

The Annual Report
of the **Director of
Public Health**



2016

**Loneliness
and Health**



**Public
Health**

"The most terrible poverty is loneliness, and the feeling of being unloved."

Mother Teresa

"In the silence of night I have often wished for just a few words of love from one man, rather than the applause of thousands of people."

Judy Garland

"Hello darkness, my old friend. I've come to talk with you again."

Simon and Garfunkel "The Sound of Silence."
Songwriter: Paul Simon
Lyrics © Universal Music Publishing Group

"A great fire burns within me, but no one stops to warm themselves at it, and passers-by only see a wisp of smoke"

Vincent Van Gogh

"And they'll all be lonely tonight and lonely tomorrow."

Del Amitri "Nothing Ever Happens."
Songwriter: Justin Currie
Lyrics © Universal Music Publishing Group

Acknowledgements and list of contributors

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Introduction



Over the last six months, NHS Highland has been running a campaign to tackle social isolation and loneliness. It therefore seemed appropriate to focus this year's public health report on this important topic.

Loneliness is an increasingly important public health issue, as social relationships are central to personal well-being and are crucial for maintaining physical health, mental health and a holistic sense of meaning and purpose. Whilst loneliness can be a problem across all age groups, it is a significant and growing issue, particularly for older people because the risk factors

for loneliness such as bereavement, reduced income and poor physical health occur more frequently in older age. This report recognises that there are different terms in use including social isolation, emotional loneliness and social loneliness. This is an emerging topic and it is understandable that different terms should be used to emphasise different aspects of the problem.

This report also builds on the concept of salutogenesis, recognising that there are a range of factors that may protect individuals and communities from loneliness, including a sense of coherence, meaning and purpose in life. A sociologist, Antonovsky, proposed that the belief that things in life are interesting, 'a source of satisfaction and worthwhile' and that there is 'good reason or purpose to care about what happens' may improve health. It may also help to protect against some aspects of loneliness.

Public health should be based on facts and figures and this year's report is therefore based on a survey of 3000 individuals aged 65 years and older. The survey assessed some of the above issues in Highland and Argyll and Bute.

I am very conscious that the public health department on its own cannot address this issue and I am very grateful for the commitment that Community Planning Partnerships in the Highland Council area and Argyll and Bute Council area have made to working together to address this challenge.

I look forward to continuing to work with many of you as we take this work forward.

Yours sincerely

A handwritten signature in black ink, appearing to read 'H. van Woerden', written in a cursive style.

Prof Hugo van Woerden
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Chapter One - Why Focus On Loneliness?



Loneliness is increasingly recognised as a significant public health concern, affecting wellbeing, quality of life, premature death¹ and contributing to diseases such as dementia², heart disease and depression³.

Loneliness can occur at any age but is particularly associated with periods of change such as moving home or job, childbirth, and experiences common to older age such as retirement and death of a spouse.

This year's Public Health report focuses on loneliness and social isolation in older age and sets out recommendations that would take us forward as a society in addressing this challenge. This report is based on published literature and local research in those over 65 years who live in the NHS Highland area.

Having weak social relationships increases the chance of an early death to the extent that it is:

- **Equivalent to smoking up to 15 cigarettes a day**
- **greater than not exercising**
- **twice as harmful as being obese.**

Loneliness has to do with the extent and quality of our relationships⁴. Most of us have experienced loneliness at some time or another, but it is particularly challenging when it becomes a long standing and painful experience.

There are a variety of different but overlapping aspects of loneliness and social isolation. Loneliness can be defined as the subjective emotion felt by people who are unhappy with their levels of social relationships. This is sometimes called 'emotional loneliness'.

Social isolation relates to a more objective measure, which is the number of relationships a person has and is sometimes referred to as 'social loneliness'.

It is important to recognise that it is possible to be socially isolated and to experience

"...if you are on your own the problems become magnified and you imagine things are wrong with you.

You're sitting on your own, there was maybe nothing wrong with you, but you imagine there are things wrong with you [...] that's what isolation does to you."⁵

Focus group participant

'social loneliness' without feeling 'emotional loneliness'. Similarly, it is possible to have regular interaction with other people, and to fall outside the definition of 'social loneliness', but still experience significant 'emotional loneliness'.

There are other related concepts including social relationships, social ties, social support, social connectedness, friendship networks, civic participation and social capital, which are valuable concepts but are beyond the scope of this report.

'Loneliness is a negative emotion associated with a perceived gap between the quality and quantity of relationships that we have and those we want.'⁶

There are environmental and personal characteristics that buffer the effects of social isolation and loneliness. One of the aims of the research underpinning this report has been to examine the relationship between a sense of coherence, loneliness and health. This work is ongoing and it is intended that the results will be published elsewhere in due course.

How common is loneliness?

The prevalence of loneliness is very dependent on how it is measured. In the survey which has informed this report, we have used a six item loneliness scale, with three items to measure 'social loneliness' and three items to measure 'emotional loneliness'.

The sub-scales can be used separately or combined into a total loneliness score⁷.

'Lonely people, in talking to each other, can make each other lonelier'

Lillian Hellman, cited in Age UK Oxfordshire, 2011

Studies have suggested that loneliness increases with age, and one study, using a slightly different definition of loneliness, found that over 50% of those aged over 80 years experienced some loneliness⁸.

Another study of the general population, using yet another definition, reported that 31% of the population felt lonely sometimes and 5% often felt lonely⁹.

The trend for increasing family dispersal and the rising elderly population mean that loneliness is likely to be an increasing societal challenge over the coming decade¹⁰.

Around 20% of the population in the UK are currently over 60 years and this proportion is expected to rise to 24% by 2030¹¹.

Across NHS Highland, 29% of the population are currently over 60 years. This figure is expected to rise to 38% by 2035. The higher elderly population across the area, both now and in the future, emphasises the importance of this issue for local public sector planning.

'In the next 20 years, in Britain, the number of people aged 80 years and over will treble and those over 90 will double'.¹²

Those living in institutional care are also susceptible to loneliness. One study found more than half of nursing home residents reported feeling lonely¹³ and an association has been identified between loneliness and dementia¹⁴.

Risk factors for loneliness

The Campaign to End Loneliness report summarises some of the risk factors for loneliness and social isolation¹⁵. Disability is associated with loneliness¹⁶, particularly in older people who have sensory impairment or a significant health condition¹⁷.

Reduced mobility can prevent people from getting out and limit their opportunities to socialise¹⁸. Sensory impairment can limit their ability to communicate and can lead to a sense of being isolated even from other people in the same room. Limited disposable income, or loss of access to a car, can reduce access to transport and limit opportunities to socialise¹⁹.

The prevalence of each of these factors rises substantially as individuals become very elderly. The presence of several of these factors has a compounding effect on the risk of social isolation.

There has been little comparison of levels of loneliness between urban and rural communities. A small-scale survey found that twice as many people in urban areas mentioned isolation and loneliness as an issue compared to those in rural areas, which may be related to better networks of support²⁰.

When combined with factors such as disability or poor health, living remotely may increase the likelihood of being lonely. The survey we have undertaken has sought to address this question in some detail.

Social stigma and discrimination can have a negative impact on individual and community health and wellbeing, for example arising out of racial or other personal characteristics. This has the potential to lead to people being excluded or isolated.

The Campaign to End Loneliness also flags specifics of ageing that can cause loneliness, for example adjusting to life after retirement can be difficult due to changes in identity, role and daily routines that perhaps involved regular contact with work colleagues.

Similarly, many older people have a caring role and becoming a carer can be a life changing event that can increase the risk of becoming isolated.

Often carers have fewer opportunities to socialise, as their caring responsibilities take up most of their time. Working unsocial hours can also affect social networks and increase the risk of social isolation, not only for the individual working the unsocial hours, but also for those who depend on that person.

There is a case for employers minimising

unsocial hours and weekend work because of its societal effects²¹.

Bereavement, particularly if it is in relation to the loss of a partner or spouse, is associated with loneliness and social isolation.

Many people find it difficult to socialise following the loss of a loved one and can be left with long standing feelings of loneliness. However, this is a complex area and there is some research to suggest supportive friends and communities rallying around can help to minimise the length of distress.

There is some evidence to suggest that our sense of loneliness is linked to the experiences of others in our social networks. Those who are close to someone experiencing loneliness are at increased risk of becoming lonely themselves²².

Salutogenesis and sense of coherence

The survey we have undertaken to support this annual report has also measured an aspect of salutogenesis called ‘sense of coherence’. This relates to a person’s ability to cope with challenging and stressful situations and is related to research on resilience and hardiness.

The concepts of salutogenesis and sense of coherence were developed by a psychologist who worked with holocaust survivors and who wanted to understand why some individuals had survived concentration camps whereas others had not.

The psychologist, Antonovsky, suggested that those individuals who had survived the holocaust had a strong sense of coherence, which had three components – comprehensibility, manageability, and meaningfulness.

Comprehensibility is ‘the extent to which events are perceived as making logical sense, that they are ordered, consistent, and structured’.

Manageability is ‘the extent to which a person feels they can cope’.

