PLAYBOOK ACTION PLAN

Connecting People and Place:

An action plan for addressing social isolation and loneliness in north Portsmouth

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Portsmouth CITY COUNCIL

NHS Solent NHS Trust

NHS Health Education England

BREAKING BARRIERS INNOVATIONS

About Breaking Barriers Innovations

Breaking Barriers is an independent project with the principal aim of radically improving the delivery of public services across the UK for maximum social impact. We are Chaired by Lord Patel of Bradford OBE and our Research Director is Dr Jon Bashford.

Breaking Barriers works to achieve this by creating an open space for debate in which public service professionals, innovative suppliers, experts and other stakeholders devise new public service models based on innovative place-based working.

Specifically, we act on a place-based agenda. Tackling the paradox of place where too many people talk about it, but not enough act on it.

We work with local authorities, NHS bodies, voluntary and community services, and private industry to deliver bespoke solutions to complex problems at a truly local level.

To do this, we focus on a series of key themes:

- **social determinants of health,**
- **place-based solutions,**
- **systems change,**
- **innovation,**
- **policy development**

Contents

Addendum to Report: Acknowledging Impact of Coronavirus

This report and the associated action plan were largely completed before the Coronavirus pandemic brought large scale social distancing and new understanding about the vulnerabilities of those who are socially isolated. Prior to the current pandemic, the health harms and risks associated with social isolation and loneliness were being increasingly recognised and responded to. The work which has informed this report and action plan was directed at preventing those harms and risks and promoting integrated, place-based actions to reduce social isolation and loneliness.

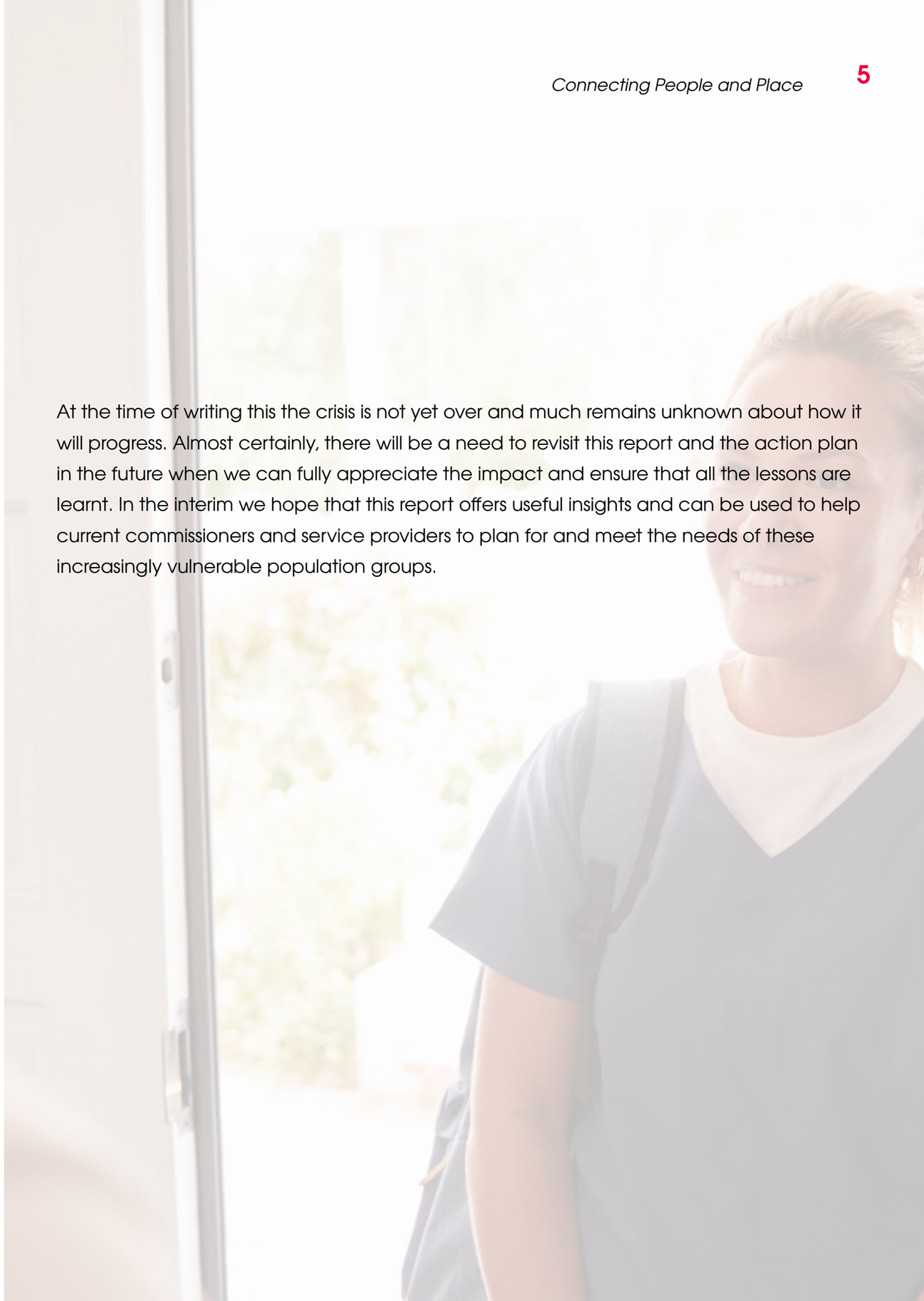
The evidence has not changed, the health harms and risks are real. But they have taken on a new urgency in the midst of the pandemic and the subsequent withdrawal and change of focus for many of the services that would normally provide support for those who are socially isolated and lonely. Those needs now apply to a much larger proportion of the population and there are some significant constraints and challenges in addressing these needs.

We believe that once the current crisis is over this report and action plan will be as relevant and important as it was before the crisis began and as such, we have not made any major changes to the content. However, we have made two changes that we think are necessary in order to reflect what is happening now and to prepare for the future:

1. We have incorporated consideration of the learning that is taking place in response to the pandemic and what this means for those who were already socially isolated and lonely.

2. We have produced an additional section to the action plan which seeks to specifically address the challenges of a widescale crisis and shutting down of normal health and care service provision, both statutory and in the voluntary and community social sectors.

At the time of writing this the crisis is not yet over and much remains unknown about how it will progress. Almost certainly, there will be a need to revisit this report and the action plan in the future when we can fully appreciate the impact and ensure that all the lessons are learnt. In the interim we hope that this report offers useful insights and can be used to help current commissioners and service providers to plan for and meet the needs of these increasingly vulnerable population groups.



1. Introduction

Breaking Barriers Innovations (BBI) and Health Education England (HEE) are leading a series of pilot projects on place and the social determinants of health across England. The pilots seek to provide a facilitated and comprehensive approach to the place-based development and delivery of health and social care services that can address the social determinants of health and wellbeing. Developed from a programme of work on housing and health with NHS West Lancashire CCG[1], the programme uses a Playbook methodology based on four building blocks, which serve as the structure for a rapid process of appraisal and action planning:

1. Strategic alignment
2. Workforce development
3. Resident, service user and community engagement and co-design
4. Action planning for service Integration and Innovation

The building blocks are inter-dependent, and the Playbook is designed to be tailored and appropriate to local variations in demographics, need and strategic priorities. For example, while one area may view the highest level of needs and priority as housing, another may view skills and employment as being more relevant. The Portsmouth North pilot is focused on social isolation and loneliness in three northern wards of the city: Paulsgrove, Cosham and Drayton and Farlington. The overall aim is to support workforce development and planning across health and social care, so that frontline practitioners, managers, and commissioners are confident and skilled in understanding the relationship between social isolation and loneliness and the health and wellbeing of local residents. In particular, it is focused on a family first approach to preventing harms associated with social isolation and loneliness.

A small steering group has overseen the programme comprising representation from NHS Solent Trust, Portsmouth City Council (Adults and Children and Young People), Public Health and Health Education England. A total of 28 interviews have been completed including frontline practitioners in health and social care (adults, families and children), managers and lead officers and volunteers from within community and voluntary organisations. In addition, approximately 15 local residents from community associations, day centres and faith organisations have contributed their views through interviews and a focus group.

This report sets out the findings from the inquiry part of the programme including feedback from professional stakeholders and local residents and desktop research of evidence and best practice. The report concludes with the action plan for service integration and innovation including a separate section for emergency planning and responses for people who are vulnerable from social isolation and loneliness in times of national crisis.

The report and action plan are being used, alongside learning from the other Playbook programmes to inform the approach to place and workforce education, training and transformation that Health Education England is seeking to include in the NHS People Plan.

Also, co-sponsorship of the Portsmouth programme by the Ministry of Housing, Communities and Local Government (MHCLG) will include scoping the development of a national toolkit for the design and planning of Prosocial places.

MHCLG want to use learning from the Portsmouth pilot to scope the development of a Prosocial toolkit to assist local planning agencies and authorities in ensuring both the physical environment and community structures foster connections and empowerment.

The aims of this additional three-month piece of work were to provide MHCLG with insights into the issues of place-based loneliness and its relation to the built environment. The specific objectives were to set out:

1. The strategic and planning context for addressing loneliness and social isolation, including ways in which the national loneliness strategy is being implemented at departmental and local levels.

2. A conceptual framework for understanding the approach to loneliness and social isolation from the perspective of quality in place-based design and development, in particular how this can be used to influence areas of new build and regeneration.
3. A framework for cross-disciplinary competency and skills framework that can be used to build an outline evaluation and/or development of a toolkit for frontline practitioners.
4. Recommendations on how MHCLG can take this work forward.

A separate report from this additional work report is currently being considered by MHCLG. Once this is confirmed the findings will be incorporated into the action plan going forward.

1.1 Place and the social determinants of health

The social determinants of health, for example the conditions in which people are born, live, grow, work and age are widely recognised as being primarily responsible for inequitable disparities in health status across population groups and geographies. Yet, despite this long-standing recognition the health and social care systems continue to struggle with making the social determinants of health a core part of place-based, local service delivery and workforce planning.

NHS England have outlined the importance of focusing on tackling health inequalities and the step change that is required on a cross system basis to improve the health of local populations:

"This requires a step-change in emphasis and an alignment of approaches across the public, private, and voluntary, community and social enterprise (VCSE) sectors as part of a 'whole systems approach' to the health of local populations." [2]

In its simplest terms, a population health management approach is required to underpin an effective place-based health and care system. This should include the full range of public services (NHS, local authority, voluntary and independent sectors) acting collectively to address the underlying health and care needs of local populations as part of a systemic approach to prevention and addressing the social determinants of health.

This is integral to The NHS Long Term Plan[3], which describes how Integrated Care Systems will need to work alongside local authorities at a 'place' level to make shared decisions about how the collective resources available to the local system can be used to improve population health and deliver integrated care. This will allow a range of public services to be delivered in a coherent and mutually supportive way with organisations collaborating together to manage the resources available to them.

However, a place-based approach must be more than just about integrating front-line services, but about considering how all the assets in a 'place', including the workforce, estates, the built environment, community assets and digital technologies can work together more effectively. The importance of this has been brought home by the Coronavirus pandemic, which has highlighted the importance of being able to mobilise community and statutory assets and services rapidly as part of a place-based response to crisis.

