchange has argued recently that loneliness among older people could be tackled by training more people to use the Internet, helping people to stay connected with friends and family.

A review conducted in 2010 by Independent Age and the Calouste Gulbenkian Foundation found that participants in a technology training initiative reported they benefited from greater social interaction the training itself provided.

<table>
<thead>
<tr>
<th>Informal</th>
<th>Includes neighbourliness and reciprocity that keep people engaged, with little</th>
<th>Individual/</th>
<th>There is inevitably a public bias towards professionally led</th>
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### Interventions

<table>
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<tr>
<th>Interventions</th>
<th>Community</th>
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<tbody>
<tr>
<td>intervention needed.</td>
<td>interventions, as many small successful community health projects operate ‘under the radar’ of formal evaluations.</td>
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</table>

**Social Prescribing**

Sometimes called community prescribing, this is a generic model that enables individuals presenting through primary healthcare to be signposted and connected to local organisations, groups and activities.

**Individual/Community Outcomes**

- Reduced social isolation
- Increased social connectedness
- Increased knowledge and awareness of health issues
- Changes in health behaviours
- Better access to services

**Social Prescribing in Yorkshire and the Humber** – partnership working between primary care and the voluntary sector. Older people reported improvements in emotional wellbeing following participation in the social prescribing pilot. More information is available [here](#).

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**Table 7: Interventions aimed at tackling Loneliness and Social Isolation: description, evaluation and case studies**
4.4.1.1 Summary of research

As shown in table 7, the evidence around interventions aimed at tackling loneliness and social isolation is mixed, even at specific intervention level.

- The evidence around befriending services is particularly mixed; whilst some users reported feeling less lonely and socially isolated following usage of the service, one systematic review concluded that the effectiveness of such in terms of impact on wellbeing was unclear;
- People who use Community Navigator services reported that they were less lonely and socially isolated following the intervention;
- The outcomes from evaluating mentoring services is less clear; one study reported improvements in mental and physical health, another that no difference was found;
- Where longitudinal studies recorded survival rates, older people who were part of a social group intervention had a greater chance of survival than those who had not received such a service; the evidence also suggests that usage of social group interventions also yields positive results in terms of lessening demand on services. Furthermore, users report high satisfaction with group services, benefiting from such interventions by increasing their social interaction and community involvement, taking up or going back to hobbies and participating in wider community activities;
- There is limited evidence to support that increasing access to the internet can reduce loneliness and social isolation, although some small scale studies and think tanks have suggested that internet usage and training can in fact ameliorate loneliness;
- Volunteering is shown to positively impact on loneliness and social isolation. However, cautions are around avoiding participant burnout, stress and also around the cost-effectiveness of setting up and implementing volunteering;
- Unsurprisingly, there is very limited evidence around informal interventions; however this does not mean that they are not effective;
- Social prescribing has been found to result in outcomes including reduced loneliness and social isolation – although the socially prescribed services must be tailored to this purpose.

4.4.1.3 Implications from the evidence

Having a range of interventions available is useful, as it means that they can be targeted to the characteristics of an individual. However, the wide variety of interventions and their different outcome measures make it difficult to be certain what will work for each individual.

There is some evidence that group interventions (e.g. self-help groups) are more effective than one-to-one support (e.g. telephone befriending services). Nevertheless, when individual studies are explored, there are differential outcomes: some group activities have no impact, whilst there are specific one-to-one interventions that are seemingly effective. Furthermore, more recent reviews have been more positive in terms of their findings about the effectiveness of one-to-one interventions.
Effective and favourable interventions tend to be:

- Either group interventions with an education focus or provide targeted support activities;
- Targeted towards specific groups, such as women, care-givers, the widowed, the physically inactive, or people with serious mental health problems. For example, in general lonely men are best engaged through specific activities related to long-standing interests, such as sport or gardening, and respond less well to loosely-defined social gatherings, which are of more interest to women.
- Flexible and adaptable. One-to-one services could be more flexible, while enjoyment of group activities would be greater if these could be tailored to users’ preferences;
- Involving partners: when planning services to reduce social isolation or loneliness, strong partnership arrangements need to be in place between organisations to ensure developed services can be sustained. This includes a focus on partnerships between health and social care statutory organisations, and the voluntary sector. Key facilitatory actions could include appropriate tendering and longer-term funding;
- Another issue to be aware of is that loneliness and isolation may also require different responses. Older people experiencing isolation may require practical support such as the provision of transport. Older people experiencing loneliness may require social support;
- Involving users in the planning, implementation and evaluation of programmes improves outcomes and ensures that services are matched with needs;
- In the planning stage of any service or intervention, there should be an awareness of the existing community resources in order to build on community capacity.

Ineffective interventions tended to be those offered on a one-to-one basis, conducted in people’s own homes. Four studies consisted of home visiting schemes, the fifth offered social support by telephone.

4.4.1.4 Evaluation
Evaluating the impact of services is important to:

- demonstrate impact on target areas
- help identify and disseminate good practice
- justify any additional investment needed

A measurement strategy should put in place for any activity, to ensure that relevant data are captured from the outset. However, it’s also important to consider wider implications and unintended outcomes.

Public Health Warwickshire have two preferred methods of evaluation for projects tackling loneliness and social isolation, as outlined in table 8.
Companionship Scale

The Companionship Scale has been developed by Health Psychologists from the Coventry University, alongside support from Public Health Warwickshire, and is designed to measure the level of loneliness and social isolation that a person feels at the time they fill it in. It can be used by anyone of any age. It is a short scale designed to be quick and easy to use.

By inviting people to complete this questionnaire we can demonstrate in a reliable way the impact that a service has had on an individual’s experience of loneliness and social isolation. The information can also be used to develop services further if we know that some people still feel socially isolated and lonely after using the service.

Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)

The Warwick-Edinburgh Mental Wellbeing (WEMWBS) scale was developed to enable the monitoring of mental wellbeing in the general population and the evaluation of projects, programmes and policies which aim to improve mental wellbeing.

WEMWBS is a 14 item scale with 5 response categories, summed to provide a single score ranging from 14-70. The items are all worded positively and cover both feeling and functioning aspects of mental wellbeing.

Table 8: Preferred evaluative methods for services aimed at tackling loneliness and social isolation

4.4.1.5 Issues to consider

- Different studies use different measures; some measure self-esteem, depression and social networks known to affect loneliness rather than loneliness per se.
- Self-selection may lead to recruitment of the ‘socially active lonely’, rather than the ‘socially isolated lonely’.
- People may be reluctant to report feelings of loneliness due to the attached stigma. Therefore there may be a significant under reporting at play.
- Lack of evidence for the consideration of different types of loneliness across the lifespan – e.g adolescence, when children leave home, chronic illness and following bereavement.

4.5 Value for money assessment

Of particular importance during this time of economic restraint, it is important for local authorities and the NHS to obtain both economic and social value from the services that they commission and deliver. This means moving away from traditional ways of looking at value as being purely financial, with a lack of regard to what communities can contribute to services. Ensuring community involvement can lead to more sustainable, relevant and equitable usage of resources. However, it must be noted that such community participation is not free; training, volunteer coordination, project management and set-up costs are all legitimate costs and so must be factored in when planning any community engagement activities. On the other hand, there is already a wide range of community engagement
activity already in existence in Warwickshire, so there would be minimal (if any) cost to linking in with this.