Meaningfulness is ‘how much one feels that life makes sense, and challenges are worthy of

commitment.’²³

These characteristics can be captured in a simple three item questionnaire, which we have used in the survey underpinning this report.

A weak sense of coherence has been linked to an increased risk of mental illness and mortality^{24,25} and sense of coherence is implicated in levels of loneliness²⁶.

Counting the cost

Loneliness and social isolation have a significant human and financial cost. Loneliness has been associated with an increased risk of death. In one study, 22.8% of the participants classified as ‘lonely’ died over the six years between 2002 and 2008 compared to 14.2% of participants who were ‘not lonely’²⁷.

Similarly, social isolation has been significantly associated with mortality in men. In another study, over an eight year follow-up period, 7% of those classed as ‘low social integration’ died compared with 1.4% of those classed as ‘high social integration’²⁸.

Loneliness also affects the demand for NHS services. Lonely people are more likely to visit their GP and to use other health services. Loneliness is a predictor of the use of accident and emergency services, after adjusting for the presence of other factors such as chronic illness²⁹.

Recommendations

- Increased publicity and awareness of the strong links between loneliness and poor health outcomes, mortality and increased service utilisation.
- Better awareness of the risk factors of loneliness and consideration of these risks during patient assessments and consultations.
- Public sector bodies should invest in interventions to reduce loneliness
- Employers should consider the potential impact of working unsocial hours and weekend shifts on the families and personal networks of their staff.

Chapter Two - Evidence From The Literature



Wider context

Loneliness is a societal challenge that has received increasing attention from researchers and policy makers across the developed world including the USA, France, Norway, Denmark, Sweden, Australia, Taiwan, Japan and the UK.

In the UK, the societal challenge has been led by the Campaign to End Loneliness³⁰, which was launched in 2011. The campaign aims to develop the research base, facilitate learning & understanding, and lead a national call to action on this important topic.

The third sector has provided much of the leadership to date, with the charity *Silverline*³¹ launched in 2013, to provide a helpline for older people in distress. The extent of loneliness is demonstrated by the fact that the helpline has since received more than one million calls, among whom 53% have said that they had no-one else to talk to.

"It was about 2am, I couldn't sleep and I felt very lonely so I called the helpline. You can't understand loneliness until you go through it yourself."

Silverline caller

Prevention better than cure

In Scotland, the Christie Report (2011), 'Commission on the Future Delivery of Public Services', which has had significant influence on Scottish policy, made reference to loneliness³². The report recognised that, 'Public services find great difficulty in prioritising preventative approaches to reduce long-term future demand. Services often tackle symptoms not causes, leading to "failure demand" and "worsening inequalities".'

The report also stated that, 'as much as 40% of all spending on public services is accounted for by interventions that could have been avoided by prioritising a preventative approach.'

The Scottish Parliament has been aware of the importance of loneliness and published a

report on the topic in 2015³³. The Committee recognised that tackling loneliness requires a multi-pronged approach. The report's recommendations included:

- developing a national strategy and the incorporation of social isolation and loneliness into all policy considerations, for example, mental health, housing, and family & early years strategy
- conducting national research into the extent of the issue in Scotland
- developing a national promotional and marketing campaign with the public
- developing the approach of social prescribing to formally link up people who are lonely with sources of support
- joining up the loneliness agenda with community transport.

The Scottish Government has also published a Fairer Scotland Action Plan, with 50 actions to help tackle poverty, reduce inequality and build a fairer and more inclusive Scotland. Part of this plan is focused on social isolation, and the intention is that the topic will be a priority in the 2017 part of the national action plan.

Providing solutions

Asking people if they feel lonely and putting them in touch with social support has the potential to enable people to live in good health for longer; and improves their quality of life³⁴. Initiatives to prevent loneliness are cheaper than treating the subsequent ill-health.

However, the evidence for what works is not widely known or understood³⁵. There are many examples of upstream investment to prevent more costly interventions or treatments later that have been collated in a systematic review.

One study identified savings of up to £300 per year from individuals receiving befriending support compared to the intervention cost of only £80³⁶. Similarly, in selected groups, arts-based community activities significantly reduce the need for acute hospital care³⁷.

The third sector is well placed to deliver activities to tackle loneliness and isolation as they are often closer to communities and more responsive to local needs³⁸.

Public Health teams can play a role in further developing partnership working between the public and third sectors, for example, supporting robust evaluation and monitoring to ensure the benefits of interventions to reduce loneliness are quantified and scaled up.

Co-production and capacity building

Empowering people and working in partnership with others are key ingredients for improving health; the Ottawa Charter for Health Promotion laid this foundation in 1986³⁹.

Over the past 10 years this has evolved in Scotland into an approach called ‘co-production’. Co-production, which is further explored in chapter 5, is defined as the collective ‘doing with’ rather than ‘doing to’ communities and recognises the equal value of contributions from the public. Local people know their communities best and often know how to solve problems where they live.

Prevention programmes require a long term focus, which is challenging in a modern context. Historically, a lot of community development has been built on short term funding, with projects constantly being created, abolished and then re-invented.

For example, seven full-time Public Health Community Development posts in Highland have had their funding withdrawn over the last year, whilst new government monies continue to emerge for fresh initiatives.

Locality planning

In recent years, Scotland has seen an increasing legislative drive towards localism of service planning and service delivery. This is known as

locality planning and could play an important role in coordinating services to reduce loneliness and strengthen a sense of coherence at individual, family and community level.

Locality plans could help by putting people who are lonely in touch with appropriate support; identifying gaps in services; and working with communities to co-produce services to fill service gaps that are identified.

Empowering individuals to self-manage their health

Empowering people with knowledge and skills about what keeps them well is key to effective self care of long term health conditions.

Addressing loneliness and increasing a sense of purpose and meaning in life may play a part in helping people live better with their health conditions.

Self-management programmes are provided by the health and social care partners to enable people to take charge of their own health, rather than be passive recipients of care.

Given the link between loneliness and many long term conditions there is a need to address issues of loneliness and social isolation overtly in self management programmes and to build a sense of coherence.

The policy context

A number of national policy initiatives that are relevant to loneliness are summarised in the following text.

The Public Bodies (Joint Working) (Scotland) Act 2014 came into effect on 1 April 2014 and requires health and social care services to come together in each area of Scotland in a process of ‘Integration’⁴⁰.

At its heart, this change is about shifting the balance of care from hospitals to the community. It relies on building capacity in communities for people to be able to lead the healthiest lives possible, self manage their own health, and address issues such as loneliness.

Reshaping Care for Older People (RCOP) is

Scotland's national strategy, covering 2011 – 2021, to improve health outcomes and services for older people⁴¹.

In anticipation of an ageing population, this strategy promotes self-management, better joint planning and delivery across the range of health & social care partners, and building resilience for communities to support healthy living of increasing numbers of older people.

This includes recognition that older people's engagement in volunteering and/or caring activities can bring benefits to individuals, and also help to sustain communities.

The Community Empowerment (Scotland) Act 2015 will give communities more control over how services are delivered⁴². The Act includes support for asset transfer of public sector buildings and land to community groups, and gives communities more influence in how services are planned and delivered.

This legislation gives weight to the co-production approach and empowers community members to take responsibility for local services. This in turn has potential to reduce loneliness and isolation.

Community Planning Partnerships, involving statutory bodies working together on identified priorities, have a role in addressing isolation and loneliness.

The partnerships have already demonstrated their commitment to reducing loneliness by signing up to Reach Out, a social media campaign launched by NHS Highland that aims to tackle loneliness through encouraging individuals, communities and workplaces to sign a pledge to take action to make a difference to someone who is lonely.

Community planning partners could help take this to the next level by:

- Continued commitment to the Reach Out campaign;
- Raising awareness amongst their staff of the risks of loneliness for themselves and their service users;

- Supporting joint community planning activity on loneliness;
- Pooling resources to invest in reducing loneliness;
- Addressing wider community planning agendas that impact on isolation and loneliness, the main example of this is community transport but could also include responding to and supporting people in distress.

Recommendations

- Service providers should regularly ask people they come into contact with if they feel lonely and signpost to local sources of support.
- Embed social prescribing in health and social care delivery to ensure people with underlying social problems get referred or signposted into appropriate sources of support by their health professional or care giver.
- Reshaping Care for Older People should be refreshed to reflect the issues of loneliness and social isolation.
- Locality plans developed as a result of the Community Empowerment Act should consider loneliness and help build a sense of coherence within communities.
- Community Planning Partnerships should consider how they can contribute to reducing the risks of loneliness and isolation.
- Ensure people experiencing, or at risk of loneliness, are able to access appropriate services. Practical barriers may be present for those who have difficulty using their own or public transport. Access to community transport should therefore be considered.
- Wherever possible, those who award grants should minimise the risk of stop/start funding cycles for preventative activity.

