Campaign to End Loneliness
CONNECTIONS IN OLDER AGE

age UK
Love later life

Promising approaches

to reducing loneliness and isolation in later life

About us

Age UK is the country's largest charity dedicated to helping everyone make the most of later life. Age UK provides a wide range of services and its information and advice reaches 5 million people each year. The Age UK network comprises around 170 local Age UKs reaching most of England. Our family also includes Age Cymru, Age NI and Age Scotland.

The Campaign to End Loneliness inspires thousands of people and organisations to do more to tackle loneliness in older age. We are a network of national, regional and local organisations and people working together through community action, good practice, research and policy to create the right conditions to reduce loneliness in later life. We were launched in 2011, are led by five partner organisations, Age UK Oxfordshire, Independent Age, Manchester City Council, Royal Voluntary Service and Sense, and work alongside more than 2,000 supporters, all tackling loneliness in older age.

Our work is funded by the Calouste Gulbenkian Foundation, the Tudor Trust and the Esmée Fairbairn Foundation.

January 2015

Report author: **Kate Jopling**
Literature searches and screening: **Konstantina Vasileiou**

Contents

List of case studies 4

Foreword 5

Introduction 6–8
- What is loneliness? 6
- About this guide 7
- The evidence on loneliness interventions 8

Chapter 1: A new framework for loneliness interventions 9–11

Chapter 2: Foundation services 12–24
- 2.1. Reaching lonely individuals 13
- 2.2. Talking and understanding – identifying individual needs 20
- 2.3. Supported access 23

Chapter 3: Direct interventions: What's on the menu? 25–37
- 3.1. Supporting and maintaining existing relationships 25
- 3.2. Supporting new social connections 25
- 3.3. Psychological approaches 36

Chapter 4: Gateway services 38–43
- 4.1. Technology 38
- 4.2. Transport 41

Chapter 5: Structural enablers 44–50
- 5.1. Neighbourhood approaches 44
- 5.2. Asset based community development 44
- 5.3. Volunteering 46
- 5.4. Age positive approaches 49

Chapter 6: Gaps and areas for development 51–57
- 6.1. Loneliness within care settings 51
- 6.2. Black and Minority Ethnic groups 54
- 6.3. Lesbian, Gay, Bisexual and Trans older people 56

Conclusions and recommendations 58–61

Appendix 1: Members of the expert panel 62

Appendix 2: Standards of evidence 63

Appendix 3: Measurement scales and tools 64

Appendix 4: Contact information for case studies 65

References 66–67

List of case studies

1 Springboard – Cheshire 14

2 Leeds Seniors Network 16

3 Community Wellbeing Practices – Halton 18

4 Rotherham Social Prescribing Scheme 19

5 Living Well – Cornwall 21

6 Village and Community Agents – Gloucestershire 22

7 Time for Life – Devon 24

8 Touchstones – Yorkshire 27

9 Brighton and Hove Carers Centre – Male Carers Social Support Group 28

10 Fit for the Future – Age UK 29

11 Open Age – London 30

12 Men's Sheds/Tools Company – Age UK Exeter 31

13 Dorset Befriending Services – Royal Voluntary Service 33

14 Dementia Friendship Scheme – Age UK Coventry 34

15 The Silver Line Helpline 35

16 Psychological Support Services – Age UK Warwickshire 37

17 Call in Time – Age UK 39

18 Active Online – Viridian Housing 40

19 Contact the Elderly Tea Parties 42

20 Shopping Service – Age UK Kensington and Chelsea 43

21 Leeds Neighbourhood Networks 45

22 LinkAge Bristol 47

23 Royal Voluntary Service 48

24 Culture Champions – Age Friendly Manchester 50

25 My Home Life – Community Visitors 52

26 HenPower 53

27 New Beginnings – Migrant and Refugee Communities Forum (the Forum) 55

28 Opening Doors London 57

Foreword

The devastating impact loneliness can have on our mental and physical health makes it an issue we can ill-afford to ignore. But loneliness is also a deeply personal experience – unique to every individual; a problem with different causes and different consequences for each and every one of us. And that makes addressing loneliness complex.