There is limited evaluation or research that includes an analysis of cost-effectiveness of interventions designed to tackle loneliness and social isolation. However, some smaller studies have investigated the financial aspects of interventions designed to tackle loneliness and social isolation:

- There is evidence to suggest that an £80 investment in befriending services would provide £35 in savings, which would continue in subsequent years. When factoring in quality of life improvements through reductions in wellbeing aspects such as depression, the savings could reach £300 per year in terms of reduced need for treatment and quality of life improvements;

- Economic benefits from Community Navigators would seem to be greater. It is estimated that the intervention cost per person would be a little under £300. When additional costs such as a visit to a Citizen’s Advice Bureau or Job Centre Plus, the total cost would be £480 per person per year. However, it is estimated that the economic benefits (e.g. move into employment, fewer services used) would amount to approximately £900 in the first year in terms of employment and reduced demand on services;

- In relation to those taking part in group activity interventions, in one study, the total cost of health service use (hospital bed days, physician visits and outpatient appointments) was £1,117 per person per year in the intervention group, compared with £1,809 in the control group. This statistically significant difference between the groups of £692 was greater by £45 than the costs of the intervention – £647 per person.

- Evidence around the cost-effectiveness of community engagement interventions, whilst limited, does suggest that cost benefits can be yielded. Again, robust evaluation of such is challenging; For example, volunteer and peer health programmes may see a proportion of volunteers gain paid employment, which generates savings to the public purse but may not be picked up in an evaluation about health behaviours. Using 2011 figures, the Cabinet Office calculated the monetary value of volunteering to the wellbeing of the volunteers as £13,500 per person per year.

- Currently there is considerable interest in developing practical methods to estimate the return on investment of community and volunteer programmes. The London School of Economics undertook an economic analysis of community capacity building using three interventions: time banking, community navigators and befriending. All three were found to deliver a net economic benefit when costs and value were calculated. For example, time banking had an estimated net value of £667 per person per year, extending to £1,312 if improvements in quality of life were included in the analysis.

- Using social return on investment (SROI) methodology, an analysis of community development in local authorities reported a return of £2.16 for each pound invested, and the value of volunteers running activities was almost £6 to a pound invested to employ a community development worker. York Economics consortium carried out
an SROI on individual case studies from ‘Altogether Better’ health champion projects and found that overall, and based a number of assumptions, there was a positive return on investment but with large variability from £0.78 to £111 per pound invested. Similar results about the positive return on investment have been found in other volunteer prevention programmes.

This recognises that whilst some types of intervention can be costly in the first instance, the cost of not investing in local provision, that can help improve health and wellbeing outcomes for local populations, could be much higher for health and social care services in the long term.

Case Study: The Economic Case for Intervention in Essex

In Essex, the 5 PCTs and 3 local authorities spent just under £1 billion on health and social care for people over 65 in 2009/10. The combined health and social care spend per PCT patch on people over the age of 65 ranged between £2,817 and £3,364 per person per annum (a 16% variance). This combined spend is net of client contributions in social care and self-funders in the residential and nursing home sector. The research indicates that some of the factors underpinning this spend are exacerbated by issues arising from loneliness and social isolation. However there is limited cost benefit analysis available to accurately identify returns on investment arising from interventions directly targeted at loneliness and social isolation.

West Cheshire and Chester Whole Community Budget Pilot

It is suggested that at least 25% of older people in an emergency hospital bed do not need to be there, and that there could be 15% fewer placements to long-term care if adequate alternative provision and a ‘whole system’ approach was in place. It is argued that continuing to work within current arrangements is not sustainable and that there are significant economic and quality of care advantages that can be realised by moving to a more innovative base of solutions which actively seek to reduce the numbers of hospital non-elective bed use. They suggest that by adopting new approaches non-elective bed use could drop by as much as 30%. Currently, this proposal is not fully evidence based, and the need for partners to build this portfolio of evidence is identified as a key activity. However as an illustration, their business case for change indicates that "to a further net efficiency of £3.94m and £1.99m respectively achievable by the close of 2017/18".

Although not directly suggesting that such savings would be solely as a result of resolving social isolation and loneliness the core actions proposed to achieve these include:

- a targeted approach to identifying older people at risk
- building a community capacity response that will enable mutual support
- develop a model to link older people to their communities and service providers through local area co-ordination developing an information strategy that facilitates older people and their carers to manage their own care.

The linking of these elements with the potential cost savings and reflecting on previous research findings around the correlations between loneliness, social isolation, ill health and hospitalisation gives a strong indication of the way thinking is developing both for economic efficiency and delivering quality service outcomes.
5.0 Supply: the services available

5.1 What services are there?

5.1.1 Warwickshire County Council Commissioned Services

A number of services are commissioned by Warwickshire County Council which seek to address loneliness and social isolation, see table 9:

<table>
<thead>
<tr>
<th>Service</th>
<th>Details</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Befriending and Community Support Service</td>
<td>For individuals with a mental health diagnosis, aged over 55.</td>
<td>Warwickshire</td>
</tr>
<tr>
<td>Dementia Befriending Pilot</td>
<td>For individuals who have a diagnosis of dementia or who are seeking a diagnosis, any age, living in Rugby. A pilot project until September 2015.</td>
<td>Rugby</td>
</tr>
</tbody>
</table>

Table 9: Services commissioned by Warwickshire County Council to tackle loneliness and social isolation

5.1.2 Services provided across the county

There are many services, projects and initiatives across Warwickshire that address (either directly or indirectly) loneliness and social isolation. These can be specific e.g. befriending services or indirect e.g. book clubs.

The identification and mapping all of these services will be considerably time and resource intensive and is therefore being addressed as part of an organisation-wide workstream around information and advice.

5.2 Consultation

5.1 Context

No consultation was carried out specifically for this needs assessment. First of all, this was due to restraints on resources. Furthermore, Public Health Warwickshire carried out stakeholder consultation in 2014 around loneliness and social isolation, and Stratford District Council ran focus a series of focus groups on the topic in 2015. It was therefore decided that carrying out further consultation would have limited benefit. The findings of the two previously mentioned consultation events are summarised in the following sections.

5.2 Public Health Stakeholder Event

5.2.1 Context

Professionals from Warwickshire County Council (Public Health and Localities and Communities) and Warwickshire CCGs came together to discuss a plan of action to begin to tackle the growing problem of loneliness and social isolation. It was decided to hold an event to bring together key stakeholders to discuss the issue of loneliness and social isolation in Warwickshire and possible interventions. Over 50 delegates attended the event from a variety of different statutory, community and voluntary organisations. Two 50 minute workshops were held and delegates were asked to debate the following:

- What are your experiences of working with people who are socially isolated and lonely?
• What interventions are in place locally to tackle this issue?
• What more can we do to tackle social isolation and loneliness?
• What more can your individual organisations do?

5.2.2 Summary of findings

5.2.3 What are your experiences of working with people who are socially isolated and lonely?

• Loneliness is not specific to age, it can affect people from all age groups
• Older people tend to take political focus.
• Loneliness and social isolation can lead to an increase in smoking and alcohol use
• A young mother who was fearful of ASB/crime in local area felt isolated as she felt she could not speak to anyone about how she felt.
• An older person who had recently been discharged from hospital lost their ability to feed themselves. They had also lost their partner. This individual experienced feelings of loneliness and social isolation.
• Isolation within different communities e.g. African community with HIV, Dementia within Punjabi community and young people overusing technology.
• Socially isolated and lonely people will often not ‘present’ to services or ask for help or they will present with an initial problem/issue but the underlying issue is actually loneliness/social isolation.
• Socially isolated and lonely people used to access services that are no longer there e.g. day centres. Consequently, they are turning up at other services e.g. housing offices, who are not equipped to deal with this issue.
• People don’t always want to admit that they are lonely or socially isolated because of the stigma attached to this condition.
• Physical health needs are addressed but social/emotional needs are not.
• Transition between stages in life seems to be a key stage when people can be susceptible to loneliness/isolation e.g. recently bereaved, leaving school, retirement.
• Key population groups:
  o Carers
  o Men
  o School Leavers
  o Young people living in chaotic homes
  o Care leavers (BME clear group)
  o Single parents
  o Unemployed
  o Bereaved
  o Retired
  o Veterans/people leaving the forces/’war widows’
• People who are lonely and isolated often have multiple support needs, most of which are outside of the officer’s skill set
• There is frustration that there is no clear referral system to get extra help / support for people who are lonely or isolated.
• Closure of day centres has had an impact on levels of social isolation and loneliness.
### 5.2.4 What interventions are place locally to tackle this issue?