Chapter Three - Investigating Levels of Loneliness Across Highland



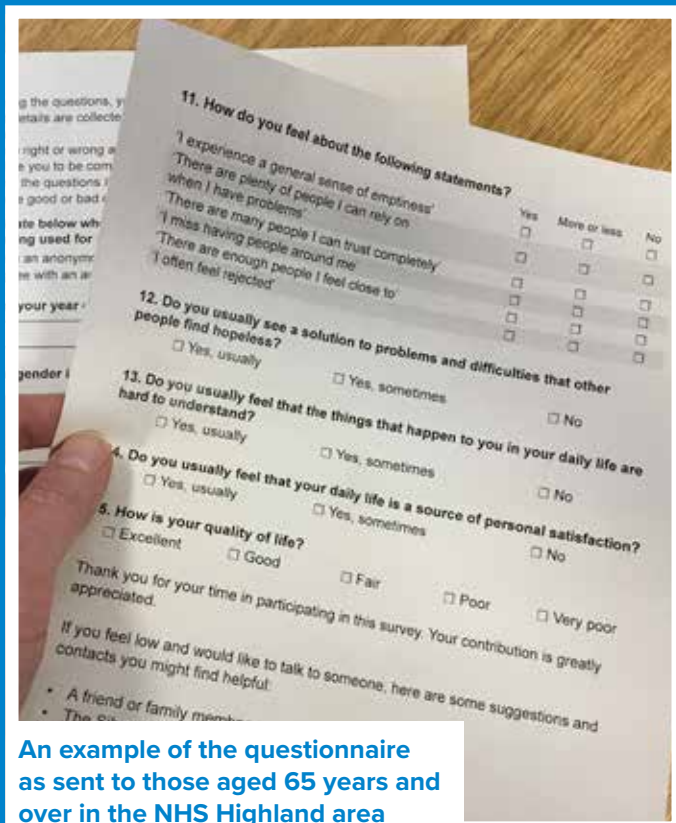
The reason for the survey

In July 2016, the public health department undertook a survey of loneliness across NHS Highland. Following ethical approval, a random sample of 3,000 people, aged 65 years and over were sent a survey called 'Keeping Connected'. The main aim of the survey was to identify the prevalence of loneliness across NHS Highland.

The survey was issued by postal questionnaire with Freepost return envelopes. Fifteen questions were asked, including demographic variables, a set of six validated loneliness questions, three 'sense of coherence' questions, and a general health question.

Within the loneliness questions, three of these assessed emotional loneliness and the other three assessed social loneliness. The loneliness subscales could only be calculated if a response was present for each of the three questions and a total loneliness score was dependent on responses to all six questions.

We were also interested in sense of coherence (SoC) which provides insight into our ability to cope with adversity. This was measured from responses to three questions.



An example of the questionnaire as sent to those aged 65 years and over in the NHS Highland area

Loneliness has two parts; social loneliness and emotional loneliness.

- **Social loneliness is the feeling of missing a wider social network (for example, feeling we lack friends and family).**
- **Emotional loneliness is a feeling of missing an intimate relationship (for example, feeling we lack a personal relationship like that of a partner).**

Finally, we asked for information about the responders such as their year of birth, postcode and their living arrangements. All responses were anonymous.

Of the 3,000 surveys issued, 1,539 (51.3%) responses were returned by the August closing date.

Of those returned, 1,119 (73%) provided valid loneliness scores, which were used to estimate the prevalence of loneliness by age, gender and other characteristics.

Survey results

The overall survey results indicated that two thirds of the sampled population aged 65 years & over are lonely and that 8% were intensely lonely.

The groups with higher rates of loneliness were:

- Those living alone
- Those with more than one long-term condition
- Those with a disability
- Those providing 20 or more hours of care per week
- Those with a weak sense of coherence

The following sections present the results in more detail.

Loneliness and age

22%

of NHS Highland's population are aged 65 years and over

67%

of those aged 65 and above, feel loneliness on some level

8%

of those aged 65 and above, feel intense loneliness

66%

of those aged 75 and above, feel loneliness on some level

10%

of those aged 75 and above, feel intense loneliness

The prevalence of loneliness was higher in those aged 80-84 years, with 71% experiencing some degree of loneliness.

For all age groups, the prevalence of social loneliness (55%) was higher than the prevalence of emotional loneliness (35%).

Loneliness and gender differences

70% of men felt lonely

9% of women felt intense loneliness

Our results show that slightly more men felt lonely; (70%) compared to women (63%) although more women (9%) than men (7%) felt intense loneliness. Social loneliness was experienced by 51% of women and 58% of men.

Emotional loneliness was experienced by 38% of women and 31% of men. Other research on loneliness and gender suggests that women over 85 years old and men who have low life satisfaction, resilience and depression are more likely to experience loneliness³⁷.

In addition, these researchers reported that those with poor social networks were more likely to experience loneliness, especially women.

Urban and rural loneliness

10%

in 'very remote small towns' feel intense loneliness

5%

in 'accessible rural' feel intense loneliness

Table 1 - Emotional and social loneliness by urban/rural location

Scottish 8-fold urban/rural classification	Emotional loneliness	Social loneliness	Combined loneliness
Urban areas	35% (7%)	45% (19%)	60% (9%)
Accessible small towns	32% (7%)	60% (19%)	71% (7%)
Remote small towns	48% (3%)	51% (24%)	66% (7%)
Very remote small towns	33% (6%)	58% (25%)	67% (10%)
Accessible rural	32% (4%)	52% (12%)	63% (5%)
Remote rural	37% (6%)	54% (21%)	65% (8%)
Very remote rural	34% (4%)	59% (19%)	72% (8%)
Undisclosed	15% (5%)	48% (24%)	67% (8%)
Total	35% (5%)	55% (19%)	67% (8%)

Figure in brackets denotes percentage experiencing intense loneliness

The prevalence of some degree of loneliness was highest in 'very remote rural areas' (72%) and 'accessible small towns' (71%) and lowest in urban areas (60%), as found in Table 1.

The prevalence of intense loneliness was greatest within 'very remote small towns' (10%), and lowest in accessible rural areas (5%).

The prevalence of social loneliness was highest in 'accessible small towns' (60%), 'very remote rural areas' (59%), and 'very remote small towns' (58%). It was lowest in urban areas (45%).

The prevalence of emotional loneliness was highest in 'remote small towns' (48%) and lowest in accessible rural areas and in accessible small towns (32%).

The prevalence of social loneliness was higher than that of emotional loneliness in every residential category.

Loneliness and living arrangements

75% of those living alone feel lonely

15% of those living alone feel intense loneliness

62% of those living with others feel lonely

5% of those living with others feel intense loneliness

Partnership status		
Divorced/separated and living alone	Widowed and living alone	Married and not living alone
75% feel lonely	74% feel lonely	26% feel lonely
20% feel intensely lonely	12% feel intensely lonely	2% feel intensely lonely

Table 2 - Emotional and social loneliness by living arrangements

Living arrangement	Emotional loneliness	Social loneliness	Combined loneliness
Alone, divorced/separated	45% (16%)	66% (37%)	76% (23%)
Alone, widowed	57% (11%)	55% (21%)	76% (13%)
Alone, never married/SSCP*	37% (4%)	70% (38%)	73% (12%)
With others, married	26% (2%)	52% (16%)	62% (5%)
With others, widowed	52% (7%)	43% (17%)	64% (7%)
With others, divorced/separated	33% (5%)	65% (30%)	68% (9%)
Undisclosed living arrangement	80% (40%)	83% (17%)	100% (20%)
Total	35% (5%)	55% (19%)	67% (8%)

Figures within the brackets indicates the percentage of people experiencing intense loneliness

SSCP= Same-Sex Civil Partnership

In line with evidence from previous research, living arrangements have an effect on levels of emotional and social loneliness. A higher proportion of those 'living alone' (e.g. divorced, widowed etc) reported some degree of loneliness (73-76%) compared to those living 'with others' (62-68%), see Table 2.

This also applies to intense social loneliness where those divorced or separated and living alone reported a higher prevalence of intense social loneliness (37%) compared to those divorced or separated and living with others (30%) and compared to the figure for NHS Highland as a whole (19%).

Those 'living alone and divorced or separated' recorded the highest percentage of intense loneliness (23%). The other two groups who lived alone were also associated with higher proportions of intense loneliness than the overall for the NHS Highland sample (8%).

We would expect that 'living with others' makes us less likely to experience loneliness. Our local findings support this in terms of those who experienced some level of loneliness.

However, for social loneliness, this is not the case for those separated or divorced where the prevalence of loneliness was higher (65-66%) compared to the prevalence for NHS Highland as a whole (55%).

Being married and not living alone was associated with a lower prevalence of emotional loneliness (26%; 2% intense loneliness), compared to the overall prevalence for NHS Highland as a whole (35%; 5% intense loneliness).

Although marriage reduces loneliness for many, the effect was not universal. This may reflect the fact that most of us require a social network that is wider than one person.