Digital technologies and use of social media have also come to the forefront of people's daily lives and digital exclusion in particular, as an aspect of social isolation has taken on a new and urgent significance.

2. Why Social Isolation and Loneliness Matters

There is increasing recognition by national government of the health and social care harms associated with social isolation and loneliness. These have been known since the 1980s, but the issues have been brought to greater prominence through the Jo Cox Commission on Loneliness and the subsequent adoption of a national strategy by the government. This strong government focus has provided an opportunity to address the harms associated with social isolation and loneliness through more coherent and integrated strategy and planning including:

- Addressing social isolation and loneliness, as part of an overarching strategy to address the root causes of ill health and reduce health inequalities is implicit throughout the NHS Long Term Plan[4]
- Strengthening the national approach to workforce planning to ensure place and the social determinants of health are addressed in the NHS People Plan[5]
- Supporting local authorities to better address social isolation and loneliness as part of their duties under the Care Act 2014[6]
- Advancing the focus on prevention and informing the pending Green Paper on Social Care[7]
- Delivering on the Grand Challenge on Ageing as party of the Industrial Strategy[8]
- Realising the benefits of digital innovation in health and social care as envisioned in the Topol Review[9]
- Taking forward the principles for putting health into place following learning from NHS England's Healthy New Towns programme[10]

There is a need to align the above with local area action planning to address social isolation and loneliness in a way that ensures a coherent and comprehensive response to the issues and prevailing health and social harms. This would also strengthen the capacity and competence of local planning authorities and health commissioners to respond effectively to emergency and crisis situations such as that caused by the Coronavirus pandemic. This is important because during normal times, the health harms associated with social isolation and loneliness are profound and far reaching, and during times of crisis it is even more important to identify and account for those who are particularly vulnerable due to social isolation and loneliness.

2.1 Health and social harms caused by social isolation and loneliness

Being lonely is associated with a 50% decrease in survival from serious health conditions such a coronary heart disease. This is because:

- Weak social connections can be as harmful as smoking 15 cigarettes a day.[12]
- Feeling lonely frequently is linked to early deaths. Its health impact is thought to be on a par with other public health priorities like obesity or smoking.[13]
- Loneliness is associated with a greater risk of inactivity (up to two thirds more likely amongst elderly[14]), smoking and risk-taking behaviour; increased risk of coronary heart disease (8% amongst elderly[15]) and stroke (14% amongst elderly[16]).[17]
- An increased risk of depression (3.4 times more likely amongst elderly[18]), low self-esteem, reported sleep problems and increased stress response.[19]

- Cognitive decline and an increased risk of Alzheimer's (1.9 times more likely to develop dementia in the following 15 years[20]).[21]
- Individuals who are socially isolated are between two and five times more likely than those who have strong social ties to die prematurely. [22]

There is a stigma attached to loneliness itself that can exacerbate isolation, for example 30% of people in Great Britain surveyed, said they would be embarrassed to say they felt lonely, making it more difficult for people to seek support.[23] Feeling lonely can also make a person more likely to perceive, expect and remember others' behaviour to be unfriendly. This can increase social anxiety and cause them to withdraw further, creating a vicious cycle.[24]

A report from the Local Government Association (LGA[25]) summarising recent research estimated that:

- Over 1 million older people say they are always or often feel lonely
- 12 per cent of older people feel trapped in their own home
- 6 per cent of older people leave their house once a week or less
- 17 per cent of older people are in contact with family, friends and neighbours less than once a week, and 11 per cent are in contact less than once a month
- Over half (51 per cent) of all people aged 75 and over live alone

If the above figures were translated to Portsmouth it would mean that there are:

- 5,416 older people whose contact with family friends or neighbours is less than once a week
- 3, 823 older people feeling trapped in their own home
- 1,900 older people who leave their house once or less a week

These are people who are likely to suffer from a higher burden of long-term conditions and to struggle when requiring support at home following a stay in hospital, which could be preventing earlier and timelier discharges. It is estimated that older people who are lonely and socially isolated are:

- 1.8 times more likely to visit their GP;
- 1.6 times more likely to visit A&E;
- 1.3 times more likely to have emergency admissions; and
- 3.5 times more likely to enter local authority-funded residential care.

It is too early to be confident, but one possible positive outcome from the social distancing measures under the Coronavirus pandemic could be an increase in public awareness and sympathy for those who are socially isolated and lonely. This could be an important turning point in how social isolation and loneliness are understood as a policy concern, in particular, from the perspective of the costs to society as a whole, apart from the evident health harms. When considered collectively the overarching costs to the health and care system of social isolation and loneliness are considerable.

For example, it is estimated that loneliness could be costing private sector employers up to £2.5 billion a year due to absence and productivity losses.[26]

On the basis that social isolation and loneliness is as harmful as smoking then it is likely to be costing the local authority in social care costs at least £760 million a year. The equivalent cost to the NHS nationally could be in excess of £1 billion including £794 million in GP visits, £111.7 million in practice nurse visits and £144.8 million on prescriptions.[27] The total cost to the UK economy of social disconnection could be as high as £32 billion every year.[28] This was before the current lockdown and appreciation of these economic impacts is likely to be higher following the current pandemic restrictions.

These costs are incremental and when considered against the projected increases in numbers of older people, the need for prevention and planning to address this now is clear.

All of this makes it imperative that there is the right strategic alignment at local levels to address the harms and reduce the risks and associated costs of social isolation and loneliness.

3. Strategic Alignment

In October 2018 the Government released its strategy for tackling loneliness.[29] The strategy largely concentrates on the role that government can play and how it can set the framework to enable local authorities, businesses, health and the voluntary sector, as well as communities and individuals, to support people's social connections. It is focused on three goals:

1. A commitment to improve the evidence base to better understand what causes loneliness, its impacts and what works to tackle it.
2. To embed loneliness as a consideration across government policy, recognising the wide range of factors that can exacerbate feelings of loneliness and support people's social wellbeing and resilience.
3. Building a national conversation on loneliness, to raise awareness of its impacts and to help tackle stigma.

Translation of these national government objectives into local area strategies, especially in health and social care is happening, but it is not yet uniform. There are some excellent areas with detailed strategies, but for most social isolation and loneliness sits at the periphery of strategic plans.

Health Education England is compiling a central database of good practice and resources that can be shared more widely. This will help, but at the level of local strategy and planning in Portsmouth there needs to be a stronger commitment to improving the evidence base for what works and increasing understanding about the impact of social isolation and loneliness locally.

Individual government departments are developing their own social isolation and loneliness strategies and there is recognition that this needs to be linked with developments at the ground in local areas. In recognition of this the Ministry of Housing, Communities and Local Government (MHCLG) have become a co-sponsor of the Portsmouth pilot programme.

The Jo Cox Commission was instrumental in establishing a national conversation on loneliness. Following her tragic murder, the Commission on loneliness was taken forward in Jo's memory by Rachel Reeves MP from Labour and Seema Kennedy MP from the Conservatives in order to, in Jo's words, 'turbo charge the public's awareness of loneliness'. Currently, Jo Churchill MP, the Parliamentary Under Secretary of State for Prevention, Public Health and Primary Care at the Department for Health and Social Care, and Baroness Barran, Parliamentary Under Secretary for Civil Society and Department for Digital, Culture, Media and Sport Lords Minister both hold portfolios for loneliness.

There is undoubtedly heightened public and professional awareness of the issue of loneliness, nationally and locally in Portsmouth. However, much of this has been focused on the elderly and while that is a very important consideration, the reality of social isolation and loneliness is that it goes across the life course.

There is also a range of vulnerable groups who are at greater risk of social isolation and loneliness and this needs to be accounted for in local strategy to address the needs of these groups. Some of the vulnerable groups highlighted by practitioners in Portsmouth include:

- People with enduring mental health problems
- Black, Asian and Minority Ethnic communities, including migrants and asylum seekers
- Carers, including young carers
- Disabled people, including those with limited mobility and those with sensory impairments
- Lone parents, especially young mothers
- Children and families with mental hlth and learning disability problems

- People with long-term health conditions

There are strategies to address the needs of each of these vulnerable groups and each strategy needs to include consideration of the role and impact of social isolation and loneliness in increasing vulnerability and risks. However, what is missing is an overarching or dominant strategy for social isolation and loneliness.

There is an aspiration for this, for example the Portsmouth Health and Wellbeing Strategy (2018 – 2021) identifies reducing the drivers of isolation and exclusion, including poverty as a priority. Examples of where the Health and Wellbeing Board can add value to this include employment, housing and reducing harmful and addictive gambling.

The local Future in Mind Transformation Plan aligns various priorities for children and young people including improving resilience and positive emotional wellbeing. Although not stated specifically, there is an implicit assumption that this includes addressing social isolation and loneliness. One of the examples of support in the plan is pre- and postnatal depression groups, which reduce isolation.

3.1 The NHS Long Term Plan

There is a window of opportunity to strengthen these local strategies through alignment with the priorities of the NHS Long Term Plan with social isolation and loneliness. For example:

- More joined up and co-ordinated care – social isolation and loneliness have multiple causes and impacts that cut across health, social care, leisure, employment, housing and education. Work to address and prevent social isolation and loneliness, must, by definition, be part of a fully integrated and well co-ordinated approach, that does not view each encounter with the health service as an unconnected, single episode of care.

- More proactive healthcare, based on population health management and predictive prevention techniques – proactive healthcare that can predict and prevent health harms requires more sophisticated means of identifying population groups at risk of social isolation and loneliness and being able to match this with effective and robust interventions. This needs to take place both at the level of supporting individual and family functionality and structurally, in terms of supportive and enabling environments.
- More choice and control – greater differentiation in the type of support and interventions offered and the ways in which people choose to enhance their own health and wellbeing, means recognising the different contexts and circumstances in which people live including the absence or breakdown of social connections. The ability and capacity of people to take control of their own health and wellbeing depends to a large extent on the degree of support someone can draw on from family, friends, informal carers and the wider community.

Action in each of these areas would also considerably strengthen the ultimate aim of the NHS Long Term Plan, which is to future proof health and social care for the decade ahead. Supporting and enabling greater social interaction and cohesion will prevent health harms associated with social isolation and loneliness and help stem the rising tide of demand for services to treat ill health. Specific development objectives that this approach could support include:

- The expansion of multidisciplinary neighbourhood teams e.g. the opportunity to consider ways in which these new contracted neighbourhood services can encompass social isolation and loneliness as part of a fully multidisciplinary team function
- Support for people in crisis e.g. those with less or no support are more likely to require a more intense level of service and/or hospital admission following crisis..
- Development of Quality Markers for primary care that seek to highlight best practice in carer identification and support e.g. encompassing risks and needs associated with social isolation and loneliness.

- Expanding the NHS Comprehensive Model of Person Care for people diagnosed with dementia e.g. including consideration of the increased risks of cognitive decline for older people at risk of dementia associated with social isolation and loneliness.
- Reducing unnecessary lengths of stay in hospital e.g. earlier recognition of the ways in which social isolation impacts on hospital discharge and how to plan for this at an earlier point in the care pathway.