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coventry &amp; Warwickshire MIND</strong></td>
<td>Carers support - Pub lunch group for carers; Rugby Carers Support Group; Dementia befriending. Wellbeing Hub – drop-in/cafè and outreach work. Based on 5 ways to wellbeing and deals with people who are suffering from low level anxiety and depression Day services for people with dementia – role in extending time before need for acute care.</td>
</tr>
<tr>
<td><strong>Stroke Association</strong></td>
<td>Working with stroke survivors discharged from the 3 acute hospitals in Warwickshire for up to 1 year – CCG funded.</td>
</tr>
<tr>
<td><strong>Bilton Community Association</strong></td>
<td>IT group in Bilton funded by Rugby Borough Council.</td>
</tr>
<tr>
<td><strong>Warwickshire Race Equality Partnership</strong></td>
<td>Women only Zumba class.</td>
</tr>
<tr>
<td><strong>Barnardos</strong></td>
<td>Any child with a Social Worker (usually in foster or residential care) receives a Befriending/independent visiting service.</td>
</tr>
<tr>
<td><strong>Citizen’s Advice Bureau</strong></td>
<td>Reach Out &amp; Help Project - Stratford Town based, door-to-door leaflet drop then follow up door knocking service. Frontline Workers Toolkit – information on sources of support across Stratford District.</td>
</tr>
<tr>
<td><strong>Youth Council</strong></td>
<td>Bullying and anti-bullying campaigns “Put up Stop”.</td>
</tr>
<tr>
<td><strong>CAVA</strong></td>
<td>CAVA, CCG (Rugby) and Rugby Volunteer Centre funds a Social Prescribing Project. Directory of services for Mental Health Services sent to GPs.</td>
</tr>
<tr>
<td><strong>Warwickshire Rural Community Council</strong></td>
<td>WCAVA – operate a volunteer car scheme for health and social care appointments in Rugby Beeline Community Transport who are a registered charity in North Warwickshire and provide a volunteer car scheme for medical appointments only Volunteer Centre Nuneaton and Bedworth who operate a community minibus scheme, assisted shopping service and a volunteer car scheme for medical appointments Voluntary Action Stratford-on-Avon District operate a large volunteer car scheme for health and social care appointments and coordinate Community Links transport scheme for social activities.</td>
</tr>
<tr>
<td><strong>Master Gardeners</strong></td>
<td>New phase – focussing on isolation and loneliness</td>
</tr>
<tr>
<td><strong>Terence Higgins Trust</strong></td>
<td>Work to help people living with HIV/AIDs Lots of examples of particular groups within this community feeling lonely and isolated e.g. LGBT</td>
</tr>
<tr>
<td><strong>New Ideas Advocacy</strong></td>
<td>Integrated youth project for 19-25 year olds; Men’s and women’s wellbeing group; Mum’s group (learning disability); Lack of friends – making people vulnerable.</td>
</tr>
<tr>
<td><strong>Community Arts</strong></td>
<td>Group art projects Positive feedback – attending the groups has helped prevent negative outcomes e.g. “I’ve stopped having panic attacks”, “I would be drinking at home if I wasn’t here” Intergenerational work has been successful People seem to get on better when groups are mixed e.g. not just having a group for older people.</td>
</tr>
</tbody>
</table>
Age UK provides a Befriending Service for vulnerable, isolated older people. Sometimes the volunteers are also lonely so the scheme is helpful for users and volunteers.

Royal British Legion
Comradeship – refers to Befriending Services, Age UK, Silverline
RBL identifies widows at funerals and offers support.

Trading Standards
Offer support to victims who have been preyed upon by unscrupulous traders – evidence of a “suckers list” (people who are more likely to be deceived)
Truecall device – device that screens for unwanted phone calls. Lonely/isolated people are particularly susceptible to these calls as it is human contact.

Nuneaton and Bedworth
Stockington Community Centre – Tea and Chat
Camphill – coach trip, lunch club, young people’s holiday scheme

Rugby
Rugby Area Volunteer Group - Healthy Living Walk

Stratford on Avon
Earlswood Lunch Club; Buzz Café; Parenting Project; Befriending Project; Men in Sheds

Warwick
Radio Abbey Community Radio Station

North Warwickshire
Kingsbury Methodist Community – Outreach Group which provides outings for over 50s
Water Orton Library & Community Centre – collect and share people’s memories of Water Orton throughout the 20th Century

Other interventions
Volunteer opportunities – Using practical skills – gardening, wildlife conservation; Using social skills – village shop, community library, lunch clubs, coffee mornings
Timebank – neighbours offering an exchange of practical help, time rather than money
Promotion of Silverline phone service for older people
Community Safety Ambassador Scheme – ‘eyes and ears’ of Police and Crime Commissioner

5.2.5 What more can we/your organisation do to tackle social isolation and loneliness?

<table>
<thead>
<tr>
<th>Theme</th>
<th>Suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engagement</td>
<td>There needs to be more of an outreach focus.</td>
</tr>
<tr>
<td></td>
<td>Place leaflets in Pharmacies, GPs, Baby Clinics, Nursery/Schools, Libraries, Children’s Centres</td>
</tr>
<tr>
<td></td>
<td>Go into schools/colleges to raise awareness of issue and supply preventative information</td>
</tr>
<tr>
<td></td>
<td>Need to raise awareness of the issue</td>
</tr>
<tr>
<td></td>
<td>Improve understanding of social isolation and loneliness and the impacts</td>
</tr>
<tr>
<td></td>
<td>Upskill people to recognise signs/symptoms of social isolation and loneliness</td>
</tr>
<tr>
<td></td>
<td>Training about isolation/loneliness for all professionals</td>
</tr>
<tr>
<td></td>
<td>Move the issue higher up everyone’s agenda</td>
</tr>
<tr>
<td></td>
<td>Need to tackle the stigma around loneliness and isolation – make it more acceptable</td>
</tr>
</tbody>
</table>

| Services       | When working with lonely/isolated people, need to find what makes a person tick. The offer needs to be packaged as something ‘good’. One service does not suit all – needs to be tailored to the individual. |
|                | Targeting can be effective but people don’t necessarily want to be clumped together e.g. all older, Look after Children – need to experiment with mixed group |
Coffee Caravan Model / MIND Wellbeing Bus
Could be run like a roadshow on particular days
Could widen ages and keep community focus
Take the services to the community rather than them coming to the service
Develop a keyring scheme – ‘Circle of Support’ – regular contact, someone to go to if need help
More intergenerational activities e.g. “Adopt a granny”
More use of “Social Prescribing”
Upscale successful local projects and replicate across the county
More emphasis on ‘door knocking’ approach to community engagement
Build on local event programmes to appeal to wider community
Bromley-by-Bow model – replication
More use of Community Navigators

<table>
<thead>
<tr>
<th>Communities/groups of interest</th>
<th>Need to do more work with BME communities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Redesign ‘victims of crime’ pack to give more balanced support on aspects of health and wellbeing as well as personal safety</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Infrastructure</th>
<th>Need more transport</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Better transport to connect people</td>
</tr>
<tr>
<td></td>
<td>Services need to be set up in GP services so the GP can refer directly – Navigator model?</td>
</tr>
<tr>
<td></td>
<td>Use existing facilities – e.g. local community centres, village halls, churches, libraries</td>
</tr>
<tr>
<td></td>
<td>Commissioners need to be braver and take more risks</td>
</tr>
<tr>
<td></td>
<td>Robust evidence base around the impact of loneliness and isolation to supports bids for funding</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Workforce</th>
<th>All workers need up-to-date knowledge of local community services/groups e.g. local ‘London Underground’ map of services, to ensure that signposting to other agencies is as simple as possible</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Need more volunteers – how do we draw more volunteers in</td>
</tr>
<tr>
<td></td>
<td>Employ a person who can support voluntary sector to write a ‘bid’</td>
</tr>
</tbody>
</table>

5.3 Stratford District Council Focus Groups

5.3.1 Context
Research undertaken in 2013 on behalf of Stratford on Avon Social Inclusion Partnership suggested that the area of Stratford Town has a high level of social isolation. In light of this, the Stratford on Avon District Council Social Inclusion Statement included actions around understanding the profile and identifying the issues of older residents and the impact of isolation, as well as using community feedback to help design service to reduce isolation.