Long term health conditions (LTCs) and loneliness

80%

of those living with one or more LTC feel lonely

18%

of those living with one or more LTC feel intense loneliness

Chart 1 - Loneliness by long term condition

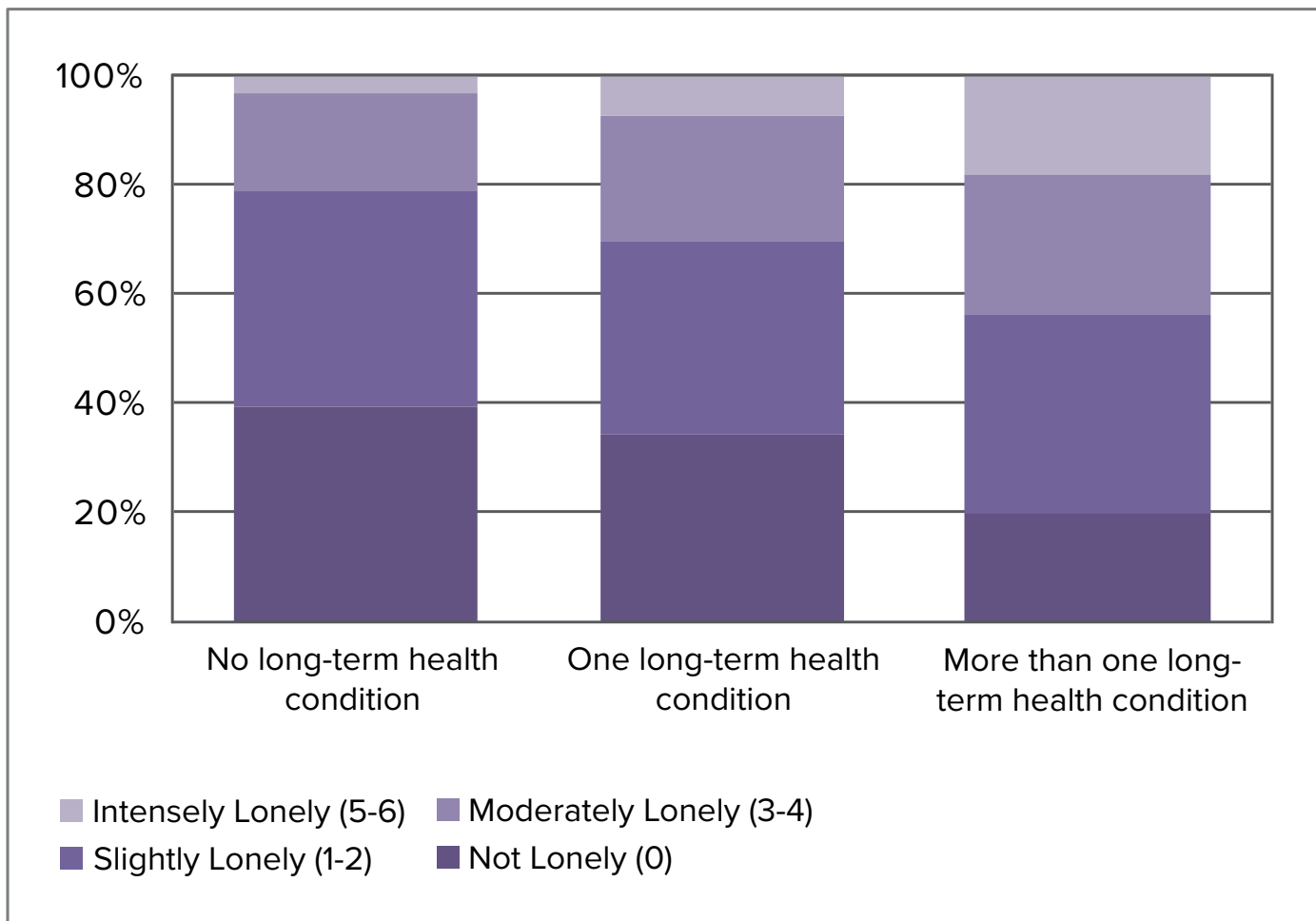


Table 3 - Emotional and social loneliness by long term condition

Number of long term conditions	Emotional loneliness	Social loneliness	Combined loneliness
No long term condition	24% (2%)	49% (15%)	60% (3%)
One long term condition	34% (5%)	53% (19%)	66% (7%)
More than one long term condition	53% (12%)	68% (27%)	80% (18%)

Figures within brackets indicate the percentage of people experiencing intense loneliness

The relationship between loneliness and long term conditions (LTC) is shown in Chart 1. Those with one or more LTC were more likely to feel some degree of loneliness than those with no LTC.

Those with more than one LTC were more likely to experience intense loneliness (18%) than either those with one LTC (7%), or those with no LTC (3%), see Table 3.

A higher proportion of those with more than one LTC experienced intense loneliness than was the case across NHS Highland as a whole (8%).

Previous research has similarly shown that those with poor health are more likely to experience loneliness⁴³.

Those with more than one LTC have the highest levels of emotional (53%) and social loneliness (68%). The prevalence is higher than that for NHS Highland as a whole in the case of both emotional loneliness (35%) and social loneliness (55%).

Our results support previous research which has highlighted that experiencing one or more LTC is a risk factor for loneliness⁴⁴. This may be because it limits a person's ability to socialise and stay connected with others in their community.

Disability and Loneliness

29% of sampled population are living with a disability

77% of those living with a disability, feel loneliness on some level

16% of those living with a disability, feel intense loneliness

Blind/visual impairment	Deaf/hearing impairment	Physical disability	Other disability
82% feel lonely	72% feel lonely	76% feel lonely	82% feel lonely
26% feel intensely lonely	12% feel intensely lonely	15% feel intensely lonely	22% feel intensely lonely

Chart 2 - Loneliness by disability

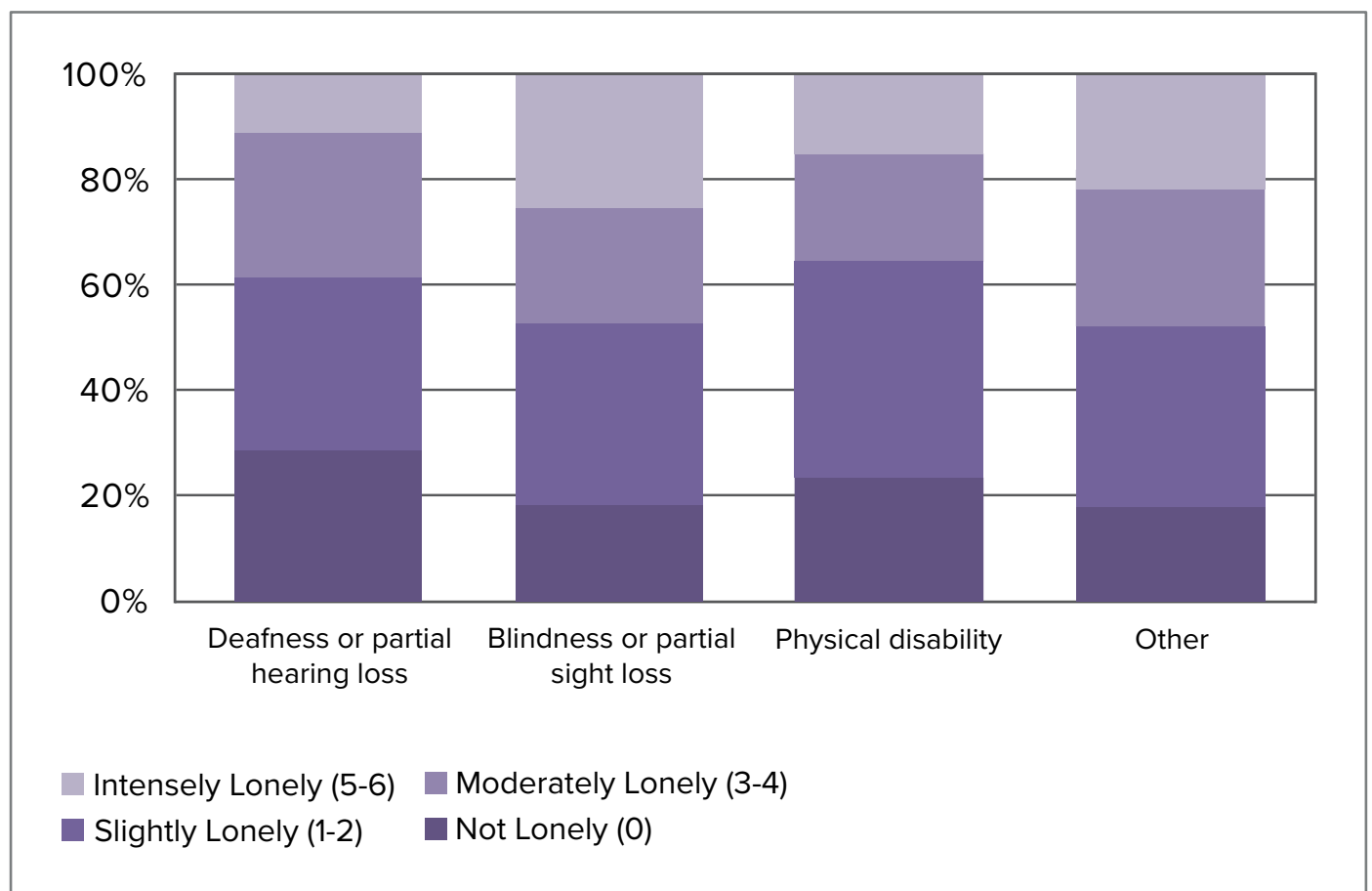


Table 4 - Emotional and social loneliness by disability

	Emotional loneliness	Social loneliness	Combined loneliness
Deaf/hearing impairment	44% (10%)	58% (25%)	72% (12%)
Blind/visual impairment	68% (11%)	59% (32%)	82% (26%)
Physical condition	51% (13%)	58% (22%)	76% (15%)
Other disability	56% (16%)	70% (35%)	83% (21%)
Living with a disability or long term condition	46% (11%)	61% (26%)	76% (15%)

Figures within brackets indicate the percentage of people experiencing intense loneliness

Those with a disability were more likely to experience some degree of loneliness (77%). This is in line with previous research, which has found that those with either physical disability or sensory impairment were at greater risk of loneliness⁴⁵.