Most of us will experience loneliness at some point in our lives, but for many it will be transitory. Sadly though, for a growing number of older people loneliness defines and devastates their lives.

The need for action is increasingly understood, but it's less clear how we can most effectively respond to such a personal problem. So I am delighted to welcome this report, which sets out a framework for a series of practical interventions to address isolation. It explores the many ways in which individuals, communities, and a variety of organisations can respond to this growing societal issue.

Let's fight loneliness – together.

Professor Kevin Fenton
National Director of Health and Wellbeing
Public Health England

Introduction

What is loneliness?

Loneliness and social isolation are widely recognised as among the most significant and entrenched issues facing our ageing society. The two are often talked about in the same breath, but there are important distinctions.

While social isolation is an objective state – defined in terms of the quantity of social relationships and contacts – loneliness is a subjective experience. Loneliness is a negative emotion associated with a perceived gap between the quality and quantity of relationships that we have and those we want.[1]

In this way loneliness is deeply personal – its causes, consequences and indeed its very existence are impossible to determine without reference to the individual and their own values, needs, wishes and feelings. As such, it is also a complex, and often time-consuming, issue to address. However it is an issue that must be addressed due to the far reaching and devastating impacts that it has on those who experience it on a daily basis.

Levels of loneliness in the UK have remained relatively consistent over recent decades – with around 10 per cent of those over 65 experiencing chronic loneliness at any given time.[2] However as the population of older people has grown, the absolute number of individuals experiencing loneliness often, or all of the time has increased – leaving more older people experiencing this distressing daily grind.

Over recent years there has been growing public attention to loneliness in our communities and this has been accompanied by a shift in our understanding of its impact – and in particular its implications for mental and physical health. We now know that, for example:

- The effect of loneliness and isolation can be as harmful to health as smoking 15 cigarettes a day, and is more damaging than obesity.
- Lonely individuals are at higher risk of the onset of disability.
- Loneliness puts individuals at greater risk of cognitive decline, and one study concluded that lonely people have a 64 per cent increased chance of developing clinical dementia.[3]

In response key figures within central and local government have placed increasing emphasis on the need for action to tackle loneliness and isolation.[4]

For more information on the prevalence, impacts and the case for action on loneliness, see:

- *Safeguarding the Convoy: A call to action from the Campaign to End Loneliness* [5]
- *Loneliness – the State We're In* [6]
- *Loneliness and Isolation: Evidence Review* [7]

This document does not seek to rehearse the case for action to tackle loneliness – which is articulated in a number of other publications. Rather it seeks to shine a light on what can be done about loneliness, drawing on the expertise and experience of leading figures in the field, as well as on the academic and other available evidence. It is intended to:

- **Guide commissioners and funders** of services that support older people – including adult social care, clinical commissioning groups and public health teams – to identify the areas of need in their communities;
- **Support service providers** in the delivery of more effective loneliness interventions; and
- **Shape future research** so that our understanding of loneliness, and how it can be addressed, continues to grow.

About this guide

In recent years there have been a number of attempts to bring together what is known about the effectiveness of loneliness interventions, however the conclusions drawn have been partial, and often contradictory.[8]

This is because these reviews have relied on the very limited number of academic papers that assess the effectiveness of a relatively small range of interventions. Yet, around the country there has been considerable innovation in the field of tackling loneliness, and new and established initiatives are responding to ever-increasing demand.

In bringing together this guide we wanted to reflect the full range of initiatives being undertaken to tackle loneliness, and which show promise in tackling this serious public health issue. We therefore decided to start by listening to the experts – those who, for one reason or another, could be considered to have an overview of what is being done to tackle loneliness in communities up and down the country.

Our expert panel comprised a range of disciplines – and included older people, academics, leaders of service delivery organisations, policy thinkers, funders, commissioners and government experts (see Appendix 1). We asked them what approaches they felt showed most promise in addressing loneliness, and why.

Out of those discussions we developed a list of approaches most commonly identified as showing promise. We then returned to the literature, conducting extensive searches, to examine what hard evidence backs these approaches. Appendix 2 gives more information about evidence standards, and how we approached the research in this area.