To address this action a range of organisations and individuals who are likely to come into direct contact with older people in the area were invited to attend focus groups to discuss the issue of social isolation in Stratford Town. Below is a summary of the key themes of the discussions of the 3 groups.
5.3.2 Key findings

- The groups suggested that both men and women experience social isolation but it affects more women than men. The thoughts were that this is due to the fact men are less likely to admit they are isolated or ask for help.

- The groups fed back that it can affect any age group and is not defined by age but rather by circumstances. However there was a consensus that those aged 60+ are more likely to experience social isolation, particularly those who have reduced mobility or who have lost a partner.

- Carers, although having regular social contact were reported as having the potential to be isolated and lonely, as their social contact may not be meaningful for them.

- People can be socially isolated only at weekends or during the week depending on their circumstances and the activities they are aware of.

5.3.3 Identifying social isolation

Each focus group raised the point that everyone is an individual and the circumstances which may result in one person becoming socially isolated may not have the same consequences for another.

The way an individual may indicate their social isolation also varies with some being overly talkative when they get the chance and others withdrawing.

Social isolation effects people’s pride, they don’t like to admit they are lonely and have limited social contacts. An individual’s personality can affect their willingness to ‘get out there and join in’.

It is difficult to identify isolation objectively and only the Age UK Care Navigator Project & Prime 75+ Project stated that they complete questionnaires with clients referred to them in order to quantify their level of social isolation.

Often it is work and life experience which gives professionals, and others coming into contact with older people, a ‘gut feeling’ that someone is socially isolated. Visiting older people at home gives more of an idea of their circumstances and often means they are more relaxed and likely to open up.

Professionals and others who come into contact with older people may consider them to be socially isolated; although an individual them self may be content.

Other signs that older people may be socially isolated included caring responsibilities, chronic physical pain, reduced mobility, deafness, poor sight, no family locally, unkempt appearance, obesity, not eating properly, having stopped driving and over attendance at GP.

5.3.4 Services

The majority of people in the focus groups would signpost to local services they knew about, depending on the specific need of an individual – CAB, Dementia Cafés, Mind, WRAP, British Legion, SAAFA, Age UK, Shakespeare Hospice or bereavement counselling

Reasons given for not signposting included lack of awareness of appropriate activities, capacity and service waiting times, managing expectations and availability of appropriate services.
transport. People were aware of larger organisations – CAB, Mind, Age UK etc but not of the small local activities ‘just along the road’ provided by local churches and voluntary groups.

The importance of identifying what activity would engage an individual and breaking down any barriers to accessing that activity was cited. Barriers could include transport, confidence, finances, or awareness. Accessible and older people friendly venues were also cited as an important consideration in attending activities.

Where work capacity allowed, professionals would follow up a referral, but this is not always possible and if they discovered the individual did not access the service what then? It was recognised that an older person may not take up a referral or signposting advice through pride, fear of the consequences or lack of suitable transport to get there. They may feel they are not ready to access the service – e.g. someone recently diagnosed with dementia or newly widowed may need time to adjust to their change in circumstances before they feel ready to access support.

The role of befriending projects was acknowledged as key. However, over dependence on befrienders and volunteers was highlighted as an issue. Volunteers become family/friend replacements and with people living longer this has an impact on volunteers. They need the training, skills and knowledge to deal with a growing range of issues, including what to do when it becomes apparent an older person is dependent on the befriender/volunteer.

5.3.5 Key issues

- **Transport**: particularly for those with mobility issues and those who have stopped driving.
- **Importance of and reliance on Befriending**: an important first step to reducing isolation but volunteers need to encourage engagement with other activities/services.
- **Lack of knowledge of local activities**: amongst older people themselves and professionals/volunteers coming into contact with them.
- **Carers**: although they have social contact, they can be isolated and lonely.

5.4 Summary of consultation activity findings

Findings from the consultation activities generally reflect findings from the literature and evidence reviews, in terms of at risk groups and risk factors.

5.4.1 Summary of key issues

- Affects all ages but older people are focussed on more; it affects both men and women
- Other at risk communities include: BME, LGBT, deprived, carers
- Lonely and socially isolated individuals are often hidden – do not seek help or present at services
- Reduction in informal services mean that lonely and socially isolated people are presenting at other services e.g. housing officers who are not equipped to deal with issues – individuals often have multiple needs
• No clear referral system or directory of services for loneliness and social isolation
• Loneliness and social isolation is experienced differently by different individuals
• It can be difficult to identify when people are lonely or socially isolated – no objective measure and not data that is collected routinely
• Transport is a key issue, particularly for those with reduced mobility or those who have stopped driving

5.4.2 Services

• There is a wide range of services provided across Warwickshire (provided by statutory organisations, charities, the community and voluntary sector) that could be used to tackle loneliness and social isolation; this may or may not be their primary purpose
• Professionals want to signpost to services but may not due to lack of knowledge about services or how appropriate they are
• Professionals are more aware of services provided by larger organisations and less aware of smaller, community based initiatives
• Befriending is key, although there are concerns over dependence on befriender volunteers and reducing the independence of an individual

5.4.3 What more could be done

• **Engagement:** outreach, raising awareness, training for frontline staff
• **Services:** personalised to the individual, innovative, small-scale piloting of projects to be rolled out across the county
• **Infrastructure:** transport needs to be improved, services should be placed in well accessed places and existing locations e.g. GP surgeries, evidence base needs to be developed
• **Workforce:** workers need up to date knowledge about services, more volunteers are needed
Appendices

Appendix 1: Methodology for developing Loneliness and Social Isolation Index

Appendix 2: Further in depth analysis of maps showing distribution of households at risk of loneliness and social isolation
Appendix 1

LONELINESS AND SOCIAL IN
WARWICKSHIRE

The development of an Index using Mosaic Data
Project Objective:
There is no precise dataset or measure regarding loneliness; in order to gain insight about the possible severity of loneliness in a population, there is a requirement to use proxy indicators. Therefore, the purpose of this project is to investigate social isolation risk factors and map available data to explore whether geographical patterns exist. Mosaic dataset will be used to investigate which individuals in Warwickshire may have an increased risk of loneliness and those most likely to benefit from interventions.

Mosaic Dataset:
Mosaic data classifies all households in the UK into 66 detailed types aggregated into 15 groups. It uses over 400 data variables and paints a unique picture of the UK in terms of socio-demographic characteristics, lifestyle, culture and behaviour. Individuals are not allocated a group, but rather the assumption is made that all individuals in a households are the same and share characteristics. The characteristics and behaviours which give each group and type their identity is determined by ‘The Grand Index’. The Grand Indices provide index values of whether a type is more or less likely to hold a certain characteristic. The benchmark of the grand indices is the indexed value of 100; if a type has a greater value than 100, they are more likely to exhibit the particular characteristic and if the value is less than 100, they are less likely. An index score of 100 for ‘Elderly Single’ for a particular Mosaic type would mean the likelihood that the household contains an elderly single is the same as the average for the UK. A score of 200 would illustrate that the household is twice as likely, and a score of 50 would mean the household is half as likely.

By using Mosaic, it is possible to enhance your population intelligence and establish different service needs that groups and types may have from a local authority. It also enables understanding on each group’s preferred channels of communication and in turn, allows for more effective service development, delivery and population engagement, which is particularly important for the socially isolated.