3.2 The Care Act 2014

The Care Act 2014 aims to improve people's quality of life, delay and reduce the need for care, ensure positive care experiences and safeguard adults from harm. Local authorities are required to consider the physical, mental and emotional wellbeing of the individual needing care, and assess the needs of carers. They must ensure the provision of preventative services and carry out their care and support functions with the aim of integrating services with those provided by the NHS or other health-related services. The Care Act calls for:

- A shared vision and culture of cooperation and coordination across health, public health, social care and local authority roles, e.g. as housing commissioners, working closely with public, voluntary and private sector providers to improve services;
- A whole systems- and outcomes-based approach to meeting the needs of individuals, their carer/s and family, based on a robust understanding of the needs of individuals, their carers and families now and in the future;
- Consideration to the health and wellbeing of the workforce and carers;
- Solutions to meet local needs based on evidence of 'what works';
- Services that will address the wider determinants of health, e.g. housing, employment.
- Integrated health, care and support, and housing solutions could make best use of the budgets across the NHS, local authorities and their partners to achieve improved outcomes for less; for example, drawing on the Better Care Fund to support service transformation.

(It is important to note that longer-term funding can achieve more than recurring funding of one year. VCSE organisations in particular often find it hard to secure longer term funding but the commitment can really help achieve longer term change sustainable change which is often not possible from funding just a short-term project).

Eligibility thresholds under the Care Act for both adults with social care needs and carers include consideration of developing and maintaining family or other personal relationship.

In particular, assessments should address:

- Is the adult lonely or isolated?
- Do their needs prevent them from maintaining or developing relationships with family and friends?

Examples of circumstances affecting the ability to achieve the outcome include:

- The adult's physical or psychological state may prevent them from making or maintaining relationships e.g. mental ill health, autism.
- The adult is unable to communicate easily and regularly – e.g. they may not have, or be able to use, a phone or computer, they may be unable to leave their home safely, they may be unable to communicate successfully or interact with others – this may prevent them from maintaining or developing relationships with family, friends and others.

The Act also requires a shift towards "outcomes focused" commissioning and market-shaping by local authorities, which the Guidance states should place greater emphasis on prevention and enablement, including ways of reducing loneliness and social isolation.[30]

Standard NHS or local authority contracts are not normally appropriate both in terms of content, support or outcomes for VCSE organisations and a more creative approach to being able to work in partnership is needed. The procurement process for VCSE organisations is often prohibitive, with greater emphasis needed on social value and grant payment mechanisms to give VCSE organisations a chance to express an interest and participate.

4. Workforce Education, Training and Transformation

Even if there is greater alignment in the above strategic plans there will need to be considerable workforce transformation to support this. The Family First approach taken in Portsmouth provides a solid bedrock in which to embed this. The family first approach is based on some key principles:

- A whole system, multi-agency response
- Making Every Contact Count
- Effective early intervention
- Needs led

These are principles that are clearly recognised by practitioners in north Portsmouth:

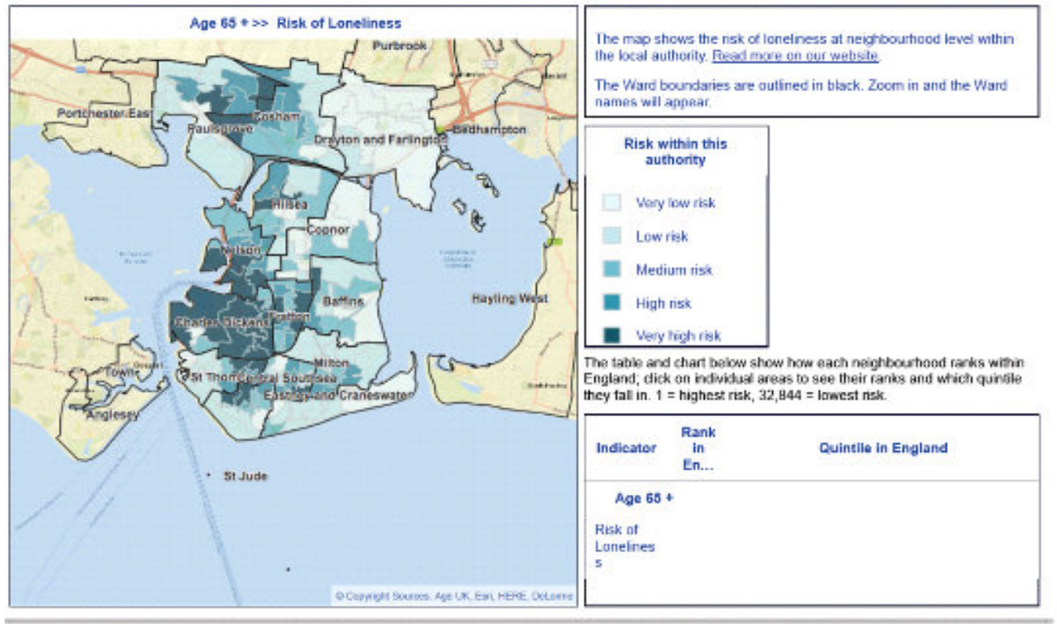
"Family first is the approach taken always, whether it's about support or the underlying causation of problems and needs".

There is also strong awareness amongst practitioners of the significance of social isolation and loneliness to their work. However, there are some workforce development challenges and barriers to making this a more systemic focus. A summary of these is given below:

Identifying people at risk	**Access to local resources**	**Early help and prevention**
Competencies and capacity	**Working with communities**	**Pathways**

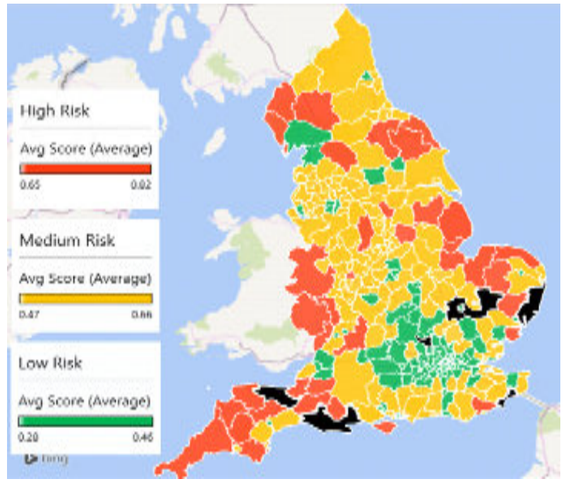
4.1 Identifying people at risk

One of the problems with addressing social isolation and loneliness is that there are not many accepted measures for identifying populations at risk. AGE UK has created heat maps for identifying older people at risk of loneliness. The following shows the data for north Portsmouth:



In light of the current Coronavirus pandemic, the team at Breaking Barriers has developed a national heat map to forecast local authority areas that are most at risk of increased cases of social isolation and loneliness while large-scale social distancing measures are in place. The map uses three pieces of data:

- the rate of digital exclusion in the local authority (calculated using metrics including the prevalence of digital infrastructure and rate of digital literacy),
- the percentage of the population aged over the age of 65,
- the percentage of the population living in one-person households.



During times of social distancing, being able to access an internet connection is vital to maintain social connections as most people have been instructed to work from home and only to leave their homes for exercise or shopping for basic necessities. Consequently, the ability to call on digital social networks is crucial to facilitate the maintenance of social connections. This is particularly important for those who have been deemed to be clinically vulnerable and been placed within the government's shielding group during the pandemic as they have been strongly advised to stay at home at all times for 12 weeks.

Fortunately, there have been a number of initiatives that have been set up to address the gap that may be emerging for those with little access to an internet connection and/or with little digital literacy. These include:

- family members and volunteers who are posting letters to those living in care homes to keep their spirits up,
- PG Tips funding the training of 2,000 volunteers to phone the elderly and the isolated as part of an initiative to make more than 100,000 calls
- Faith group leaders and volunteers making phone calls to call in members of their respective communities

Having access to local data as part of the enactment of the action plan for Portsmouth and other areas would allow for more localised heat maps to be produced that consider more factors including:

- those at risk of and already dealing with long-standing mental health problems
- those with long-term conditions
- those with learning disabilities
- those with physical disabilities
- differential impacts on minority ethnic groups

4.1.1 Improving metrics for identifying people at risk

The Jo Cox Commission on loneliness noted that, while there are increasing measures of loneliness in older people there are far fewer for adults and young people:

"Over the years, studies on loneliness have reached different conclusions about the levels and overall distribution of loneliness across the UK and among different groups. Studies have found relatively consistent levels of chronic loneliness among older people – with between five and 15 per cent reporting that they are often or always lonely. However, we have much less robust data on loneliness among children, young people and adults of working age.."[31]

Part of the problem is that the terms `social isolation' and `loneliness' are often used interchangeably, though they in fact refer to different things. The government definition of loneliness, based on research from the early 1980s[32] is:

"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."

Social isolation is defined more by quantitative measures, for example an objective measure of the number of contacts that people have. It is about the quantity and not quality of relationships.[33]

In January 2018, the Prime Minister tasked Office for National Statistics (ONS) with developing national indicators of loneliness suitable for use on major studies to inform future policy in England, including people across society and of all ages.[34] The ONS have agreed an Interim Harmonised Principle for loneliness with indicators to be rolled as part of a new Government Statistical Service (GSS) from December 2018.

It will take some time for these new national measures to appear in statistics; however, some local authorities have been developing their own local measurement systems. For example, Essex County Council[35] have developed an isolation index using Mosaic which covers a range of variable household measures including:

- Single pensioners
- Widowed
- Retired
- Unlikely to meet friends and family regularly
- Unlikely to interact with neighbours
- Poor health
- Suffering from depression
- Suffering from poor mobility
- Visually impaired
- Hard of hearing
- Struggling financially

Lancashire County Council has taken a similar approach with the capacity to generate heat maps at local neighbourhood levels.[36] The Lancashire risk index[37] includes:

- Single pensioners; Widowed
- Retired; Struggling financially; Not employed
- Poor health; Permanently sick;
- Suffering from depression
- Suffering from poor mobility;
- Visually impaired; Hard of hearing
- Unlikely to meet friends or family regularly; Unlikely to interact with neighbours
- Less educated (no further education, no degree)

Southampton City Council has also used Mosaic and the local Joint Strategic Needs Assessment (JSNA) to develop local ward profiles for measuring social isolation and loneliness. This includes risk factors for both personal and wider societal variables[38]:

Personal	Wider Society
Age	Lack of public transport
Poor health	Physical environment (e.g.no public toilets or benches)
Sensory loss	Housing
Loss of mobility	Fear of crime
Lower income	High population turnover
Bereavement	Demographics
Retirement	Technological changes
Becoming a carer	-

Mosaic is able to produce data on 1,200 variables matched across 66 housing types, which can be combined into an overall index for each type. However, there are some limitations to the data, for example:

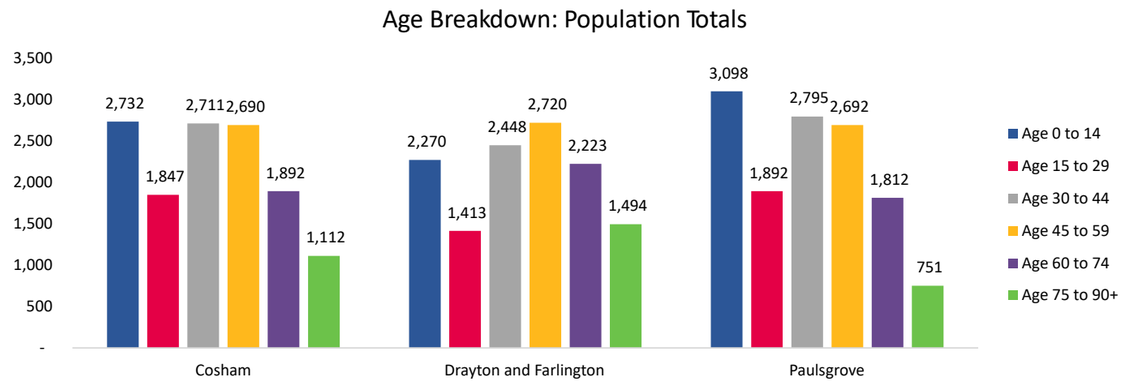
- The choice of variables and how to weight these is not always systematic and can appear arbitrary
- Some of the data is old, for example Census data from 2011 – though in many cases this is the latest available data at ward and neighbourhood levels
- Scoring can only provide a proxy measure and is not an absolute measure of social isolation and loneliness
- The results cannot be subject to statistical proofs and there may be significant margins of error that are not known
- The data does not easily measure changes over time

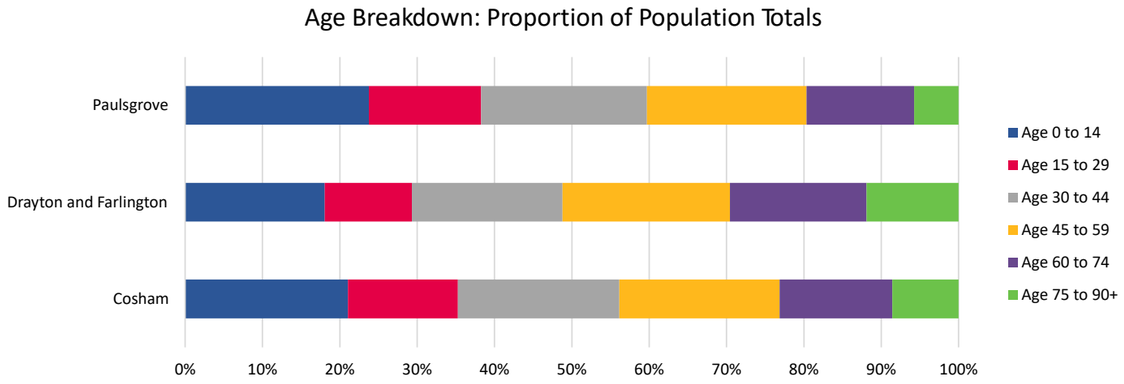
Nevertheless, understanding the full range of population needs and being able to identify populations at risk of loneliness is an essential tool for developing an appropriate and targeted service response. The following variables (using data from NOMIS) have been collected to assess the likely populations at risk in Paulsgrove, Cosham and Drayton and Farlington.

Age

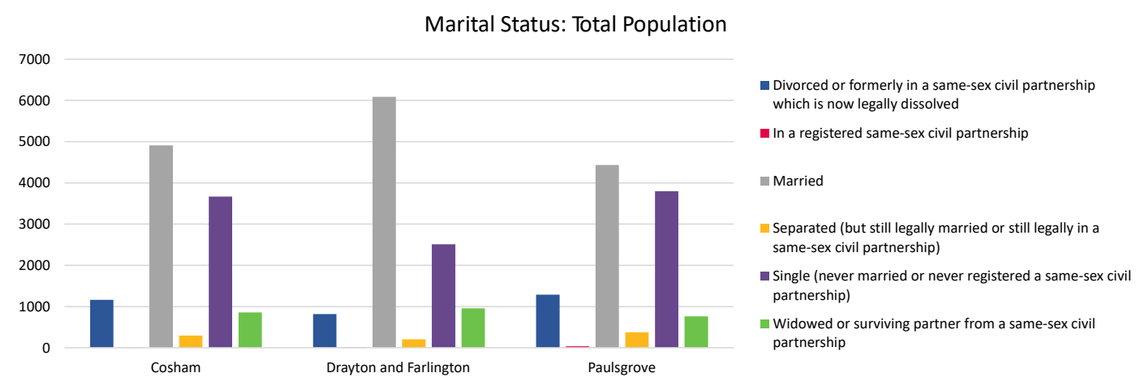
The data on age shows some large differences across the three wards, in particular the larger number of older people in Drayton and Farlington. However, as was seen in the Age UK heat map above, this does not translate into an increased risk of isolation and loneliness. This is likely due to protective factors in the neighbourhood such as higher numbers of married people and relatively lower levels of deprivation. These differences can be seen in the following graphs.

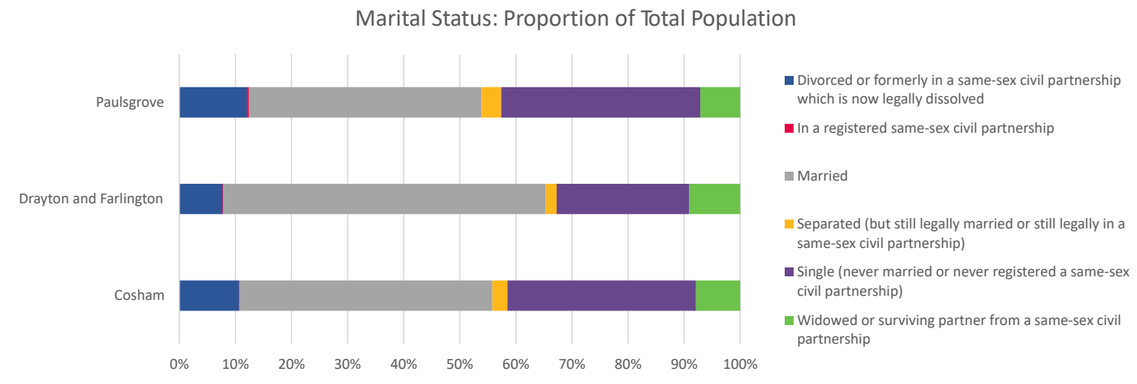
Age





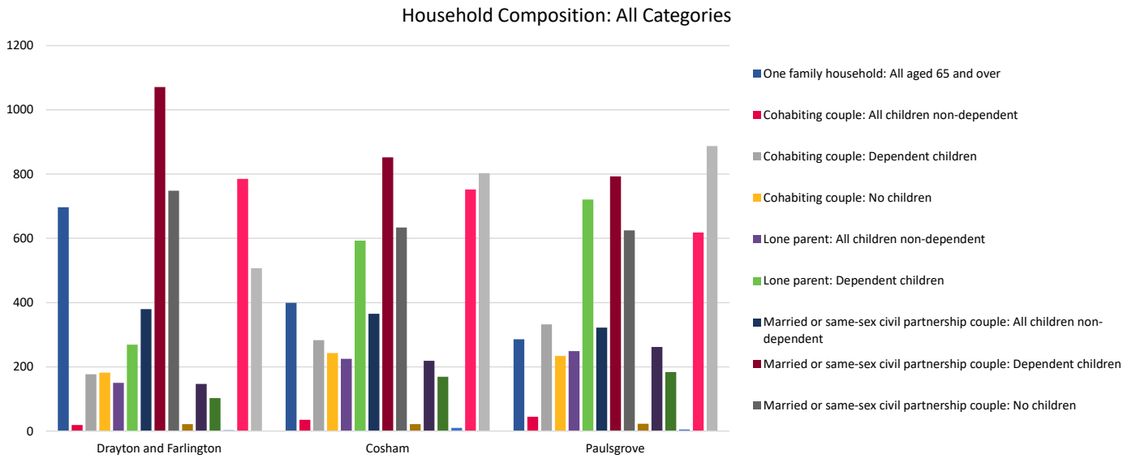
Marital Status

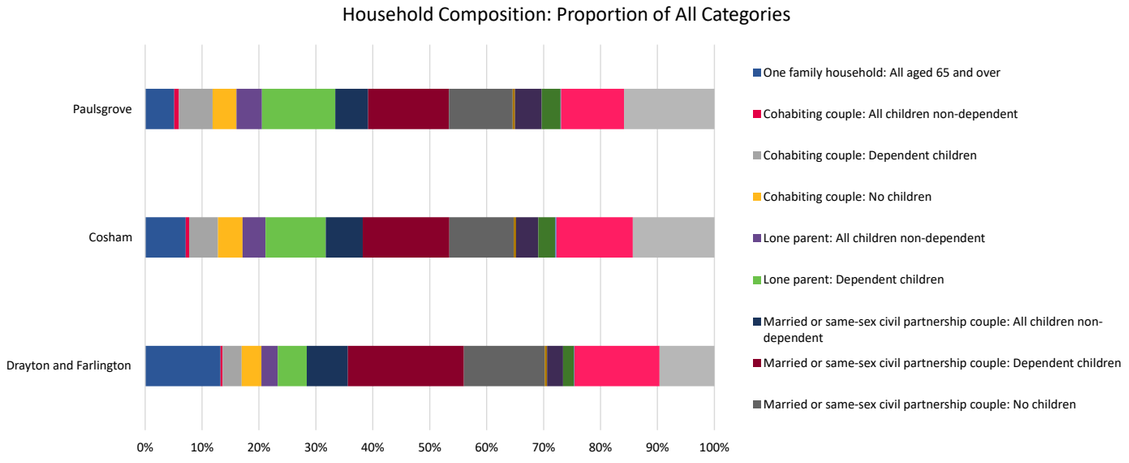




Paulsgrove and Cosham have higher numbers of single people compared to Drayton and Farlington. Paulsgrove and Cosham also have higher numbers of lone parents:

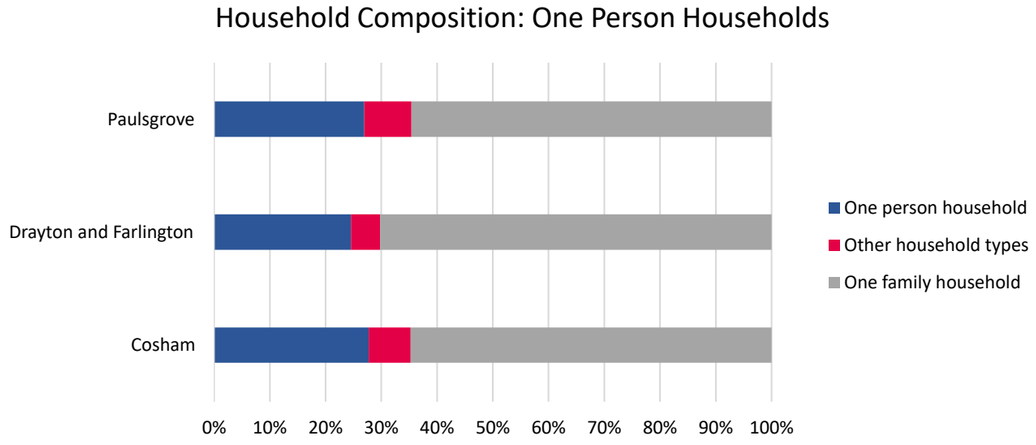
Household Composition

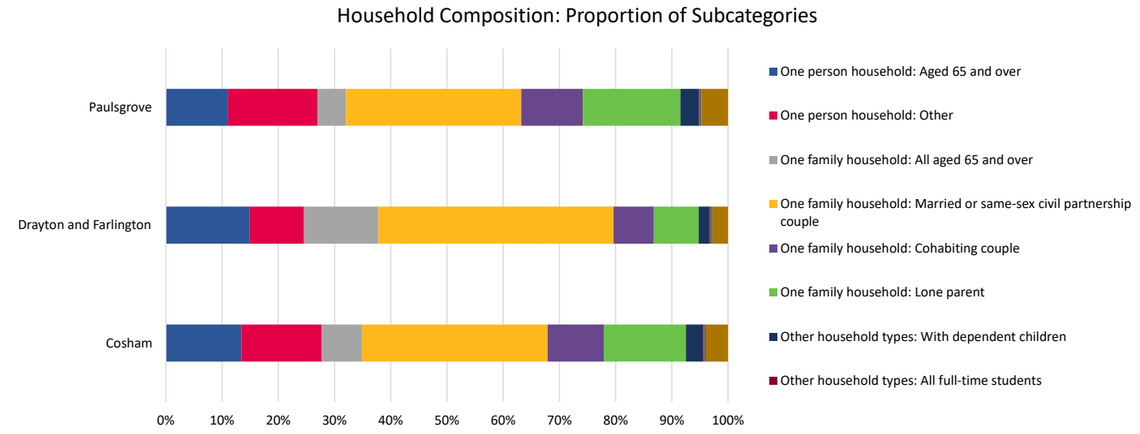




Lone parents are a known group for risks of social isolation. Data on household composition also shows some potential risk factors such as one family households:

One Family Households

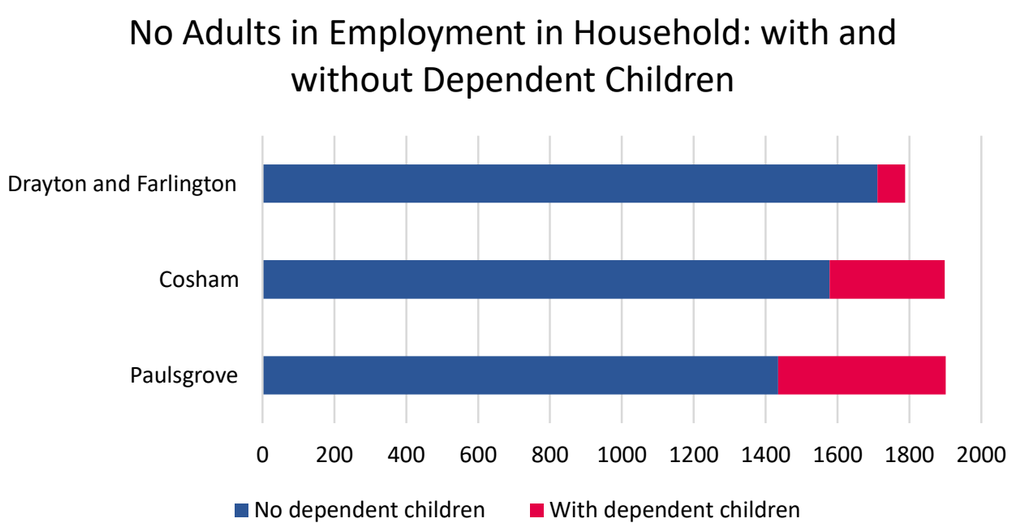


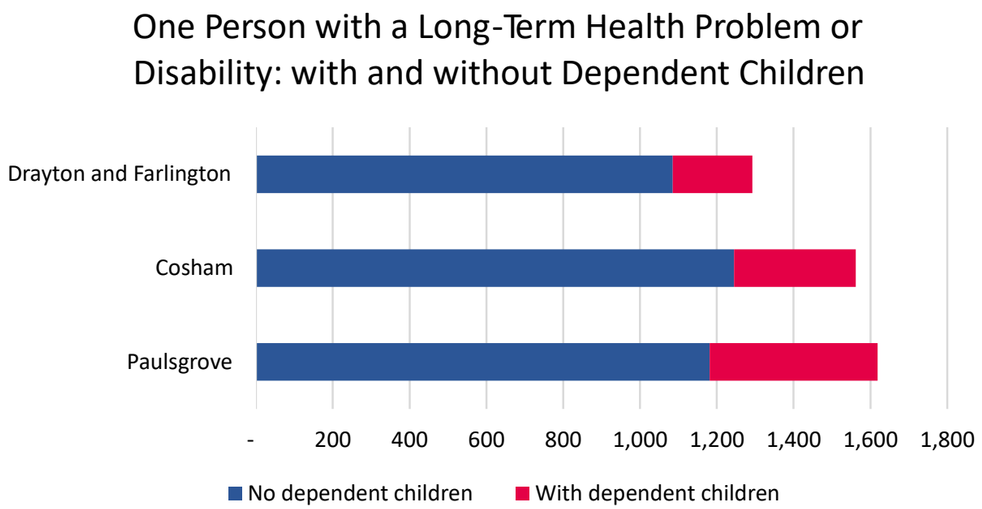


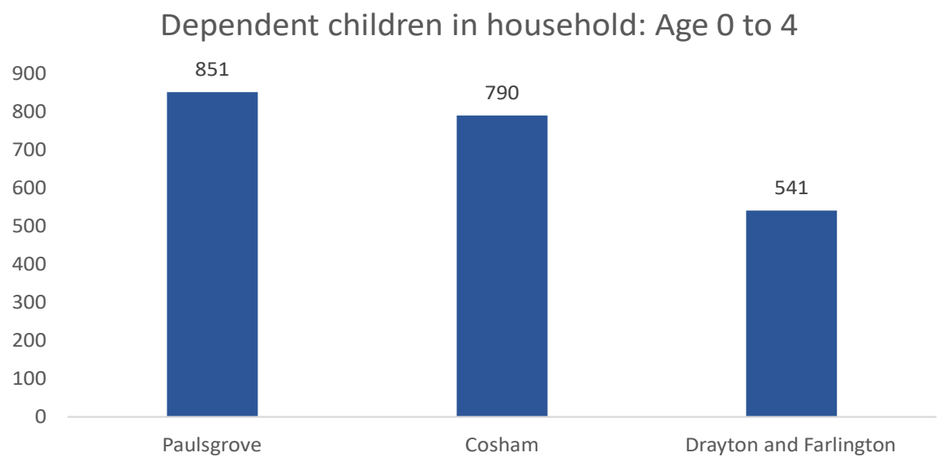
There are also some important indictors with respect to economic activity, dependent children and long-term health problems or disability:

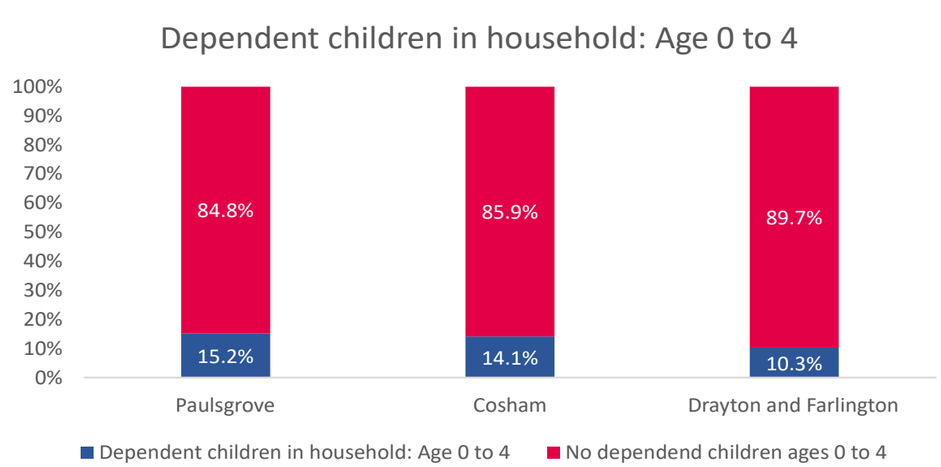
Lone parents are a known group for risks of social isolation. Data on household composition also shows some potential risk factors such as one family households:

Employment, dependent children and long term health problem or disability



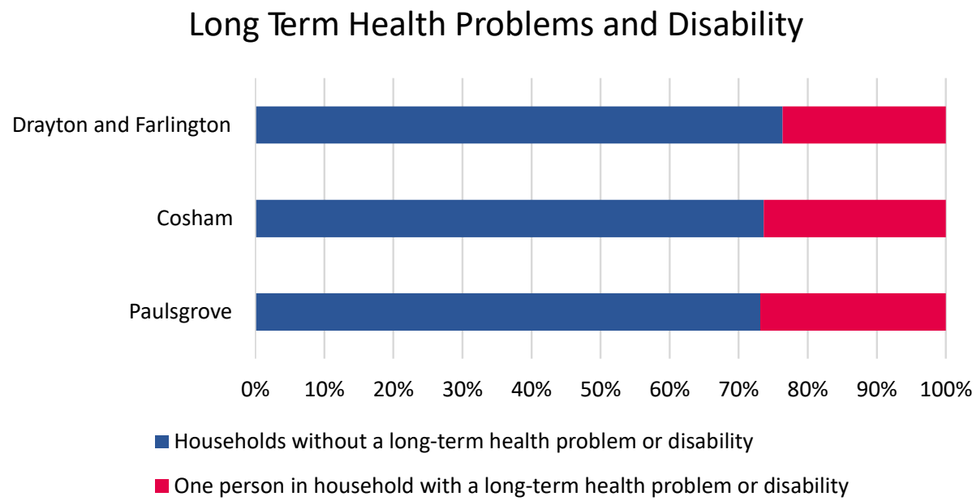


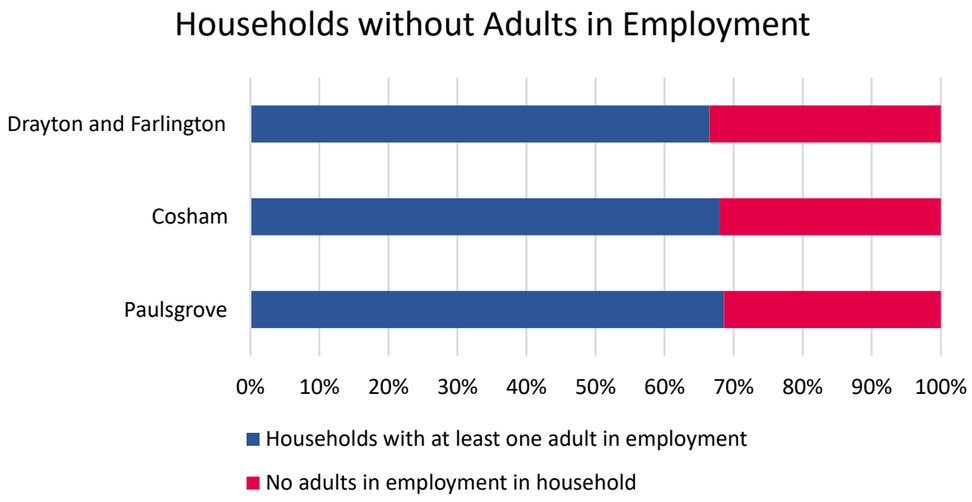


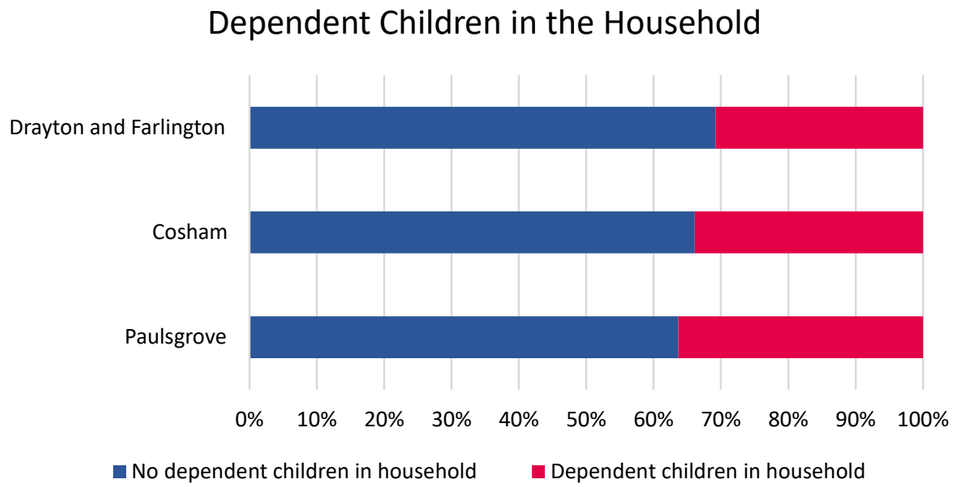


The risk factors for Paulsgrove in particular are starting to become clearer, with larger numbers of people who are not in employment, have dependent children (many of which are under four years old) and higher numbers of people living with a long-term health problem or disability.

Long-term health problem or disability

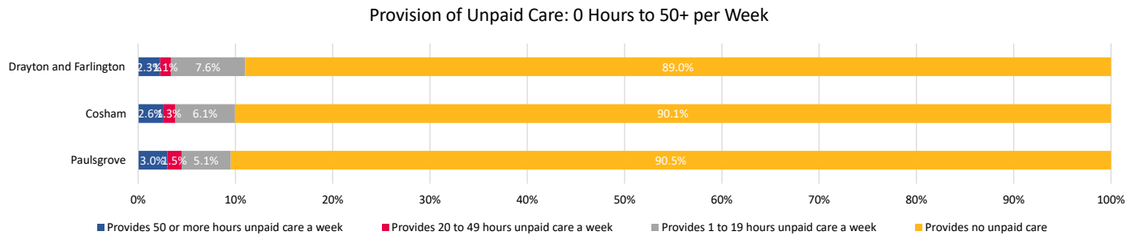


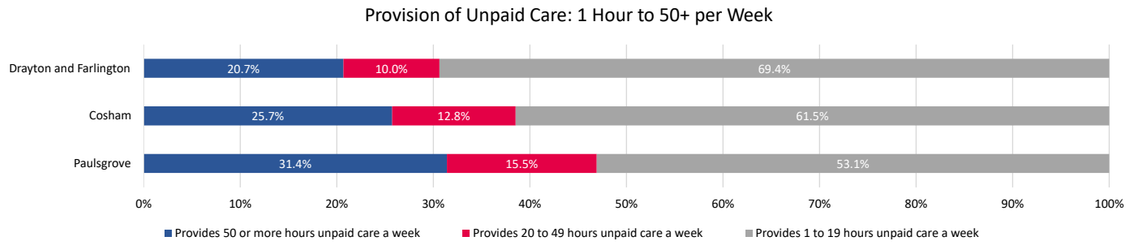


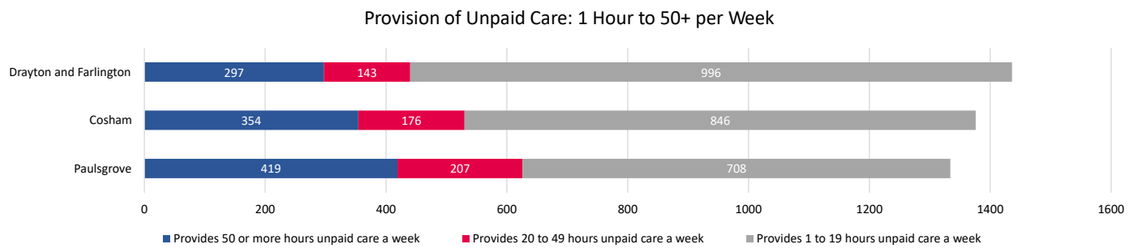


Unpaid care

The data on long-term health problems and disability can also be compared to the numbers of carers and people providing unpaid care:

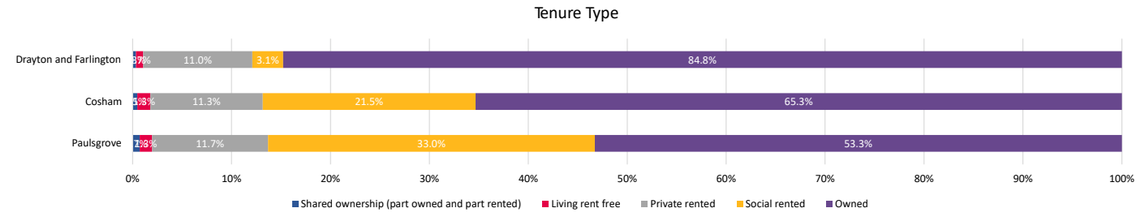


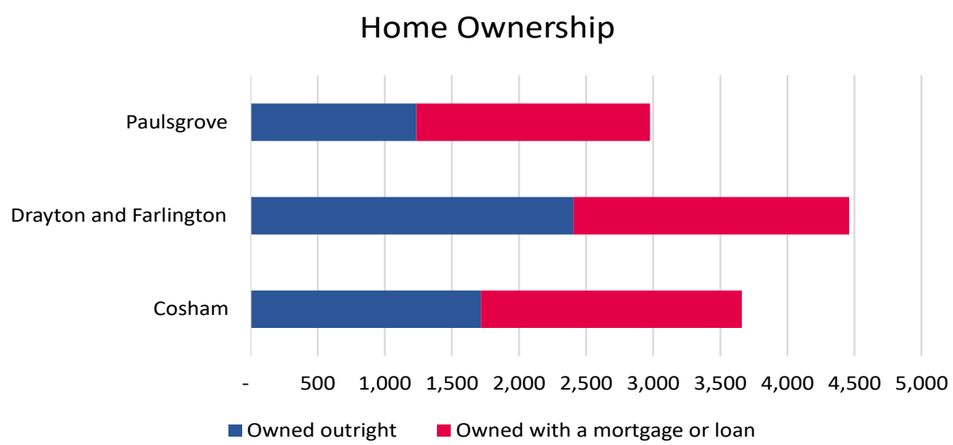


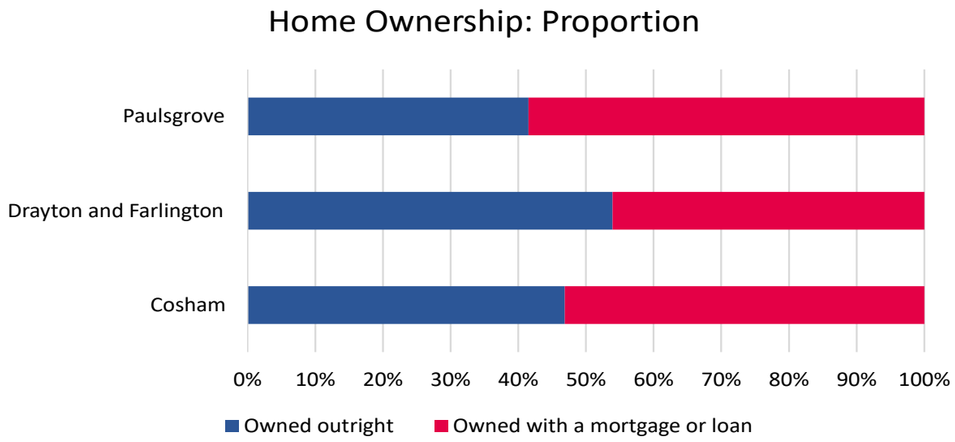


Some large differences in the type of household tenure across each ward can also be seen:

Primary tenure



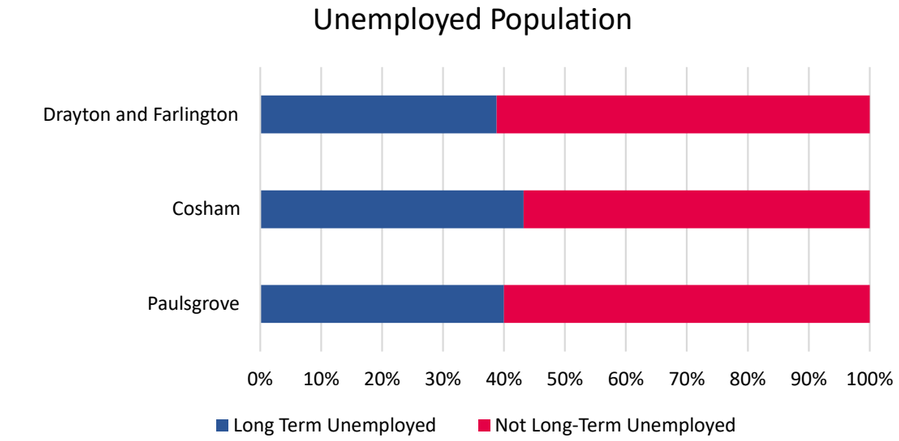


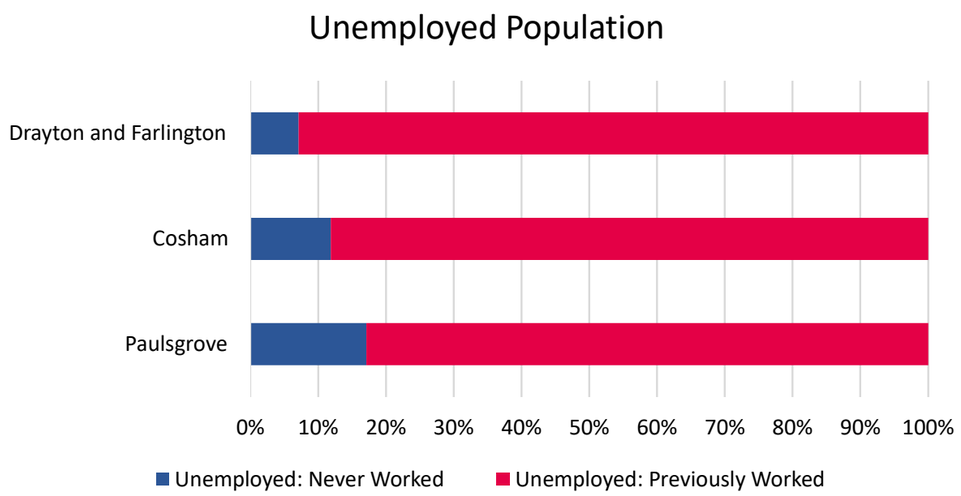


Paulsgrove and Cosham have high numbers of people in social rented accommodation.