The evidence on loneliness interventions

As in previous studies, this project has identified a lack of high quality evidence to demonstrate the impact of different interventions on loneliness.

However we recognise that evidence exists on a spectrum (see Appendix 2), and even where the evidence is of a lower quality it can be an important step in the development of a firmer understanding of what works.

The approaches featured in this document are those that were most commonly identified by our experts, and whose promise was supported by some form of evidence. We have sought examples of these approaches in action from around the country, wherever possible profiling those which have made efforts to demonstrate a measurable impact.

As well as identifying an overall lack of evidence, we also found worrying signs of a growing gap between the understanding of what constitutes a 'loneliness intervention' demonstrated in the academic literature, and that of those involved in delivering interventions. The approaches in which most experts saw promise were not the lunch clubs, social groups, and befriending schemes that have most commonly been evaluated in previous studies. Instead experts focused on two other types of approach, including services that worked with individuals at the stage before they started to access lunch clubs, book groups, etc; and approaches that were less centred on the individual and more about the way in which a community responds to the challenge of loneliness.

In producing this report we have sought to offer a new framework for understanding loneliness interventions that better reflects the account given by the experts we consulted.

'There seems to be a **growing gap** between the understanding of what constitutes a 'loneliness intervention' demonstrated in the academic literature, and that of those involved in delivering interventions.'

Chapter 1: A new framework for loneliness interventions

Most evaluations of loneliness interventions have looked at individual services, groups, or activities and have sought to assess whether attending, or being served by, these leads to a reduction in loneliness. This has created a debate to-and-fro among experts about whether social clubs are more effective than befriending schemes, or robot dogs more effective than walking groups.

However, most of the experts we consulted saw the biggest challenges, and the greatest innovations, taking place in broader areas of operation. The approaches that our experts most often identified were those designed to address three key challenges:

1. **Reaching** lonely individuals
2. **Understanding** the nature of an individual's loneliness and developing a personalised response
3. **Supporting** lonely individuals to access appropriate services

These approaches were focussed on the individual, and were the first steps taken as part of the work to reduce an individual's loneliness, coming before and providing a way into the more commonly recognised loneliness interventions, such as social groups and befriending schemes described above. We have termed these '**foundation services**' and they are discussed in more detail in Chapter 2.

As well as identifying these 'foundation services', experts were also excited about approaches which aimed to create the right environment for loneliness to be reduced. These were not direct interventions such as lunch clubs, or book groups, but rather the mechanisms by which these groups came into being.

Experts favoured these approaches not just because they saw them as effective ways of creating the social activities and groups that supported thriving social connection, but also because they believed that bringing initiatives into being through these mechanisms could in itself help to reduce loneliness. We have characterised these approaches as '**structural enablers**' – as they are approaches that support the development of new structures within communities – including not only specific groups and services, but also the foundation services. These are discussed in more detail in Chapter 5 and include:

- Neighbourhood approaches – working within the small localities with which individuals identify.
- Asset based community development (ABCD) – working with existing resources and capacities in the area to build something with the community.
- Volunteering – with volunteers working at the heart of services, wherever possible creating a 'virtuous circle of volunteering' whereby service users become volunteers.

- Positive ageing – approaches that start from a positive understanding of ageing and later life as a time of opportunity – including Age Friendly Cities, Dementia Friendly Communities, etc.

While these more holistic approaches generated the greatest interest, experts were also asked to consider the services and groups that have more traditionally been thought of as loneliness interventions, and that have been subject to most scrutiny – we have characterised these as '**direct interventions**'. These are discussed in more detail in Chapter 3.

Drawing on the insights of Professor De Jong Gierveld et al[9] into the mechanisms for reducing loneliness, we have identified three main categories of direct loneliness intervention:

- Services to support and maintain **existing relationships**
- Services to foster and enable **new connections**
- Services to help people to **change their thinking** about their social connections

It is clear the vast majority of loneliness interventions currently available seek to reduce loneliness by increasing the quantity and quality of relationships, and most do this by supporting individuals to develop new relationships.