Methodology:
Primarily, research was undertaken to investigate past work which has utilised Mosaic in a Social Isolation and Loneliness project.

A model to identify the Lonely in Essex:
The Essex Council Joint Strategic Needs Assessment (JSNA) 2012 describes a model which they developed to identify their lonely population (Loneliness and Social Isolation – A Special JSNA Topic Paper 2013). To make an estimation of numbers and determine the geography for Essex, Mosaic was used to map older residents vulnerable to Social Isolation and Loneliness. It was initially developed to help identify individual households potentially at risk so further research through focus groups and interviews could be undertaken to help inform service delivery.

An ‘Isolation Index’ was created using variables that the research indicated as potential drivers of isolation, this included:
- Single pensioners
- Widowed
- Retired
- Unlikely to meet friends regularly
- Unlikely to interact with neighbours
- Poor health
• Permanently sick
• Suffering from depression
• Suffering from poor mobility
• Visually impaired
• Hard of hearing
• Struggling financially
• Not employed
• Less educated

The index values for the above variables were extracted at a household level and combined to make a social isolation index. Different scenarios were explored by placing weightings on the variable values. Consequently, in Essex it was revealed 12,973 households had an ‘above average risk’ of isolation and 15,257 households were at ‘high risk’ of isolation.

The Mosaic dataset utilised by Essex Council is an older version; the indicators and groups have since been restructured. In order to use a similar approach to discover loneliness in Warwickshire at a household level, scoping of the new and updated Mosaic indicators was required to identify similar topics and themes. A literature search informed which available indicators were most appropriate to utilise. The following indicators in Mosaic were consequently chosen for this project in Warwickshire:

• Older Single*
• Elderly single*
• Single household*
• Lone parent at address
• Part time / Housewife*
• Retired*
• Health problem or disability limits activities / work
• Visits to GP – more than once a month
• Depression
• Anxiety
• Heart problems
• Provides 20-49 hours unpaid care a week*
• Provides 50+ hours unpaid care a week*
• Values and personality - There is little that can be done to change life
• Do not take care of self as well as should
• Should do a lot more about own health
• Index of multiple deprivation
• Indices of deprivation – Income
• Indices of deprivation – Employment
• Indices of deprivation – Housing barriers
• Indices of deprivation – Geographic barriers
• Indices of deprivation – Living environment
• Indices of deprivation - Indoors
• Indices of deprivation - Outdoors
• Community safety, Crime rate per 1000 households - Burglary
• Community safety, Crime rate per 1000 households - Criminal damage
• Community safety, Crime rate per 1000 households - Anti-social behaviour
• Community safety, Crime rate per 1000 households - Public disorder
• Community safety, Crime rate per 1000 households - Violent crimes
• Financial stress - Difficult on household income
• Financial stress - Very difficult on household income
• Attitude to new technology - Do not like new technology and only change when necessary
• Internet usage - Less than every day*
• Email access - Not at all
• Internet surfing – Not at all
• Car ownership - No

Index values for each indicator were extracted for each Mosaic Type (66 types in total). An emphasis was placed on the indicators ‘Older Single’, Elderly Single’, ‘Single Household’, ‘Part time / Housewife’, ‘Retired’, ‘Provides 20-49 hours unpaid care a week’, ‘Provides 50+ hours unpaid care a week’ and ‘Internet usage’; a simple weighting was generated by including these indicators twice. In order to reveal which types are most at risk, conditional formatting of the data was undertaken. Initially, indicator values >125 were first filtered; the total number of indicators >125 for each type was combined to make a ‘social isolation index’. If the types had >18 indicators >125, i.e. a social isolation index greater than 18, it was seen as having an above average risk for loneliness as 36 indicators were used in total.

Results:
In total, 11 Mosaic types were identified as having a social isolation index greater than 18; the number of individual households of the 11 Mosaic were extracted; in total, there are 241,148 households in Warwickshire, of which 19,142 (7.9%) have been identified as having an ‘increased risk’ of social isolation and hence loneliness. The 11 identified types had >18 indicators >125, i.e. a social isolation index than greater than 18; these types have an increased likelihood of exhibiting the risk factors due to higher initial indicator values. The 11 identified types are listed below, along with their identifiable key features (Table 1).

The indicators were then filtered as a means of further targeting those most at risk; four ‘loneliness risk levels’ were identified based on indicator values;
• Level 1 125-149
• Level 2 150-174
• Level 3 174-199
• Level 4 ≥200

The total number of indicators falling in each level for the 11 types was calculated. Level 1 and 2 were grouped together as ‘above average loneliness risk’; level 3 and 4 were grouped as ‘high loneliness risk’. The cut-off for the higher risk group is >175 as the loneliness indicators/risk factors are nearly, or greater than, twice as likely to be exhibited by individual (i.e. levels 3-4 have more indicators of higher values, therefore are more likely to exhibit them). Subsequently, types were firstly ranked by how many indicators they had in the high risk level and secondly by how many indicators they had in the lower risk level (Table 2).
### Table 1: Mosaic Types identified as being at risk of Loneliness in Warwickshire

<table>
<thead>
<tr>
<th>Mosaic Type</th>
<th>Key Feature 1</th>
<th>Key Feature 2</th>
<th>Key Feature 3</th>
<th>Key Feature 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>I38: Asian Heritage</td>
<td>Extended families</td>
<td>Areas with high South Asian population and tradition</td>
<td>Low property value</td>
<td>Never worked and long-term unemployed</td>
</tr>
<tr>
<td>L49: Disconnected Youth</td>
<td>Aged under 25, mostly living alone</td>
<td>Have lived at address less than 3 years</td>
<td>Limited employment options</td>
<td>Some lone parents</td>
</tr>
<tr>
<td>L50: Renting a Room</td>
<td>Singles and homesharers</td>
<td>Short term private renters in low rent accommodation</td>
<td>Low wage occupations</td>
<td>High index of Multiple Deprivation</td>
</tr>
<tr>
<td>M55: Families with Needs</td>
<td>Cohabiting couples and singles with kids</td>
<td>Areas with high unemployment</td>
<td>Pockets of social housing</td>
<td>Very low household income</td>
</tr>
<tr>
<td>N57: Seasoned Survivors</td>
<td>Very elderly Age 81-85</td>
<td>Most are living alone</td>
<td>Retired from routine / semi-skilled jobs</td>
<td>Claim support allowance</td>
</tr>
<tr>
<td>N60: Dependent Greys</td>
<td>Ageing singles Age 66-70</td>
<td>Vulnerable to poor health</td>
<td>Living on estates with some deprivation</td>
<td>Bad health</td>
</tr>
<tr>
<td>O62: Low Income Workers</td>
<td>Older households Age 56-60</td>
<td>Renting low cost semi and terraces</td>
<td>Areas with low levels of employment</td>
<td>Very low household income</td>
</tr>
<tr>
<td>O63: Streetwise Singles</td>
<td>Singles and sharers Age 26-30</td>
<td>Low cost social flats</td>
<td>Shortage of opportunities</td>
<td>High index of Multiple Deprivation</td>
</tr>
<tr>
<td>O64: High Rise Residents</td>
<td>Singles and sharers Age 31-35</td>
<td>High rise social flats</td>
<td>Very low household income</td>
<td>Least likely to own a car</td>
</tr>
<tr>
<td>O65: Crowded Kaleidoscope</td>
<td>Many lone parents with multiple children</td>
<td>Non-nuclear household composition</td>
<td>Socially rented, overcrowded households</td>
<td>Significant proportion of adults not born in the UK</td>
</tr>
<tr>
<td>O66: Inner City Stalwarts</td>
<td>Mostly single adults Aged 56+</td>
<td>Health problem or disability limits activities/work</td>
<td>Renting from social landlord</td>
<td>Never worked and long-term unemployed</td>
</tr>
</tbody>
</table>