Chart 2 indicates the prevalence of the degree of loneliness in those who have disabilities. The proportion of those with disabilities who experience intense loneliness (16%) was higher than the average for NHS Highland as a whole (8%).

Experience of loneliness and intense loneliness varied depending on the type of disability (Table 4).

Those with a visual impairment or physical disability were more likely to experience some degree of loneliness (82% and 76% respectively), whilst 72% of those with a hearing impairment reported some degree of loneliness.

Those with a visual impairment were most likely to feel intense loneliness with 26% reporting this compared with 12% of those with a hearing impairment and 15% of those with a physical disability.

The prevalence of some degree of emotional loneliness in those living with a disability was 46%, compared to 35% in the overall NHS Highland surveyed population.

This group also experienced greater levels of intense emotional loneliness (11%) compared to the overall NHS Highland surveyed population (5%).

A similar pattern was seen in relation to social loneliness with 61% of those with a disability reporting some degree of social loneliness compared to 55% in the overall sample.

More than a quarter (26%) of those with a disability experienced intense social loneliness compared to 19% of the overall population sampled.

The results show those living with a disability are more likely to experience loneliness (76%) than the overall population of older people across NHS Highland (67%). This is in line with previous research⁴⁶.

Furthermore, those with a disability were more likely to experience intense loneliness (15%) than the overall population sampled (8%).

Carers and loneliness

9%

of sampled population provide care (paid and/or unpaid) for another

79%

of those providing 20 hours or more of unpaid care feel loneliness on some level

14%

of those providing 20 hours or more of unpaid care feel intense loneliness

Chart 3 - Loneliness by amount of unpaid care provided

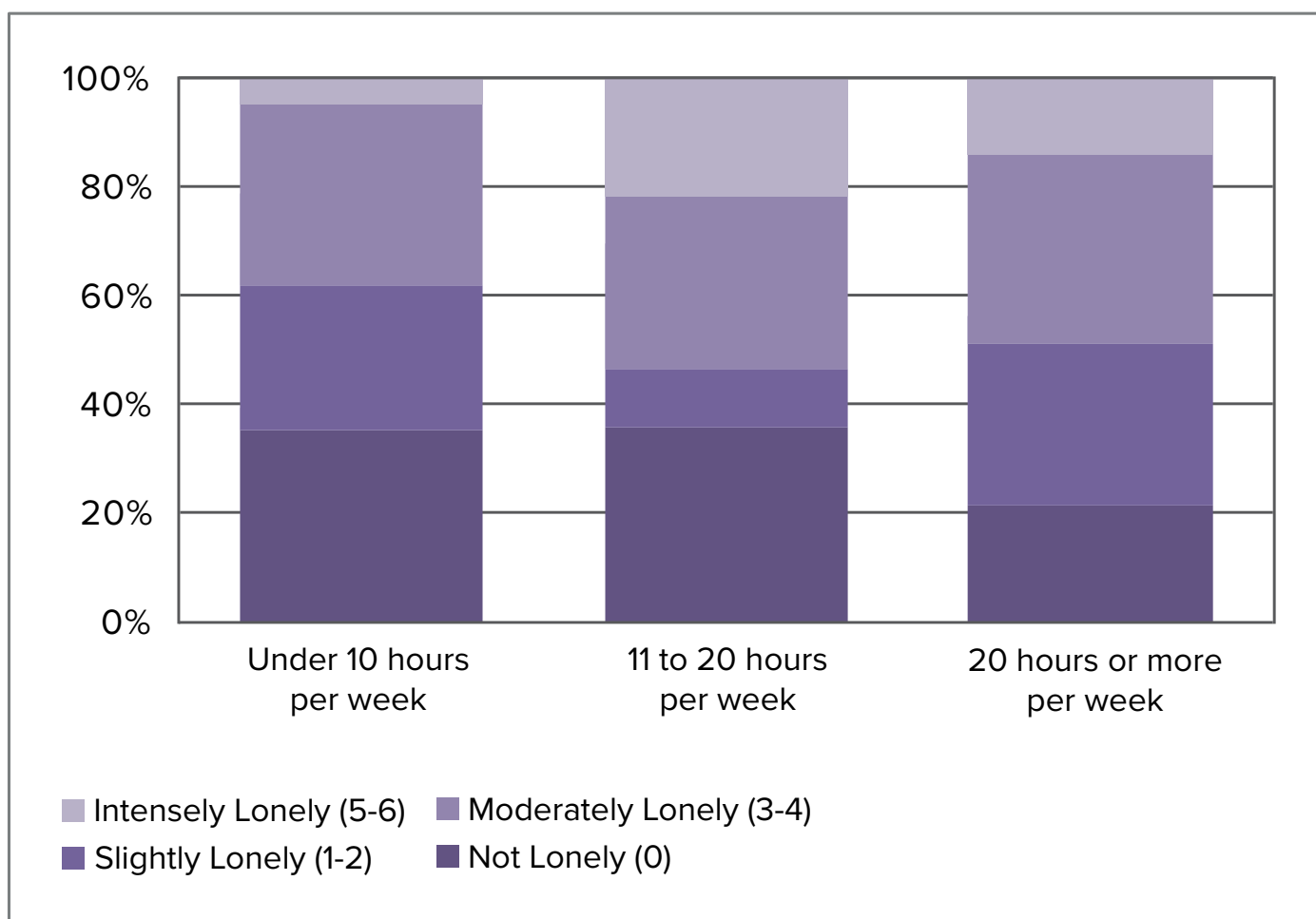


Table 5 - Emotional and social loneliness by hours of unpaid care provided

Number of hours of unpaid caring	Emotional loneliness	Social loneliness	Combined loneliness
Under 10hrs per week	36% (0%)	64% (23%)	65% (4%)
11-20 hrs per week	54% (8%)	64% (36%)	58% (17%)
20hrs + per week	42% (9%)	69% (34%)	79% (14%)
Unpaid carers combined	44% (8%)	67% (32%)	74% (13%)

Figure in brackets denotes percentage experiencing intense loneliness

We found that 74% of all unpaid carers experienced loneliness with 13% feeling intense loneliness. Both these percentages were higher than those measured in the NHS Highland population (67% and 8% respectively), see Table 5.

Carers experienced greater levels of social (67%) and emotional (44%) loneliness than the overall Highland sample (55% and 35% respectively).

Those who provided over 20 hours of unpaid care per week were more likely to experience some degree of loneliness. Those who provided 11-20 hours per week of unpaid care report the most intense levels of loneliness.

Overall, those who provided care were more likely to experience loneliness, and more intense levels of loneliness, compared to those who did not provide care. Previous research has demonstrated that caring responsibilities reduce carers' ability to maintain social networks including relationships with friends and family⁴⁷.

All categories of carers experienced a higher prevalence of social loneliness (67%) compared to emotional loneliness (44%).

10% of the respondents to our survey provided paid or unpaid care for someone else; of these 10% provided invalid responses and were excluded from the analysis.

As almost all of the valid responses were from those providing unpaid care, the results presented here relate to unpaid carers.

Chart 3 shows that the prevalence of some degree of loneliness was highest in those who provided 20 hours or more of care per week (79%) compared to the NHS Highland population (67%).

Those who provided 11-20 hours per week experienced the highest prevalence of intense loneliness (17%) compared to the prevalence in the NHS Highland population (8%).

Previous research shows that carers are more likely to have experienced loneliness, with Carers UK suggesting that 83% of carers feel lonely or socially isolated.