Most experts believed that these kinds of interventions were effective in tackling loneliness, but few held up specific examples as showing significant promise over others. Instead they argued that any and all such interventions could be helpful if they were chosen by the older person and well-suited to their needs (hence the importance of the foundation services). Many experts talked about the need for communities to offer a **menu** of such approaches.

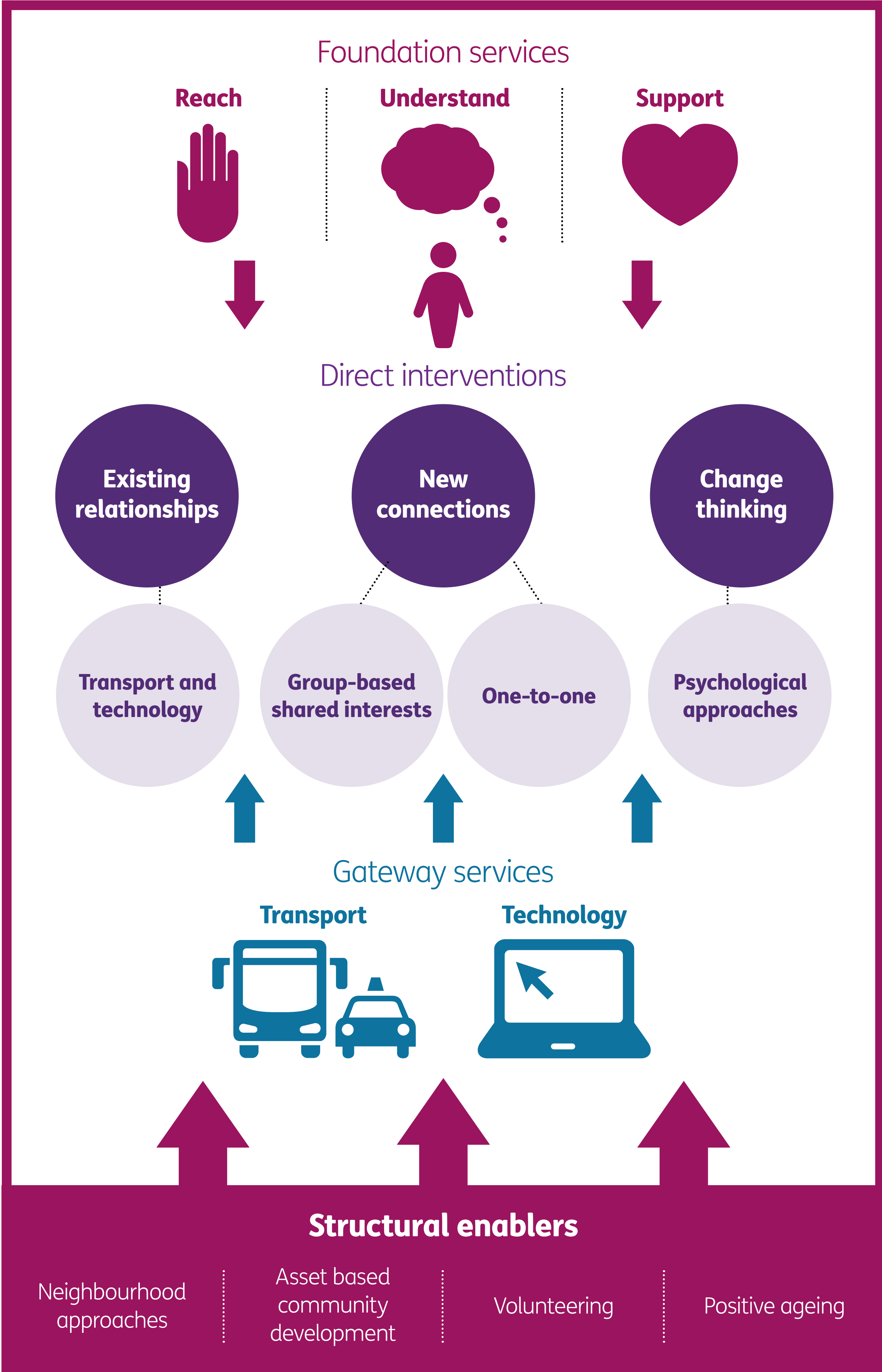
Most experts highlighted **group-based** services, of one form or other, as most promising, and many endorsed the criteria for effective loneliness interventions set out by Cattan et al[10] in her 2005 systematic review – i.e. that services should be group-based, and focused on shared interests.