### Table 2: Mosaic Types Loneliness risk levels in Warwickshire

<table>
<thead>
<tr>
<th>Loneliness risk level</th>
<th>Mosaic Type</th>
<th>Number of households in Warwickshire identified at increased risk of loneliness</th>
<th>Proportion of households in Warwickshire identified at increased risk of loneliness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1-2 'above average loneliness risk'</td>
<td>L49: Disconnected Youth</td>
<td>2,511</td>
<td>0.010</td>
</tr>
<tr>
<td></td>
<td>N57: Seasoned Survivors</td>
<td>3,391</td>
<td>0.014</td>
</tr>
<tr>
<td></td>
<td>M55: Families with Needs</td>
<td>2,613</td>
<td>0.011</td>
</tr>
<tr>
<td></td>
<td>L50: Renting a Room</td>
<td>2,331</td>
<td>0.010</td>
</tr>
<tr>
<td></td>
<td>I38: Asian Heritage</td>
<td>569</td>
<td>0.002</td>
</tr>
<tr>
<td></td>
<td><strong>Total households</strong></td>
<td><strong>11,415</strong></td>
<td><strong>0.05</strong></td>
</tr>
<tr>
<td>Level 3-4 'high loneliness risk'</td>
<td>O65: Crowded Kaleidoscope</td>
<td>36</td>
<td>0.0001</td>
</tr>
<tr>
<td></td>
<td>O62: Low Income Workers</td>
<td>2,211</td>
<td>0.009</td>
</tr>
<tr>
<td></td>
<td>O66: Inner City Stalwarts</td>
<td>139</td>
<td>0.001</td>
</tr>
<tr>
<td></td>
<td>O64: High Rise Residents</td>
<td>414</td>
<td>0.002</td>
</tr>
<tr>
<td></td>
<td>O63: Streetwise Singles</td>
<td>2,709</td>
<td>0.011</td>
</tr>
<tr>
<td></td>
<td>N60: Dependent Greys</td>
<td>2,218</td>
<td>0.009</td>
</tr>
<tr>
<td></td>
<td><strong>Total households</strong></td>
<td><strong>7,727</strong></td>
<td><strong>0.03</strong></td>
</tr>
</tbody>
</table>

**Increasing Loneliness Risk**
Mosaic Types at risk of Loneliness in Warwickshire:
The number of individual households ‘at risk’ of loneliness by 2.5km grid squares

The above map represents total numbers of individual households identified as being ‘at risk’ of loneliness (19,142 households) by 2.5km grid squares. In areas with >1,001 households at risk of loneliness, there could be as many as 1,338 individual households.

The map suggests the greatest number of individual households ‘at risk’ of loneliness tend to be situated in more urban areas (Nuneaton ad Rugby); there appears to be many smaller concentrations of ‘at risk’ households in more rural locations. The loneliness risk levels were also mapped to explore whether there was variation in the distribution of households at ‘an above average risk’ (level 1-2) and a ‘high risk’ (level 3-4) of loneliness. The below maps suggest there is little variation in the number of individual households in the two loneliness risk levels. Regardless of loneliness risk level, the greatest numbers of households at any increased loneliness risk tend to be situated in more urban areas.

However, all the maps are using total number of households; therefore, these observed distributions would tend to be expected due to greater populations in urban locations. Conversely, the identified mosaic types at an increased risk of loneliness are acknowledged as having high urbanity scores and therefore these households more likely to be situated in urban areas.

Nevertheless, it was considered appropriate to conduct mapping using proportions of households at risk of loneliness by 2.5km grid squares to explore this possible limitation.
Number of households at 'above average loneliness risk'
Levels 3-4 loneliness risk levels in Warwickshire:
The number of households at ‘high loneliness risk’ by 2.5km grid squares
The above maps represent the numbers of individual households identified as being ‘at risk’ of loneliness (19,142 households) and the loneliness risk levels (level 1-2 and level 3-4) by 2.5km grid squares.

Of the 19,142 households ‘at risk’ of loneliness, the greatest number of households are concentrated in central Nuneaton and central Rugby. There are no stark differences in the distribution of number of ‘at risk’ households across the loneliness risk levels. Regardless of the fact that there are more households in the lower risk level, there are no major differences in the distribution of households in levels 1-2 (above average risk) and levels 3-4 (high risk). However, there does appear to be a slight increase in the number of households in levels 3-4 from levels 1-2 located in the Nuneaton area, meaning there could be more households in this area at the highest risk of loneliness.

The maps suggest households ‘at risk’ of loneliness are clustered in urban areas; however, this distribution would be tend to be expected due to greater populations in more urban locations. Conversely, many of the Mosaic types are characterised as living in urban areas, therefore this distribution would also be anticipated on this basis. To investigate the possible limitation of using absolute numbers of individual households ‘at risk’ of loneliness, the proportion of ‘at risk’ individual households per total households in 2.5km grid squares were also explored in the below map.
Proportion of Mosaic Types at risk of Loneliness in Warwickshire:
The proportion of individual households ‘at risk’ of loneliness per total households in 2.5km grid squares.
The above map represents the proportion of households identified as being ‘at risk’ of loneliness (19,142 households) per total households in 2.5km grid squares. The total number of households in each 2.5km grid square across Warwickshire was found and the proportion of those identified as ‘at risk’ for loneliness was calculated.

Comparing the mapping by household numbers and proportions, the loneliness risk identified in central Nuneaton and Bedworth appears more pronounced when looking at the proportion of total households. The proportion data may therefore be more representative of the possible loneliness risk severity and pinpoint key areas in this urban location.

Central Nuneaton and Bedworth has the highest proportion of households with an ‘increased risk’ of loneliness, with as many as 1 in 2 households ‘more likely’ to experience loneliness in a 2.5km grid square. The greatest proportion of loneliness in Nuneaton and Bedworth is concentrated in the North and South West, in the wards of Camp Hill, Abbey, Attleborough, Bar Pool and Wem Brook. These wards are located in and around the main town centre of Nuneaton.

The next area of high proportion of loneliness risk is central Rugby, in the wards of Benn Ward and New Bilton. These wards are also located in and around the main town centre of Nuneaton. In these areas, there could be as many as 1 in 3 households being ‘more likely’ to experience loneliness.

There also appears to be some hotspots in the North West of North Warwickshire in the wards of Atherstone South and Mancetter and in the South East in Arley and Whitacre. The locations of these hotspots are on the outskirts of housing areas.

**Engagement & Communications:**

Mosaic allows exploration of preferred communication methods to promote more effective service development, transmission and therefore engagement. Communication channels for these identified ‘at risk’ groups have been investigated and presented below.

There are some stark differences in preferred communication methods across the identified ‘at risk’ groups. For example, I household groups are over twice as likely (219 Mosaic index score) to want to receive communications via SMS compared to N households groups who are likely to be less receptive (60 Mosaic index score).

The preferred communication channels of identified ‘at risk’ groups include;
- **Group I** = Mobile phone call or SMS
- **Group L** = SMS or mobile phone call
- **Group M** = SMS or mobile phone call
- **Group N** = Post or landline phone call
- **Group O** = Mobile phone call or landline phone call

Furthermore, N group is identified as most likely to prefer no contact out of all 15 Mosaic groups. The N type ‘Dependent Greys’ has been identified as the type most ‘at risk’ of loneliness; this is an important reflection as the individuals most likely to be in need of intervention may be most reluctant to engage.

This demonstrates the importance of tailoring intervention methods to ensure effective exposure and delivery. Communication methods need to be altered to most effectively get across the desired intervention message.