Deprivation and loneliness

79%

of sampled population reported a 'good' or 'excellent' quality of life

Similar levels of loneliness were evident whether living in least or most deprived areas

Living in least deprived areas

Living in most deprived areas

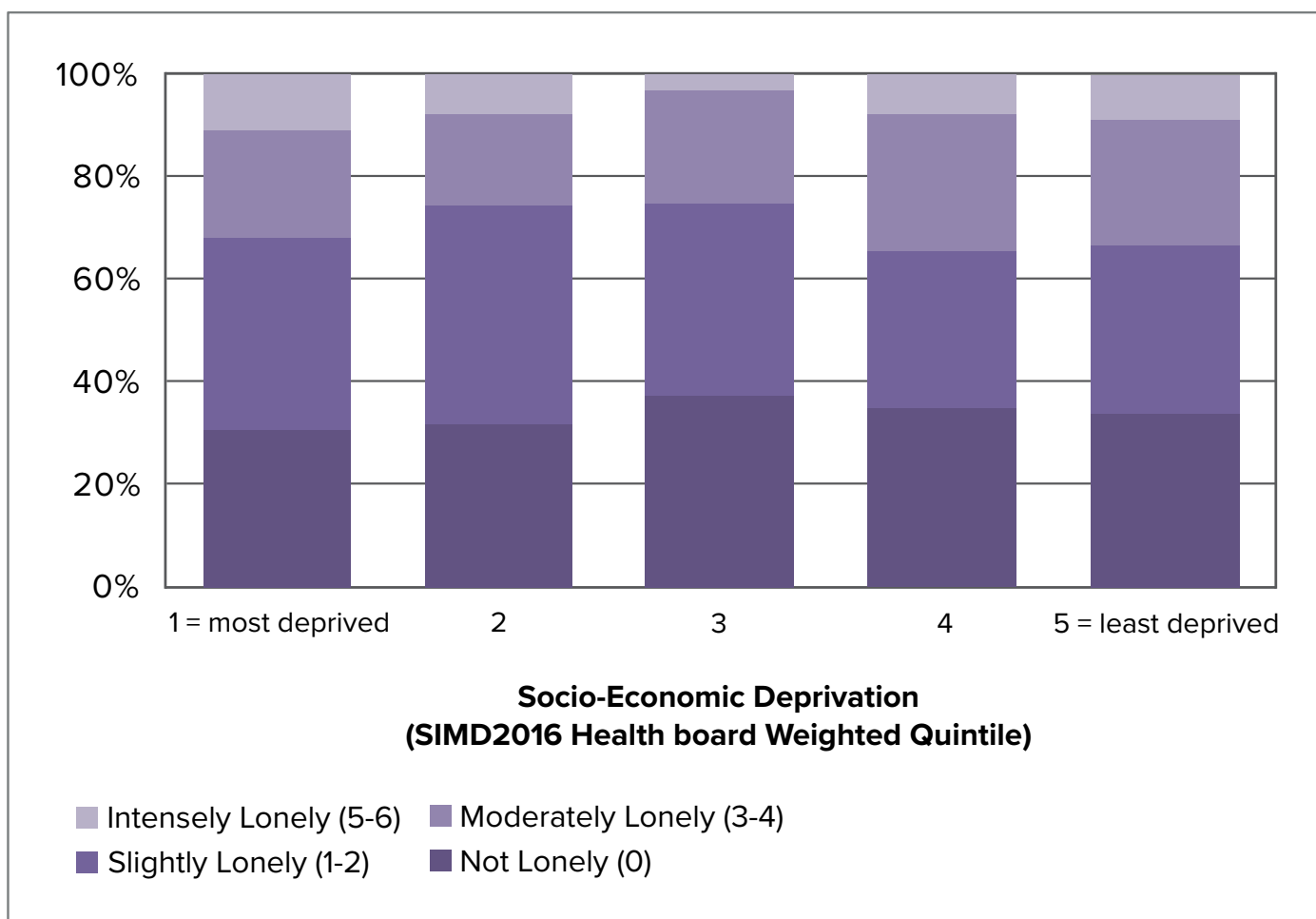
67% feel lonely

69% feel lonely

10% feel intensely lonely

11% feel intensely lonely

Chart 4 - Loneliness by socio-economic deprivation



Research indicates that deprivation and loneliness are linked, and that higher levels of deprivation increase the likelihood of loneliness⁸.

However, we found little difference in the prevalence of loneliness between those living in our least deprived areas (67%) compared to our most deprived areas (69%).

This was also the case for those experiencing intense loneliness, with 10% reporting intense loneliness in our least deprived areas compared to 11% in our most deprived areas (Chart 4).

This suggests that in the context of NHS Highland, factors other than social-economic deprivation are key drivers of loneliness.

Sense of coherence

95%

of those expressing a weak sense of coherence feel lonely

40%

of those expressing a weak sense of coherence feel intense loneliness.

Table 6 - Emotional and social loneliness and level of sense of coherence

Level of sense of coherence	Emotional loneliness	Social loneliness	Combined loneliness
Strong sense of coherence	23% (2%)	48% (14%)	58% (4%)
Intermediate sense of coherence	39% (5%)	55% (19%)	69% (7%)
Weak sense of coherence	77% (29%)	87% (54%)	95% (40%)

Figures within brackets indicate the percentage of people experiencing intense loneliness

A weak sense of coherence (SoC) has been linked to increased risk of mental illness and mortality^{24,25}. There is limited research on the link between a sense of coherence and levels of loneliness. This study, therefore, provided an opportunity to examine this relationship.

Of the valid loneliness scores in our survey, 95% had a valid SoC score. These cases were used in the analysis below.

Our results indicated that 95% of those with a weak SoC experienced some degree of loneliness, whereas the figure was 58% in those with a strong sense of coherence. The overall NHS Highland figure was 67%.

The relationship between SoC and the likelihood of feeling lonely, also applied to feelings of intense loneliness. In those with a weak SoC, 40% experienced intense loneliness compared to 8% of the overall sample and 4% in those with a strong sense of coherence.

In addition, those with a weak SoC experienced the highest levels of emotional (77%) and social (87%) loneliness – higher than the NHS Highland sample figures of 35% and 55% respectively.

Only 2% of those with a strong SoC experienced intense emotional loneliness compared to 29% of those with a weak SoC. Similarly those with a weak SoC were more likely to report intense social loneliness (54%), compared to those with a strong SoC (14%).

Previous research has demonstrated higher prevalence of a low sense of coherence in females, older people, those most socio-economically deprived, and in those with more than one long-term health condition. Our findings are consistent with that found in younger adults²⁵.

Key messages

67% of people aged 65 and over in the NHS Highland area experience some degree of loneliness and 8% experience intense loneliness

Risk factors for loneliness in those aged 65 years and over include:

- living alone
- living in very remote rural areas or very remote small towns
- having a disability
- having one or more long-term conditions
- providing more than 10 hours per week of unpaid care

Protective factors for loneliness in those aged 65 years and over include:

- a strong sense of coherence
- living in a town or accessible rural area
- married and living together



Chapter Four - What Older People Think



In 2014, three focus groups were undertaken in the Cowal area to investigate older people's views of social relationships and health.

The focus groups took place at:

- A sheltered housing complex, where six residents took part
- a community befriending group, where seven members took part
- a third sector community resilience project, where seven participants took part.

Participants ranged in age from 60 to 99 years and although men and women were invited, only women took part. Although this may limit the generalisability of the findings, it still provides significant insight into the experiences of older people within NHS Highland.

Focus group discussions were recorded and transcribed word for word. This was analysed using a technique called thematic analysis, which involves looking for common ideas and themes. The required approvals were obtained for this project, which was undertaken as part of a Masters dissertation.

Focus group findings

The focus group findings are summarised as per the quotations in the following content.

Whilst quotes have been used to illustrate these themes, the names of those involved have been changed to preserve confidentiality.

Identified themes

1. Relationships:
 - a. Family
 - b. Peers
2. Maintaining social relationships:
 - a. Opportunities for meeting people
 - b. How ageing affects the maintenance of relationships
3. Loneliness
 - a. Alluding to loneliness or talking about loneliness in others
 - b. Explicit loneliness



Theme 1 - Relationships

Participants spoke in vivid terms about their relationships. One participant, Mauve, spoke about the high level of value she placed on social relationships with friends and family.

"There's a circle of people with whom I'm in touch about once a month and they're people that have known me a long time and I can talk to them about absolutely anything..."

Nessie also referred to the importance of relationships to her:

"I've got loads of, loads of friends, more friends than I had when we lived in Lanarkshire and they're just wonderful, wonderful people."

a. Family

Relationships with family members were particularly important⁴⁸. Several participants had contact and support from their children. Annette explained how her daughter gave practical support:

"I'm very fortunate because my daughter just stays across the road and she tends to help out a lot and do things for me, [...] I know that if there's anything wrong you just need to pick up the phone..."

Mavis mentioned practical barriers affecting family support:

"...the family are all down in Reading, my daughter comes up when they can but they're starting to depart a bit 'cause they're getting more children themselves."

b. Peers

Peer relationships were expressed as spending time with people of a similar age, background or experience⁴⁹. All groups spoke about relationships with peers. Mauve described the closeness that can come from knowing someone well:

"...the long term friends possibly know me better than my family."

With increasing age, peer groups got smaller, for example, friends may have died⁵⁰. Mavis spoke about being the only surviving member of her bridge group:

"...there are 12 of us and every 12 met every Wednesday [] all of them have died, which is a bit of a shock, suddenly every single one..."

Peer support was apparent when Mavis talked about her close friendship with Maggie who attended the same activity as she did:

"Maggie is my godsend, because I'm usually on the telephone 'Oh Maggie I'm not feeling very well!..."