However some experts strongly argued that for many older people **one-to-one** interventions, such as befriending, would remain the most realistic option for providing social support, and highlighted the wide variations between different models in operation.

There was also growing interest among experts about the need for **psychological approaches** to help people change their thinking about their social connections.

In considering services that could reduce loneliness by rekindling and/or improving the quality of existing relationships **transport and technology** were most often identified. However, experts were clear that these also played a wider role as enablers of effective intervention across the piece. It was also recognised that when transport and technology were not available, or not accessible, they could also act as 'disablers', rendering broader attempts to reduce loneliness ineffective. We therefore have characterised these as '**gateway services**' – playing a critical role in directly enabling existing relationships and a vital supporting role in those interventions designed to support new social connection. They are discussed in Chapter 4.

In the subsequent chapters we explore the approaches identified by experts, within this new framework.


Foundation services
Reach
Understand
Support
Direct interventions
Existing relationships
New connections
Change thinking
Transport and technology
Group-based shared interests
One-to-one
Psychological approaches
Gateway services
Transport
Technology
Structural enablers
Neighbourhood approaches
Asset based community development
Volunteering
Positive ageing

Chapter 2: Foundation services

As noted in Chapter 1, most of the approaches highlighted by experts as showing promise in tackling loneliness were not specific activities or interventions, but rather services designed to address one or more of the key challenges faced in working with lonely individuals.

These were:

1. **Reaching** lonely individuals;
2. **Understanding** and responding to the specific circumstances of an individual's loneliness – rather than offering a 'one-size-fits-all' response; and
3. **Supporting** individuals to take up the services that would help them make meaningful connections.

These were the vital 'first steps' or foundations to approaching a lonely individual and supporting them to achieve a better state.

However the approaches that experts felt were most effectively achieving these ends were often framed not as loneliness solutions, but as holistic and person-centred services, aimed at promoting healthy and active ageing, building resilience and supporting independence.

Importantly, though, experts were clear that these holistic services for older people did not tackle loneliness incidentally or accidentally, in the process of addressing other concerns, but were in fact best placed to tackle loneliness, given its reality as a highly individual experience, affected by a range of other compounding life challenges. Furthermore they recognised that not all apparently holistic services would automatically recognise and reduce loneliness. Only those which had built in understanding of, and insight into, the loneliness experience to the service design – for example, by ensuring the risk factors for loneliness were effectively taken into account, and assessment processes gave time and space for highly personal loneliness issues to come to the fore – would be effective.

The good news is that these approaches fit with the grain of reform of older people's services by both national and local government over the past decade and into the future, including: the drive towards targeting those at risk and intervening early; the integration and consolidation of services to streamline individuals' experiences and to generate efficiencies; the new emphasis on wellbeing as the core aim of care and support services; and the focus on moving individuals towards independence.[11]

The case studies featured in this section demonstrate how services along these lines can be particularly tailored to meet the needs of lonely individuals. Unfortunately, the firm evidence to show whether these initiatives work is scant. Most academic endeavours on loneliness have focused on the specific groups and interventions to which these foundation services ultimately refer older people, and few of these broader approaches have been reviewed with particular emphasis on their effect on loneliness. However there is a strong logic behind experts' enthusiasm for such approaches, and we believe for that reason they warrant further evaluation.

We have identified three main areas in which these foundation services operate – in identifying and establishing contact with lonely individuals (reaching); in drawing out the

specific circumstances of an individual's loneliness and establishing what they most want and need (understanding); and in supporting individuals to make use of available services and support (supporting). However it should be noted that many services sit across several of these categories – identifying individuals and then understanding their personal circumstances and needs, or working to develop plans and then supporting individuals to put them into action.