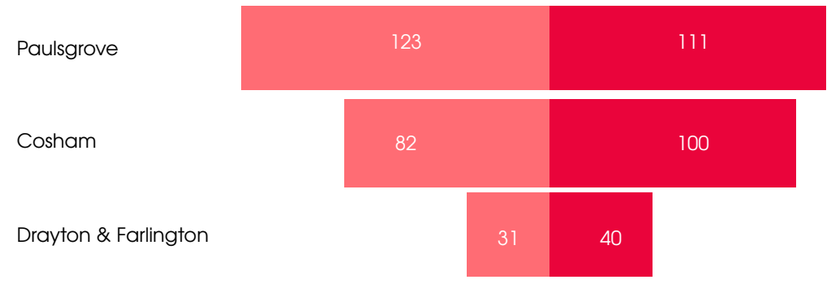
However, it should not be assumed that higher rate of home ownership on Drayton and Farlington suggests greater protection from economic factors that influence social isolation and loneliness, as people may be relatively cash poor.

For example, rates of long-term unemployment are more similar across the three wards, though there are differences between men and women:

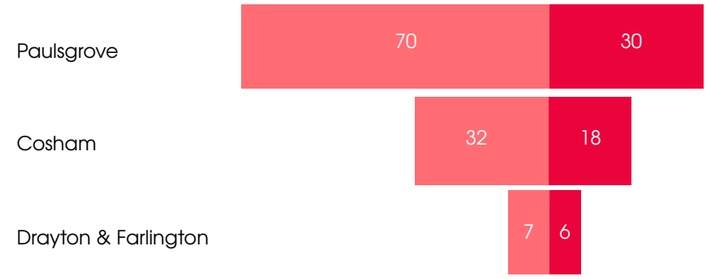




Long-term unemployed by sex: (Men left, women right)



Unemployed, never worked by sex: (Men left, women right)



The above data demonstrates how it is possible to generate local heat maps of the key variables that suggest risks associated with social isolation and loneliness. There is a need to develop these metrics further and how to make these a serviceable tool for planning and informing frontline workforce development.

4.2 Competencies and capacity

While there is strong recognition of the importance of addressing social isolation and loneliness, there is a need for greater focus on the competencies required to do this. From discussions with practitioners suggested areas for competency development include:

- Raising the issue – workers need to be able to recognise the stigma associated with loneliness and social isolation and to feel confident to raise this in assessments
- Assessment – there is a need for the workforce to have a coherent way of assessing social isolation and loneliness
- Motivational interviewing – some practitioners struggle when confronted with resistance amongst clients who are reluctant to take up offers of social support
- Working with complex family dynamics – while some practitioners have higher levels of competency in working with complex family dynamics, others find this challenging. This is particularly important when there are poor family relationships or a breakdown in these.

Intervening in the break down of family relationships is where restorative practice comes into play, but it is a highly skilled area of work that requires a strong degree of competence and knowledge of family dynamics:

"Restorative practice is a really good approach, it means providing high levels of support and challenging people to do more for themselves, but the challenge is having skilled workers to do the high support, high challenge, having difficult discussions with people."

However, the reality is that an individual is the unit of referral into the service and the focus on individual needs can conflict with the family (however family is defined) context and intentions. For example, an individual may not wish to have their family involved and some family contexts can be complex and marked by conflict. In such a case the individual's wishes are paramount and consent for family involvement can be a contentious issue:

"The rules about confidentiality can be a barrier, but they are there for a reason. We can't betray a patient's confidentiality because if we did, they wouldn't trust us again".

The principle of consent is only usually compromised when there is a lack or absence of mental capacity in the individual, for example in the case of dementia.

This goes to the heart of professional practice, where the legal-ethical basis of professionalism is based on the principles of confidentiality and consent. While no one would suggest this is not essential, workers need to have confidence in addressing the issue of consent and the primacy of family involvement and working effectively with family dynamics.

Capacity can also be an issue when dealing with more complex cases. In particular, the time required to work through a challenging family situation:

"If relationship with family members is really poor, it can be tricky to try and repair it because for me, I've had no training on this and also it is the time commitment involved".

4.3. Care Pathways

Social isolation and loneliness need to be taken account of within care pathways. There are various factors that are currently complicating this including:

- Risk assessment
- Sign posting and referral systems
- Social prescribing

The significantly higher risks of poor health outcomes and reduced mortality require social isolation and loneliness to feature more prominently in risk assessments. In the absence of this, practitioners are reliant on sign posting and referral systems, which can often fail. For example, some practitioners describe repeated referrals and long waiting times for some services:

"We can refer people to day centres, but it has to go through the social work team. People have to go through so many repeated assessments".

There is also little to keep people motivated while they wait, which can result in people failing to take up the offer when it comes:

"We can suggest social activities and signpost people, but some patients don't pick up the call."

The Community Connectors service is valued but this is a short-term intervention, that in itself relies on sign posting and referral to other resources and services. Practitioners also report that there can be insufficient feedback systems as to whether someone attended and how they are progressing. This may partly be the result of over reliance on sign posting and referral rather than incorporating social isolation and loneliness more fully within a set pathway.

Social prescribing services are designed to address social isolation and loneliness and Portsmouth has had a social prescribing service for the last year. There are also new opportunities with respect to the development of additional social prescribing services through Primary Care Networks, as the new GP contract provides full re-imbursement for GPs who take on a social prescriber.

While practitioners welcome these developments, there is a concern that the system could become fractured. It is also important that the social prescribing offer for social isolation and loneliness is not diffused over time and that there is sufficient monitoring and evaluation of activities and initiatives. Additionally, there has to be sufficient capacity amongst receiving organisations to take new referrals.

Identified gaps have to be addressed, otherwise social prescribers will become a bottle neck holding onto people without active intervention. The Community organisations will be able to achieve sustainable change, and in effect represent the structural natural changes people need, as opposed to social prescribing being the temporary functional intervention.

4.4 Access to local resources

One of the biggest challenges identified by practitioners is access to local resources. There is a view that a number of services are concentrated in the centre of the city and that this can present both practical and cultural barriers to use for residents in north Portsmouth:

"In the north, there is not much going on because services are concentrated in the city centre. There is a lack of resources in the north and the city is quite a distance away so there is actually only limited access to support services."

Examples of social support services that have been lost in the north include:

- Young mothers and babies' groups
- Day centres
- Carer services (outside term time)

Transport can be a big issue for people when being asked to attend services in the city centre; both on a cost basis but also the time it can take for public transport to go and from the city centre.

Practitioners also need accurate and up-to-date directories of local resources for supporting social isolation and loneliness. Existing directories tend to be limited as they are may be paper based and not reviewed frequently enough or they do not specifically identify those resources and services that can help with social isolation and loneliness. The HIVE in Portsmouth is working on bringing together existing resources onto one, easy-to-access digital resource with plans to roll this out in the coming months. Phase 2 of this piece of work would be to include service access to promote the use of personal health budgets within the digital resource.

4.5 Early help and prevention

There is also a view that not enough is being done at earlier stages of intervention, for example those practitioners with the higher skills level to work with family breakdown feel that they receive the referral too late:

"By the time we get the referral it is too late, if we saw people at an earlier point then more could be done to prevent people becoming isolated due to family break down."

So, with respect to social isolation and loneliness that is associated with a poor family dynamic, there is a potential disconnect between earlier recognition of the risks and later stage interventions. If we are to prevent the health and social harms associated with social isolation and loneliness, there needs to be greater recognition of these risks at a much earlier point in the referral system.

One way to achieve this is by broadening the early help base for addressing social isolation and loneliness through the inclusion of the wider public sector and community workforce as part of Making Every Contact Count (MECC). There are examples of this in other authorities, such as Sheffield, where 1,000 frontline workers, including housing officers, community pharmacists and supermarket staff, have been trained to recognise loneliness and link people with support.

Some practitioners thought that cases were not always escalated soon enough from early help or tier two level services, with the result that the complexity of the case and degree of social isolation, family breakdown and loneliness was higher than it may have been if a more in depth intervention had happened sooner:

"There may be a problem with the thresholds between tiers two and three, I don't know what the criteria is, but if we saw people sooner at tier three, we could do more to prevent a crisis, act before things have broken down so much."

4.6 Working with communities

Although the focus of work is Family First and that family is not strictly defined, there is much less emphasis on directly working with communities. The nature of professional education, training and practice is that it is about cases and conditions, albeit for the social care workforce these are often social conditions. There is a shift in emphasis, as evidenced in restorative practice to working on individual strengths and assets, but in the context of social isolation and loneliness it is often community assets that are more directly relevant and effective. Practitioners know the local area well, its neighbourhoods, families and the culture of people living there.

But working to support and grow local community assets is not considered a formal part of their role. The community and voluntary sector represent a significant resource for addressing social isolation and loneliness, but they do not appear to be involved the professional health and care services at a level of formal, partnership and co-production.

There is an opportunity to strengthen this approach through the Hive, which is seeking to create a more co-ordinated, integrated and involved role for the community and voluntary sector as a whole across Portsmouth. HIVE Portsmouth advocates that VCSE should be a formal, equal, trusted and respected player in a person's care pathway. The initiative is in its infancy but there is a strong willingness to be more involved in development of a partnership approach to addressing social isolation and loneliness that is about building community assets and resources. This could benefit practitioners in health and care in various ways, including:

- Increasing awareness about activities and services that are provided in the community and voluntary sector.
- Improving referral and feedback systems.
- Sharing resources such as training for social isolation and loneliness
- Identifying gaps in current service provision and jointly planning to address these, which would also fit well with developing the approach to resident, service and community engagement and co-design.

5. Resident, Service User and Community Engagement and Co-Design

Bringing the lived experience of residents, service users and local communities into the design and delivery of services is increasingly recognised as essential. There are few dissenting voices to this and there are increasing examples of where it is being done well, but in the context of people who are socially isolated and lonely it is challenging. In the focus groups and interviews with local residents and service users some common themes have been identified:

- Being isolated and lonely can often result in a crisis and there is a perception that few services that can respond to this.
- Services that are located in the city centre feel remote and hard to access.
- People lack knowledge about how to navigate the health and care system and can sometimes feel that they are being passed from one service to another, which can make people feel more isolated.
- Carers can sometimes feel excluded.
- There are very few resources for young people in the area and if they are congregating round the shops this can lead older people to feel intimidated and less likely to come out of their home.
- Transport links are poor.

The local churches provide some excellent services for people who feel isolated such as informal drop-ins and cafes where people can meet and access other resources. However, these are reliant on volunteers and there are capacity constraints that mean they cannot be run all year round. These services are advertised through leaflets and fliers, but people said that the main way they found access was through meeting someone who knew about it.

There are synergies between some of the resident perceptions and concerns and those of practitioners. For example, with respect to the local area, residents also feel that there has been a loss of local services. In particular, those that were perceived to be very good at helping people feel less lonely such as mother and baby clubs and the loss of community centres.

There is a willingness to be more involved in work to address social isolation and loneliness, in particular creating more opportunities for people to act as volunteers.