<table>
<thead>
<tr>
<th>Loneliness risk level</th>
<th>Preferred communication channels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1-2 ‘above average loneliness risk’ Groups I, L, M, N</td>
<td>SMS or mobile phone call</td>
</tr>
<tr>
<td>Level 3-4 ‘high loneliness risk’ Groups N, O</td>
<td>Post, Landline phone call or mobile phone call</td>
</tr>
</tbody>
</table>
Communication Channel Preference of Mosaic Types:

Channel preference | SMS

Channel preference | Mobile call

Channel preference | Email

Channel preference | Post

Channel preference | Landline

Channel preference | Prefer not to be contacted


Appendix 2

Distribution of Loneliness and Social Isolation: Detailed Analysis

The county maps show that, in terms of gross numbers, households risk of loneliness and social isolation according to the Mosaic Types are clustered around the more densely populated urbanised areas of the county. The greatest numbers of households at risk of loneliness are located in Nuneaton and Rugby, with significant numbers also seen in Warwick, Leamington and Bedworth. There are also clusters in Stratford-on-Avon, Polesworth, Atherstone, Coleshill, Studley, Alcester, Kenilworth and Henley-in-Arden. The map demonstrating households at risk as a percentage of the total number of households within an area again shows broadly the same sort of distribution, favouring the larger towns. It particularly highlights that the households at risk are far more concentrated in these areas than in other areas, suggesting that these areas are the ones most likely to benefit from intervention.

It is important to note at the outset that Mosaic typing is a subjective measure as it is a judgment as to what factors could be potential drivers of risk of loneliness and social isolation.

North Warwickshire

The map looking at North Warwickshire borough highlights a hotspot of households at risk of loneliness and social isolation in Atherstone South Mancetter Ward, where there is one area in which 47-56% of households are at risk, with neighbouring areas in the Atherstone North and Atherstone Central Wards also appearing, although the percentage of households at risk in these areas is lower, ranging from 1-18% or 19-28%. There is also an area in the south-east of Arley and Whitacre Ward in which 38-46% of households are at risk of loneliness and social isolation, with some of the neighbouring areas in this ward containing households of which 1-18% are at risk.

Figures for the borough as a whole show that rates of deprivation, violent crime and long term unemployment are all better than the national figure. The obesity rate, however, is higher in North Warwickshire than it is nationally.

Looking at the health profile for Atherstone South Mancetter Ward, which contains the area where risk of loneliness and social isolation appears to be highest, there are several indices that suggest why this might be. Firstly, looking at the age profile of the ward, the proportion of the population over the age of 65 appears to be significantly higher than the national average, with 19.3% of the population aged 65-85 compared with 14.6% nationally and 3% aged over 85 compared with 2.3% nationally. The indices of deprivation are comparable with national figures, as are employment indicators, with 3.4% unemployed (claiming JSA) compared to 3.8% nationally and 7.4/1000 long term unemployed compared with 10.1/1000 nationally. Moving on to looking at health, however, shows that the general health of this ward is very much worse than that of England overall. Data from the latest census shows that 7.4% of the population of Atherstone South Mancetter Ward described their general health as bad or very bad compared to 5.5% nationally, with 22.2% of people having a long term illness or disability compared with 17.6% nationally and 3.4% providing 50 hours or
more of unpaid care a week compared with 2.4% nationally. The proportion of adults who are obese is also high with 31.2% of adults classed as obese compared to the national figure of 24.1%. Another interesting figure is the Standardised Admission Ratio for hospital admissions due to self-harm, which for this ward is 145.8 (100.0 nationally)\textsuperscript{47}. In Arley and Whitacre Ward, which has an area with the second highest proportion of households at risk of loneliness and social isolation, along with other areas in which 1-18% of households are at risk, many of the indices of interest are comparable with or better than the national figures. The proportion of people aged above 65 is lower, as, very significantly, is the proportion of people whose ethnicity is not “White UK” (3.9% versus 20.2% across England). Indices of deprivation are favourable in this ward when compared with the national average, although they are very slightly higher than the rest of the borough. Indicators of unemployment are again better than the national average and health indicators are fairly similar to the national figures. The indicator that is worse here than in the country as a whole is the proportion of people providing more than one hour of care per week (11.3% against 10.2%)\textsuperscript{47}.

**Nuneaton and Bedworth**

There are several main areas of high risk of loneliness and social isolation in the borough of Nuneaton and Bedworth. In particular, there are two neighbouring areas where the percentage of households at risk is 47-56% which lie largely in the Camp Hill Ward but also overlap slightly into the Bar Pool and Galley Common Wards. There is also another high density area that straddles the Wards of Abbey, Wem Brook, Attleborough and St Nicolas. In addition, there are areas other areas within Abbey, Camp Hill, Bar Pool and Wem Brook Wards in which 38-46% of households are at risk. This large combined area all seems to fall in and around Nuneaton itself. Whilst it is unsurprising that Nuneaton and its immediate surroundings rank highly in terms of gross numbers of households at risk of loneliness and social isolation (given that it is the most densely populated area in the borough, meaning the areas highlighted will have a higher number of households within them than other areas), it is interesting to see that these areas remain as hotspots for risk of loneliness and social isolation when the proportion of households at risk within these areas is considered. One might have thought that living in a well-populated area with close access to amenities and public services might have reduced the risk, however this may not be the case or they may be other factors that outweigh this. There are numerous other areas throughout the borough that have areas containing households at risk of loneliness and social isolation ranging in proportion from 1-18% through to 29-37%.

In Nuneaton and Bedworth, rates of deprivation, violent crime and long term unemployment are at or just below the national average, which is interesting to note given the relatively higher levels of risk of loneliness and social isolation in this borough compared to the others. There are, however, significantly higher rates of statutory homelessness, teenage pregnancy and hospital admissions due to self-harm, along with a higher rate of obesity in adults when compared with the rest of the nation\textsuperscript{46}.

The three main wards in which risk of loneliness and social isolation is highest are Camp Hill, Abbey and Wem Brook wards. Looking at Camp Hill, potential indicators that stand out are indices of deprivation (income deprivation, child poverty and older people in deprivation), which are significantly higher in this ward than in the rest of the borough and the country. The rates of unemployment and long term unemployment are also far higher at 6.2% and
17.7/1000 respectively, compared with national figures of 3.8% and 10.1/1000. There are also health factors that provide possible reasons for the higher risk of loneliness and social isolation; 7.1% of people in Camp Hill Ward rate their health as bad or very bad compared with 5.5% nationally, 21.1% of people have a limiting long term illness or disability compared with 17.6% nationally and 3.4% of people provide 50 or more hours of unpaid care per week compared to 2.4% nationally. Although the proportion elderly people in this ward is slightly lower compared to nationally, it is worth noting that 34.8% of pensioners live alone compared with 31.5% nationally. The Standardised Admission Ratio for hospital stays due to self-harm is also higher than the national figure. The picture is very similar in Abbey Ward, although in addition there is a higher proportion of black and minority ethnic people (23.4% versus 8.7% in the rest of Nuneaton and Bedworth and 14.6% nationally) and of people whose ethnicity is not “White UK” (27.5% versus 11.1% in the rest of Nuneaton and Bedworth and 20.2% nationally).

Rugby

The areas at highest risk of loneliness and social isolation in the borough of Rugby are largely centred around the town of Rugby itself. Most prominent is Benn Ward, which is largely taken up by an area in which 38-46% of households are at risk of loneliness and social isolation. There are two areas neighbouring on either side that lie partially within Benn Ward but also in New Bilton Ward to the west and Eastlands Ward to the east where the proportion of households at risk is 29-37%. Other wards in and immediately surrounding Rugby mostly contain areas where 1-18% of households are at risk of loneliness and social isolation, with a few areas where 19-28% of households are at risk. These wards include Newbold and Brownsover Ward, Coton and Boughton Ward, Rokeby and Overslade Ward, Bilton Ward, Paddox Ward, Hillmorton Ward, Admirals and Cawston Ward and Wolston and the Lawfords Ward. Wolston and the Lawfords Ward also contains two neighbouring areas further to the west in which 1-18% of households are at risk of loneliness and social isolation, and Dunsmore Ward, to the south, also contains one such area. Once again, the main areas at risk of loneliness and social isolation are within the most urbanised parts of the borough, despite being nearest to public services such as schools, hospitals, police station and local government offices.