In the sheltered housing group where the participants knew each other well, peer support was described by Muriel:

"In this community everyone cares about everyone else, and that goes a good deal towards good health if you like, if no one ever chaps on your door it's a very lonely existence..."

Theme 2 - Maintaining social relationships

The second theme identified in the discussions was maintaining social relationships.

a. Opportunities for meeting people

Participants gave many examples of how they established and maintained social relationships. These included neighbours, churches, and wider community activities like evening classes and volunteering.

Elsie talked about neighbours:

"I find too, good neighbours, I mean the house I'm in is far too big for me but I really don't want to move because I've got good neighbours and I'm really quite happy where I am."

On a practical level Elsie knows her house is too big but she does not want to leave. Conversely, Alice's neighbour moved away:

"...she used to just knock my door [...] and then she moved up to Edward Street and do you know it's quite funny because you're waiting on her coming to your door or you go to knock her door and you realise – 'Oh she's not there!'"

Several participants mentioned activities specifically for older people, examples included social clubs, a structured befriending service and social activities organised by sheltered housing. Maggie spoke about her participation in the community befriending group:

"The best thing that happened to me was the day I joined the befrienders [...] I never looked back. I look forward to this special day every week."

There was evidence of community resilience, and the ability to withstand problems and overcome adversity⁵¹. Mona spoke about her clubs:

"Well I go to three clubs [...] I have done for the last 20 years. It doesn't seem like that but it is. But that's not everyday and some days it is pretty boring, but on the whole [...] you're meeting people, joining in whatever's going on."

This comment about clubs being 'pretty boring' is interesting. Research on interventions to reduce loneliness has found that active involvement from participants in the planning of activities is likely to achieve the most benefit⁵². Her comment suggests that this may have been lacking in the activity she was attending.

Several participants spoke about volunteering, working in charity shops or church activities. There is considerable evidence that community participation and specifically volunteering is beneficial, for example, meeting other people or developing social networks often provides a 'sense of purpose' and of 'doing something worthwhile'⁵³.

b. Ageing and relationships

Ageing is associated with failing health and reducing capability. Participants in all three groups spoke of decreasing ability. Annette said her physical health had deteriorated:

"I wasn't very well early on in the year and now I've got a zimmer and a walking stick, which I try to avoid using...."

There is evidence that physical decline stops older people maintaining social relationships⁵⁴. Eleanor recognised the limiting effect her capability has on social interactions and said:

"Yes. I can't go out on my own. My sight you know, I'm registered blind."

Some participants were less confident about taking part in social activities as they got older. In Betty's case a connection was made to failing health:

"...when you're on your own, the older you get, I think you get more cautious [...] I might fall, I might have a stroke or a heart attack or something it's being pessimistic but it's possible..."

A number of participants spoke about the challenge of continuing to drive. Elsie said:

"I was perfectly competent but I didn't have all the confidence in the world, you know it takes years of driving to build up your confidence. When my husband died just over a year ago I gave the car up."

Mavis also stopped driving:

"I, erm, bashed the car, which was a pity so I had no car..."

Transport affects the ability of older people to get to activities, especially in rural areas where transport options may be limited⁵⁵. Giving up driving was found to be a significant factor in contributing to loneliness in a Canadian study of loneliness in older people⁵⁶.

Theme 3 - Loneliness

The challenge of loneliness was well described. Elsie expressed her sense of isolation as follows:

"... if you are on your own the problems become magnified and you imagine things are wrong with you. You're sitting on your own, there was maybe nothing wrong with you but you imagine there are things wrong with you [...] that's what isolation does to you."

Betty gave the following reply to Elsie:

"Yes that's right, you've got no-one to bounce things off..."

a. Recognising loneliness

Loneliness was expressed as having stigma attached to it⁵⁷. This could be the reason Sarah spoke about loneliness in the second person:

"...if you are lonely and you've got nothing to do, you sit there and feel even more lonely and depressed, but if you've got something on the go, knitting or something and you're concentrating on that, you're not so lonely."

Participants spoke more about loneliness in others, for example Maggie talked about her friend:

"I have a friend like that and she is always lonely especially when she draws the blinds at night puts on the light and it's a long, long evening and a long, long night."

Alice remarked about feeling lonely, although she is married:

"I've got a husband and still sometimes you can feel lonely [...] he'll sit at his computer [...] for hours and you'll say to him 'I want to go out' [...] I say to the dog 'I wonder how long the 5 minutes will last this time, come on we'll just get ready and go ourselves' and then he'll say 'Are you not waiting on me' and you feel like choking him."

b. The effect of loneliness

Notwithstanding the sensitivities of discussing personal experiences of loneliness in a focus group and acknowledging this was not a specific question asked of participants, two people in different groups spoke about the effects of loneliness. Betty told the group:

"Sometimes I just can't be bothered doing anything and then I'll sit and watch the soaps but I don't think that's where my loneliness comes from."

Loneliness is often experienced by people following the death of a spouse⁵⁸. Molly also spoke of the effect on her:

"I would like to say how lonely I am and there is a reason, I'm not long widowed and I've never been on my own in my life and I feel it, but I'm getting better. I nearly went into a black hole but I'm getting better because I'm determined to do it, but I have been very lonely..."

Conclusion

This qualitative research provided an insight into what loneliness and social relationships mean for older people in the context of their everyday lives.

It is clear that older people are not a homogeneous group, and that a range of community based services and activities are required to reduce their isolation and loneliness.

The groups also brought to light the importance of co-production and the importance of involving older people in the design of the services that they receive.

Chapter Five - Reducing Loneliness



Developing and maintaining social relationships

The logical answer to reducing the incidence of loneliness is to increase opportunities for social interaction for people who feel lonely, or who are at risk of loneliness.

However, this is easier said than done. The assumption amongst some older people that it is normal to be lonely in old age should be challenged, as new friends can be made⁵⁹.

Having frequent contact seems to be more important than the number of friends that someone has.

A small number of meaningful relationships may be better than a large number of acquaintances. Support in developing or refreshing the social skills required to make new friends is key, as is encouragement to 'give it a try'.

Evidence suggests that interventions which support people to become active participants in group activities rooted in their communities is one of the most successful ways of reducing loneliness.

A review of the evidence undertaken in 2014, about what works to prevent social isolation and loneliness in older people, suggests the following characteristics are relevant for any successful intervention to enable the development of meaningful relationships:

- older people are active participants rather than passive recipients⁶⁰
- older people are involved in the planning and implementation of support⁶¹
- support is flexible and adaptable to the needs of the participants⁶¹
- support consists of group activities, particularly those with a defined goal³⁷
- support is rooted in the community³⁷
- the intervention has a theoretical basis (i.e. is evidence informed)¹².

These characteristics are key to a co-production approach, which may be defined as:

"Professionals and citizens making better use of each others' assets, resources and contributions to achieve better outcomes or improved efficiency."⁶²

Bovaird & Loeffler, 2012

Contact with children is a particularly effective antidote to loneliness. This appears to apply to cross-generational contacts in general, i.e. contact with children and young people as well as contact with one's own (grown-up) offspring.

Asset mapping

Asset mapping is a term used to find out what is going on in communities, for example, what services and activities there are as well as having good up to date contact details so that people are able to easily access them.

Information from asset mapping can be provided in a variety of ways including posters in community locations; through word of mouth; and increasingly online information sharing on websites and social media.

Asset mapping can help signpost people who are lonely to appropriate support and activities.

Social prescribing

Social prescribing is the process of referring people to appropriate sources of support for social problems within their community.

For social prescribing to be effective, health professionals need to know where to refer people to by having accurate lists of community activities and services.

There is a key role for primary care in undertaking social prescribing.

Solutions to reducing loneliness need to be multi-faceted and include more than one of the following:

Information and signposting services

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

Support for individuals

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

Group interventions – social

- day centre services such as lunch clubs for older people
- social groups that aim to help older people broaden their social circle, and possibly focusing on particular interests, such as reading

Group interventions – cultural

- initiatives that support older people to increase their participation in cultural activities (e.g. use of libraries and museums)
- community arts and crafts activities
- local history and reminiscence projects

Health promotion interventions

- walking groups for people over 50
- healthy eating classes for people over 50

Wider community engagement

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

Source: Loneliness and Isolation: a toolkit for health and wellbeing boards, The Campaign to End Loneliness (www.campaigntoendloneliness.org.uk/toolkit/)

Loneliness is not often spoken about and many people experiencing loneliness are reluctant to admit they feel lonely. It can even be viewed as a personal failing.

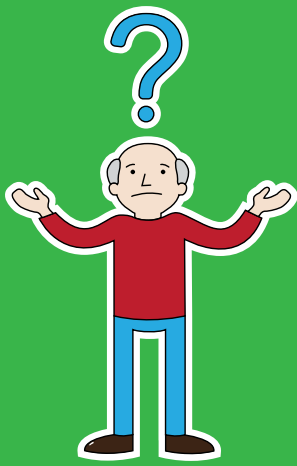
Front line health and social care staff may not ask people if they feel lonely due to a lack of understanding of what to do to support them. There also seems to be no systematic or consistent approach to raising the issue during routine contact with services.