6. Action Planning for Service Integration and Innovation

The following action plan has been developed from synthesis of all of the previous sections. This is not a wish list or series of recommendations, but rather it is an attempt to create a conceptual framework for thinking about the issues of social isolation and loneliness. This is rooted in the concept of place, but it also distinguishes between the structural aspects of addressing the issues and those that are functional:

Functional aspects create a buffer against the negative impacts of social isolation and loneliness	Structural aspects promote and sustain the degree of natural social integration
• Befriending services • Support groups • Bereavement counselling • Day centres • Received health and care services e.g. mental health, addictions etc. • Safeguarding and family conferencing	• Breakfast clubs • Faith groups • Sports and recreation • Employment • Volunteering • Civic participation • Social media • Men in sheds

Functional and structural aspects are a necessary part of a system of health and care, but the evidence for effectiveness lies with structural interventions that promote and sustain the degree of natural social integration over the long term.

The workforce transformation challenge is getting the balance right between the two and shifting the focus from one that is largely short term and based on signposting and referral to one that builds on individual and community assets.

The purpose of the action plan is to create a framework that unites both functional and structural aspects as part of a coherent strategy for reducing the harms associated with social isolation and loneliness. It is based on three core tenants:

- Be aware - There is a need to raise awareness across the health and care workforce of the harms and risks associated with social isolation and loneliness
- Recognise - There is a need to increase the capacity and competence of the workforce to recognise social isolation and loneliness. This should encompass more effective assessment methods but also more targeted use of sign posting to ensure people are directed to the right level of support at the earliest stage.
- Respond - Social isolation and loneliness is multi-faceted and there is no single response or service that can address all the issues or respond to every need. There is a need for an overarching response strategy that can ensure the right workforce competencies and skills to respond in the right way at the right time.

Be aware

Actions	Lead agency responses	Functional benefits	Structural benefits	Resource implications
Create bespoke team learning briefs that address the evidence base for the health and social harms associated with social isolation and loneliness	Led by public health but developed through NHS Solent, PCC Adults and children leads, and VCSE	Recognition of the limitations of sign posting	Increased understanding about the value of natural social connectedness	Relatively easy to develop a resource – time and capacity constraints need to be addressed in delivery
Use a population risk model to map needs at neighbourhood levels including the implications of demographic trends	Public health led	Identification of areas that require more concentrated functional support	Stronger risk profile of where social connectedness is weakening	Can be derived from existing data sets but needs dedicated resource to complete for each area. Should be a function of the JSNA
Identify community champions to create local area campaigns against loneliness that increase public awareness of the issues and what services and support is available	Could be led by a dedicated coordinator at the Hive (VCSE) but needs also needs involvement from NHS Solent, PCC and primary care	Increased local awareness of support services. Also, would enable knowledge and skills development of community champions such as Behaviour Change/MECC skills along with training focused around social determinants of health	Can act as a social movement force for generating more avenues of social connectedness. Community champions are empowered to link the experiences they see and have within the context of the wider determinants	Would need a dedicated co-ordinator role. Could be developed in a single area as a pilot to evaluate cost model and benefits. Increase in volunteering would bring associated cost benefits. Potential for the Wessex School of Public Health to help with developing this.
Include social isolation and loneliness within the Sanctuary city programme	PCC	Increased local awareness of support services	Strengthens potential for city wide social connections	To be done within existing programme

Recognise

Actions	Lead agency responses	Functional benefits	Structural benefits	Resource implications
Raise awareness of the harms associated with social isolation and loneliness across the life course as part of MECC.	PCC, NHS Solent, VCSE, primary care and CCG – widens workforce focus	Improved sign posting response	Secondary benefits from improved sign posting to appropriate support	Training of workforce to better understand the impact of social isolation and loneliness and begin to develop the skills to empower and support people to come up with their own solutions (MECC).
Adopt one of the social isolation and loneliness scoring measures within assessments including Care Act assessments.	PCC Care Act assessors	Assessments better aligned with received support offer	Increased awareness of individuals at risk	Learning and development in use of appropriate measures – may need some trialling to find best one locally.
Raise the risk profile of social isolation and loneliness so that it is equivalent to that of other significant health and social harms.	NHS Solent, PCC adults and children, CCG, and HIVE	Better alignment of received support with specific risks and conditions	Potentially shift focus of service responses to strengthening degree of natural social connections	Potential for significant cost savings across health and care system
Use ward and neighbourhood profiles to assess the likely impact of service changes and to target resources.	NHS Solent, PCC adults and children, and the HIVE (their new digital resource will have a customer relationship manager sitting behind it which will collate information and analysis of demand and usage)	Better alignment of received support with specific risks and conditions	Potentially shift focus of service responses to strengthening degree of natural social connections	Potential for significant cost savings across health and care system
Increase the capacity to recognise people and groups at risk of social isolation and loneliness by engaging local residents and service users through local neighbourhood forums for action on social isolation and loneliness	Could be led by Hive as part of local area campaigns	Increased perception of support for social isolation and loneliness in communities	Forums could lead to increased natural social connectedness at local community level	Needs appropriate level of financial support for local communities to lead. However, at neighbourhood levels this need not be significant to have a large impact

Respond

Actions	Lead agency responses	Functional benefits	Structural benefits	Resource implications
Use the risk profile to escalate cases so that when more complex interventions are needed these can be used sooner	NHS Solent, PCC adults and children, VCSE, and Primary Care	More appropriate targeting of received support/services	Secondary benefits from improvements in crisis and reductions in complex need	Capacity implications if caseload widened but could save resources from more effective earlier interventions
Develop the competence of early help teams to strengthen resilience at key life events, for example unemployment, bereavement etc	NHS Solent, PCC adults and children, HIVE, and VCSE	More appropriate targeting of received support/services	Secondary benefits from improvements in resilience against social isolation and loneliness at earlier stages	Training a development
Bring the community and voluntary sector, including faith groups together in a partnership for addressing social isolation and loneliness	NHS Solent, PCC adults and children, and VCSE	Strengthens co-ordination of received support	Enables stronger approach to harnessing and developing support for degree of natural social connectedness	Co-ordination and capacity
Ensure suitable integration of social prescribing with core primary and community services	Primary Care Networks and HIVE	Strengthens co-ordination of received support	Depends on nature and type of social prescribing offer	Reduce duplication and improve cost effectiveness of wider system approach
Promote the use of personal health budgets to support social isolation and loneliness including more flexible options for spending budgets on social activities	PCC	Greater user control and choice over received support	Potentially high if budgets support activities that increase degree of natural social connectedness	Within existing budgets.
Enable local communities to re-establish mother and baby support groups in local areas	NHS Solent and PCC adults and children	Targeted use of received support to high risk group	Strengthens degree of natural social connectedness	Requires locations and facilitation
Develop the capacity of digital innovations to provide up-to-date mapping of support services and groups that can help prevent social isolation and loneliness	NHS Solent, PCC adults and children, and HIVE	Greater user control and choice over received support	Strengthens degree of natural social connectedness	Development costs for IT infrastructure and maintenance costs to update

Respond (continued)

Actions	Lead agency responses	Functional benefits	Structural benefits	Resource implications
Develop stronger links between health and social care and transport, housing, planning and regeneration to ensure a whole system approach to creating and sustaining Prosocial neighbourhoods	NHS Solent, PCC, VCSE, Primary Care, and CCG	Greater targeting in use of received support services	High potential in supporting and sustaining development of Prosocial neighbourhoods	Better use of existing resources on shared basis
Use the action plan for social isolation and loneliness to develop the local area response to the Industrial Strategy and the Grand Challenge on Ageing	PCC	Improved targeting of received support services for the elderly	High potential in supporting and sustaining development of Prosocial neighbourhoods	Funding opportunities from national government/lead agencies

Be aware				
Actions	**Lead agency responses**	**Functional benefits**	**Structural benefits**	**Resource implications**
Know who is vulnerable – this may be very specific to the context and require co-ordination of data and communications across different health and care systems. Maps like the one included in the body of this report could give early indications of vulnerable hotspots	The principle of subsidiarity applies e.g. decisions and actions should be taken at the lowest appropriate level, with coordination at the highest necessary level	Service response can be targeted at those most in need	Increased ability to mobilise community assets including family networks, neighbours and community groups. There have already been movements across social media platforms to mobilise community networks that must be promoted by statutory organisations	There are cost implications prior to the crisis occurring e.g. preparedness at local levels to be assured that systems are in place to identify those at greater risk as a result of social isolation and loneliness
Communicate with community champions as they will have more knowledge about who is self-isolating. Work with them to ensure people have sufficient provisions. Provide information e.g. leaflets about online services to go through the door	Local Health Resilience Partnership (LHRP)	Improved co-ordination of community assets and local emergency responses	Increased ability to mobilise community assets including family networks, neighbours and community groups	Additional financial and other resources to support functioning of community champions including lead coordination role

Recognise				
Actions	**Lead agency responses**	**Functional benefits**	**Structural benefits**	**Resource implications**
Understand urgent and emerging risk profiles of sub-groups who are/or become socially isolated and lonely	Local Health Resilience Partnership (LHRP)	Risks can be mitigated by increased ability to respond to specific sub-group needs	Increased ability to mobilise community assets including family networks, neighbours and community groups	Variable and unpredictable – depends on scale of risk profiles and populations affected
Understand that feelings of loneliness can be greatly heightened for those who are self-isolating or subject to quarantine. This may manifest itself in the form of mental health problems or may be worsened for those with pre-existing conditions	Local Health Resilience Partnership (LHRP)	Reduce depression and/or behaviours that may break isolation/quarantine rules as a result of increased loneliness	Increased ability to mobilise community assets including family networks, neighbours and community groups.	Variable and unpredictable – depends on scale of risk profiles and populations affected.
Map closure and/or interference in normal social activities and resources. These are likely to be widespread and it may be necessary to help to facilitate communication of alternative resource delivery	Local Health Resilience Partnership (LHRP)	Identifying individuals or groups that access these services so that alternatives e.g. outreach through community champions can be targeted	Increased ability to mobilise community assets including family networks, neighbours and community groups	Variable and unpredictable – depends on scale of risk profiles and populations affected

Responding in times of crisis: Learning from the Coronavirus pandemic

Respond				
Actions	**Lead agency responses**	**Functional benefits**	**Structural benefits**	**Resource implications**
Before community activities are shut down, it will be crucial to highlight those in attendance and finding an alternative platform to stay in touch with fellow members of the group.	Local Health Resilience Partnership (LHRP)	Risks can be mitigated by increased ability to respond to specific sub-group needs	This will help members stay in touch with one another and should any of them need to go into self-isolation, a possible friend to help with any needs during that time	Variable and unpredictable – depends on scale of risk profiles and populations affected.
Early help teams to be able to use intelligence gathered previously to seek out those in danger of social isolation and make efforts to check on their wellbeing during times of quarantine through phone calls, text messages or digitally.	Local Health Resilience Partnership (LHRP)	Risks can be mitigated by increased ability to respond to specific sub-group needs	Increased ability to mobilise community assets including family networks, neighbours and community groups	Variable and unpredictable – depends on scale of risk profiles and populations affected.
Use digital tools to help link people together.	Local Health Resilience Partnership (LHRP)	Raised awareness of these digital applications and how frontline professionals are able to connect with service users through these tools too.	Increased ability to mobilise community assets including family networks, neighbours and community groups	Variable and unpredictable – depends on scale of risk profiles and populations affected.

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