Overall, Rugby compares well with the rest of the country in terms of its health profile. Deprivation, statutory homelessness, violent crime and long term unemployment rates are all significantly better than the national average. Levels of obesity in children and adults are also slightly better. Once again, however, the standardised rate of hospital stays due to self-harm is markedly higher compared with nationally.

Benn Ward contains the highest proportion of households at risk of loneliness and social isolation in Rugby borough. Here, the black and minority ethnic population as a proportion of the whole is significantly higher than the rest of the borough and the national average. The percentages of people with income deprivation and of older people in deprivation are also higher (as is the percentage of pensioners living alone). However, the rates of unemployment and long term unemployment are comparable with the national average, and the health and care indicators are again very similar or better in the case of proportion of people providing unpaid care or living with limiting long term illness or disability.
Stratford-on-Avon

The borough of Stratford-on-Avon contains the fewest areas containing households at risk of loneliness and social isolation of any of the boroughs in Warwickshire. This seems to be in keeping with the general pattern in that this borough is comprised of smaller towns and villages compared to other boroughs, where risk of loneliness and social isolations is mainly centred around the larger towns. There are small foci in the towns of Stratford (Stratford Guild and Hathaway, Stratford Avenue and New Town Wards), Alcester (Kinwarton and Alcester Wards), Studley (Sambourne and Studley Wards) and Henley-in-Arden (Henley Ward) where 1-18% of households are at risk. There are other isolated areas throughout the borough containing households of which 1-18% of households are at risk; these are in Claverdon Ward, Bidford and Salford Ward, Wellesbourne Ward, Kineton Ward and Southam Ward. There are no areas in which a greater proportion of households are at risk of loneliness and social isolation.

Perhaps unsurprisingly, given the above map of Stratford-on-Avon borough, the overall health profile of the borough is very favourable. There are in fact no indicators relating to risk of loneliness and social isolation where the local rates are worse than the national average. Indeed most are better, particularly deprivation, violent crime and long term unemployment. The proportion of black and minority ethnic people and those whose ethnicity is not “White UK” is significantly lower across the borough than it is nationally47.

Henley Ward, one of the areas where there is a slightly higher risk of loneliness and social isolation, seems to highlight age and age-related issues as the main driver here. 28.3% of the population here are aged 65-84 and 4.4% are 85 or older, compared to national figures of 14.6% and 2.3% respectively. The percentage of people with limiting long term illness or disability is 21.2% (17.6% nationally) and 11.5% of the local population provide 1 or more hours of unpaid care per week (10.2% nationally). It is likely that these figures are related to the higher proportion of older people in the ward. The proportion of pensioners in the ward living alone is 35.7%, compared to a national average of 31.5%. Other health indicators related to higher risk of loneliness and social isolation are generally comparable or better than national figures47. Analysis of the health profile of Alcester Ward reveals similar findings47. In Stratford Guild and Hathaway Ward, the overall proportion of people over 65 is lower than in Henley Ward, although the percentage above 85 is higher at 5.5% (the percentage of people aged 65-84 still remains higher than the national average at 20.7%). Interestingly, though, the health and care indicators are all fairly similar or better than they are nationally, with only 4.7% of people rating their general health as bad or very bad compared with 5.5% nationally and 18% of people, despite the older health profile, having a limiting long term illness or disability, virtually identical to the national figure of 17.6%. The percentage of pensioners living alone in this ward is again high, at 39.4% compared to the national average of 31.5%.47 Studley Ward contains a slightly lower proportion of people aged 65-84 and over 85 (18.8% and 3.3% respectively), although again still above the national average. Indices of deprivation and employment indicators are better than the national average, and the percentage of pensioners living alone is also better at 26.5% compared to 31.5% nationally. Looking at health indicators, however, reveals that 19.6% live with a limiting long term illness or disability compared with 17.6% across the country and 11.8% of people provide more than 1 hour of unpaid care per week compared with the national average of 10.2%. Looking further into this, it is interesting to note that elective
hospital admissions for knee and hip replacements are high, with Standardised Admission Ratios 130.7 and 131.1 respectively (100.0 nationally)\textsuperscript{47}.

\textbf{Warwick}

The areas of increased risk of loneliness and social isolation in the borough of Warwick lie in and around Warwick and Leamington Spa, once again the more densely populated areas of the borough. There are areas in which 1-18\% of households are at risk in Clarendon, Crown, Manor, Milverton, Willes, Brunswick, Warwick South, Warwick West and Warwick North Wards. All of these are either in or close to the towns of Warwick and Leamington. There are also neighbouring areas slightly towards the east of Leamington where there is a slightly higher risk of loneliness and social isolation, with 19-28\% of households being at risk. In addition, there is also an area in Bishop’s Tachbrook Ward where 1-18\% of households are at risk along with another area in Park Hill Ward that overlaps slightly into Abbey Ward (this area lies in the town of Kenilworth). Finally, there are neighbouring areas in the north part of Stoneleigh Ward that represent a section of the southern border of Coventry with Warwickshire where 1-18\% of households are at risk of loneliness and social isolation.

Like Stratford-on-Avon, the health profile of Warwick borough compares favourably with that of the country as a whole. Levels of violent crime, unemployment and deprivation re all significantly lower than the national average, although the rate of statutory homelessness is higher\textsuperscript{47}.

Crown Ward appears to have the highest proportion of households at risk of loneliness and social isolation within Warwick borough. The total proportion of people aged over 65 is actually lower than the national average. Health indicators within this ward are comparable with national figures. The percentage of people with income deprivation here is 17.6\% compared with a national figure of 14.7\%. Rates of unemployment are also higher compared to nationally, with 5\% unemployed and 14.6/1000 in long term unemployment compared with 3.8\% and 10.1/1000 respectively\textsuperscript{47}. In Brunswick Ward, in almost all of which 1-18\% of households are at risk of loneliness and social isolation, 29.9\% of people are aged 16-24, much higher than the national average of 11.7\%. The proportion of people whose ethnicity if not “White UK” is 28.6\% compared with 20.2\% across the country as a whole (18.4\% from black or minority ethnic groups compared to 14.6\% nationally), with indices of deprivation all significantly higher than the national averages (16.1\% in income deprivation compared with 14.7\%, 33.1\% child poverty compared with 21.8\% and 31.3\% of older people in deprivation compared with 18.1\%). Indicators of unemployment and health tend to be better in this ward. There also appear to be issues with Housing and Living Environments, with 15.5\% of households overcrowded compared with 8.7\% nationally and 43\% of pensioners living alone compared with 31.5\% nationally\textsuperscript{47}.
Crime as an Indicator of Loneliness and Social Isolation

There is a variable correlation between crime and risk of loneliness and social isolation. Most strikingly, the high rate of crime in the Wolvey and Shilton Ward of Rugby borough seems to cause no risk of loneliness and social isolation. Similarly, Clifton, Newton and Churchover Ward in Rugby also have a relatively high crime rate of 0.12-0.15 offences per household and two areas on the border of the ward with only 1-18% of households at risk. On the contrary in Warwick borough, areas with low crime rates (0.0-0.003 per household) seem to correlate with a slightly higher risk of loneliness and social isolation than, for example, Leek Wootton Ward, where the crime rates are 0.06-0.09 but where there is no risk of loneliness and social isolation according to Mosaic.
Deprivation as an Indicator of Loneliness and Social Isolation

In contrast to crime, deprivation does seem to have more of a clear association with risk of loneliness and social isolation. When comparing the map showing percentage of households at risk with the map showing levels of deprivation within the county, areas that are shown as being deprived also generally tend to contain higher proportions of households at risk of loneliness and social isolation. In the boroughs of North Warwickshire, Nuneaton and Bedworth, Rugby and Warwick, the areas highlighted in the map of deprivation are very closely matched to areas highlighted as having a high proportion of households at risk of loneliness and social isolation.
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