However, there is a case for health and social care staff to regularly ask about loneliness and social isolation and signpost people

to opportunities to develop stronger social networks.

Community-led interventions often cost less than treatment of conditions that are linked to loneliness. For example, this is the case in dementia.

However, building ongoing local solutions requires sustained funding to ensure the longevity of services and activities. Currently third sector funding is short term and fragile and by consequence, so are many of the services delivered by this sector.

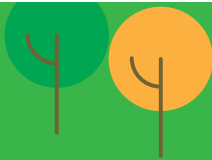


Accessing community activities and support

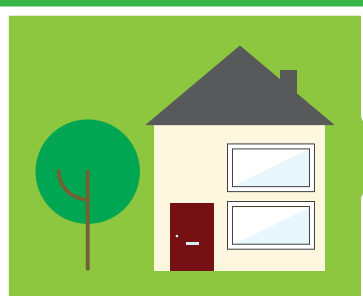
Some people who are lonely may be able to access their own support with appropriate signposting but others need more help to do so. In the case of people who are already lonely it is very likely they will need help and encouragement to be able to take part in community activities.



Places of Worship



Community Centres



Family and/or friends



Colleagues at Work



Places of Education



Examples across NHS Highland

The following information describes some of the initiatives across the NHS Highland area that help to tackle loneliness and social isolation.

Shopper Aide

Shopper-Aide is a social enterprise delivering services to people aged 60 years and over, to help them remain as independent as possible in their own homes.

Their client base is made up of people receiving statutory services, such as home care, but needing additional help, and also people living independently with no health and social care input. The initiative is highly valued by service users and by health and social care practitioners as one that keeps people socially connected.

Community Resilience Workers

Argyll and Bute Health and Social Care Partnership invest in the Third Sector Interface (TSI) to pay for seven community resilience workers for older people across Argyll and Bute.

These staff work very closely with their local communities to provide support for individuals on a one-to-one basis and in addition, develop group based activities.



Members of the Kintyre community group on a recent trip to the Corrivrekan whirlpool.

Befrienders Highland

Befrienders Highland offers befriending to people across the Highlands including those who live with mental health issues or dementia, as well as carers of people with dementia who are socially isolated.

Volunteers now support 100 people who are known as 'friends' across the length and breadth of NHS Highland. Befriending increases wellbeing, social connectedness and a sense of belonging within the community.



Shopper Aide clients, staff and volunteers enjoying a day out at a local tea-room in Kintyre.

Step It Up Highland

Step It Up Highland co-ordinates a network of volunteer-led health walk groups throughout the Highland Council region. Many participants say that the social interaction aspect is their main reason for joining a walking group. A number of those who joined a walking group have gone on to become walk leaders, starting their own groups in other areas.

Community Transport Schemes

There is a range of Community Transport Schemes across NHS Highland that operate with volunteer drivers. Schemes meet the needs of people who cannot get out and about and fills gaps in existing public transport, either with volunteer drivers using their own car or using the scheme's own vehicles, which can be hired and are fully accessible to those with disabilities.

“I think it is so handy and it gives me my independence. If there was no car scheme I would be stranded in my own home”

Living it Up

Living it Up is a web-based health and well being self management hub, which supports people aged 50 years with long term conditions and their carers.



Volunteer walk leader, TJ, who has provided support to a number of walking groups in the Inverness area.

Living it Up facilitates peer support through the use of inspirational user stories and experiences and users are asked to contribute to 'experience guides' and online articles.

The scheme supports the development of digital skills and health literacy. One of the popular aspects of Living It Up is the activity logs and community challenges that it organises. It also contains information on local activities and services. These tools encourage and motivate people to get out and about more.



Living It Up provides motivation for people over 50 to get out and increase their physical activity.

Cathy Steer, NHS Highland Head of Health Improvement, Steven Ferguson, Ross County's Head of Youth and Community and Roisin Connolly, Connecting Carers Manager with the Reach Out pledge



Reach Out

'Reach Out' provides an overarching framework for a wide range of initiatives to address loneliness and social isolation across NHS Highland. The scheme has been very well supported.

The local press have done an excellent job of promoting the campaign, resulting in extensive coverage of the campaign in local newspapers and radio channels. It has also been backed by a wide range of local organisations.

Reach out has its own online presence on Facebook, Twitter and Instagram and has a dedicated website: www.reachout.scot.nhs.uk

Many pledges have been signed online. Examples of personal pledges include:

- Smiling and talking to people in the street
- telling friends and family about the pledge and encouraging them to sign up
- knocking on your neighbour's door to get to know them better
- inviting people you know who live alone to have a meal with you.

Employer pledges include:

- Raising awareness of the pledge with all staff emails and web links
- encouraging staff to volunteer with community groups
- providing information on local social support for staff who may be feeling lonely.

In summary, Community Planning Partners across Highland and Argyll & Bute have made major strides in developing a sustainable platform for addressing social isolation and loneliness via the Reach Out campaign, but much more remains to be done.

Recommendations

- Build capacity in the Third Sector so they can further invest in community based support. Careful consideration of funding models is required here due to the fragility of long term funding solutions for these services.
- Showcase examples of what is working in local communities to reduce social isolation and loneliness.
- Ensure the principles of co-production are fully embedded in service design and delivery i.e. older people informing and shaping the services they want.
- Enable people to access these services, considering community transport for those who may have difficulty using their own or public transport.
- Embed the principles of social prescribing to ensure people with underlying social problems at the root of their health problems get referred or signposted into appropriate sources of support.
- Local ownership and value of Third Sector community support for loneliness and isolation by Health and Social Care partners.



Chapter Six - Conclusion



This report has drawn together a range of published and local evidence regarding the importance and impact of loneliness and social isolation.

The costs associated with loneliness are significant in terms of mortality and morbidity and in relation to the cost to public services. Additionally, the significant human impacts of distress and poor quality of life for people experiencing loneliness are recognised.

A number of factors have been identified in the published literature that increase the risk of being lonely including having a disability, a long term health condition or being a carer.

Conversely, there are protective factors against loneliness including having a strong sense of coherence, regular opportunities to socialise and good social and family structures such as living together or being married.

The published evidence indicates that a range of measures to reduce loneliness are cost effective, can reduce health service costs and represents value for money for the public purse. Some of these approaches are being provided across NHS Highland.

The risk of feeling lonely increases as we get older. The proportion of older people is expected to increase over the next decade; this will have a bearing on the impact of loneliness on our communities and the requirement for interventions to reduce loneliness delivered by communities themselves, public sector and third sector organisations.

A 2016 survey in Highland indicated that 67% of the population over 65 years experienced some degree of loneliness.

Living in very remote rural areas or very remote small towns was associated with an increased prevalence of loneliness compared to urban or accessible rural areas. Those who reported having a strong sense of coherence had a lower prevalence of loneliness.

This report makes ten recommendations for implementation by the NHS as well as wider

health and care partners and the general public, these are outlined below:

1. Increase awareness of the strong links between loneliness and poor health, mortality and increased service utilisation. In order to achieve this:
 - The Public Health Department will continue to raise awareness of the risks of loneliness and isolation.
 - There will be comprehensive promotion and marketing to showcase examples of what is working in local communities to reduce social isolation and loneliness.
 - The community nature of the problem of loneliness and the need for a partnership approach to finding solutions will be advocated. This is an ideal topic for Community Planning.
2. Health and social care services should consider the risk factors of loneliness and raise the issue during patient assessments and consultations. Staff should regularly ask people they come into contact with if they feel lonely and signpost to local sources of support.
3. Embed social prescribing in health and social care delivery to ensure people with underlying social problems get referred or signposted into appropriate sources of support by their health professional or care giver.
4. Ensure people experiencing or at risk of loneliness are able to access appropriate services. There may be practical barriers present so consider community transport for those who may have difficulty using their own or public transport.
5. Public sector bodies should invest in interventions to reduce loneliness as part of a wider focus on preventing health problems before they arise. The promotion of a preventative approach to loneliness should focus on building capacity in the third sector so they can further invest in community based support. Careful consideration of funding models is required, due to the fragility of long term funding for these services.

6. Ensure the principles of co-production are fully embedded in service design and delivery so that older people inform and shape the services they want.
7. Those who award grant funding should minimise the risk of stop/start funding cycles for preventative activity and recognise the financial difficulties of sustaining third sector services.
8. Employers should consider the potential impact of working unsocial hours and weekend shifts on the families and personal networks of their staff.
9. Work on Reshaping Care for Older People should be refreshed to reflect the issues of loneliness and social isolation.
10. Locality plans developed as a result of the Community Empowerment Act and the integration of health and social care services should consider loneliness and help build a sense of coherence within communities.

The Reach Out campaign is an exciting new approach to health improvement and provides NHS Highland with an overarching framework for addressing loneliness and social isolation.

Since May 2016, a wide range of local community support initiatives have signed the pledge to make a difference to someone who is lonely.

Investment in community services needs to be sustained over the long term. This is challenging in a tight financial context, but represents an important opportunity when one considers the overall wellbeing of our population and the potential for improving public service delivery.



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