2.1. Reaching lonely individuals

Lonely individuals are notoriously difficult to identify because many, but not all of them are also socially isolated,[12] and also because the strong stigma attached to loneliness limits the potential for individuals to ask for help, or readily reveal their needs.[13]

There is concern that without explicit targeting, loneliness initiatives will only serve people with a more naturally outgoing nature and those who may be more able to support themselves.[14] It is therefore argued that steps should be taken to ensure that such services are pro-actively offered to those most likely to be affected by loneliness, rather than simply being made universally available.

Evaluating this process is difficult, as reductions in loneliness do not result directly from the identification of individuals, but only once effective interventions are put in place. As a result the evidence base in this area is weak. This is a potential area for development in future.

Three broad categories of approach are being taken to address this issue:

a) Using data to target action

There is a large body of literature on the key risk factors for loneliness and social isolation – which include marital status, and mental and physical health status.[15] These approaches use available data pertaining to these issues to identify areas or households where there is a high incidence of risk factors. This information is then used to target services. In Cheshire (see case study 1) data matching is used to identify individual households to target for services. In Essex and Gloucestershire data has been used to identify neighbourhoods in which high numbers of older people who match risk criteria live, so that these can be prioritised.

Case study 1: Springboard – Cheshire

Springboard is a partnership between Age UK Cheshire and Cheshire Fire and Rescue Services (CFRS) that uses advanced data sharing to target home visits to older people by CFRS staff, who act as a gateway to a range of early intervention and support activity.

Springboard was developed out of a desire to maximise the value of the CFRS's work to provide safety advice and information to older people. In 2005 CFRS and Age UK Cheshire started to work together with the local authority and NHS to identify data sets that would help pinpoint older people who were most likely to be in need of support, due to the presence of a range of risk factors for poor wellbeing in later life.

A data sharing protocol was established to allow CFRS to use 'personal' NHS data, and this is overlaid with information from the index of multiple deprivation, MOSAIC and other open data sets, for example on households receiving assisted bin collections. Using this information Springboard delivers around 30,000 'smart' home visits per year. They have a 98 per cent success rate in being invited into homes, due to the trusted brands of partners CFRS and Age UK.

At each visit a 'contact assessment form' is used as a gateway to a menu of support options including help with building or improving social networks, healthy lifestyles, advice and information, maximising income and reducing unnecessary expenditure, as well as receiving fire safety advice from CFRS.

Social isolation is addressed by connecting people to local resources, signposting to befriending services, tea/coffee clubs, social and leisure networks and Men's Sheds schemes, maximising income, and offering lifestyle and confidence building, educational opportunities and opportunities to volunteer. This joint community capacity approach focuses on people's capabilities rather than deficits.

Springboard's work has led to more people receiving help and support at home who are below local social care eligibility levels – using community networks and developing community capacity – and an increase in the number of older people who are involved with their communities.

Mrs W is 85, recently widowed, lives alone in a rural area, and has increasing care needs. Through Springboard she received a home visit from Age UK Cheshire, and was referred for befriending and to Support Brokerage to organise a more personalised package of support. She recently joined a local social club, and now attends every week. She explained:

'**I now feel far more confident**, it's a great comfort to know that you are there.'

www.cheshirefire.gov.uk/partnerships/springboard

b) Eyes on the ground

In contrast to the relatively 'high tech' world of data-matching, other areas have opted to work through human networks, in recognition of the fact that the majority of lonely individuals have some contact with the outside world.[16] These initiatives work by recruiting and training individuals and professionals within a community, with whom older people may be likely to make contact. The training gives them the skills to recognise the signs of loneliness, and to enable them to make appropriate referrals and offer support.

Where these services have been developed in the UK, for example in Leeds (see case study 2) they have built on the model that was first developed and evaluated in the USA, where they are commonly known as 'gatekeeper' services. The key feature of these services is the training of 'non-traditional' referral sources to reach out to otherwise hard-to-reach groups. These services have been subject to robust independent evaluation in the USA and have shown positive results in terms of their ability to effectively identify and engage with older people who might otherwise not access services.[17, 18]

'**23 per cent** of people aged **75+ who live alone do not see or speak with someone every day**.'*

'**13 per cent** of people aged **55+ only speak to someone three or four days a week**.'*

* Williams, B, Bhaumik, C and Brickell, E, Lifecourse Tracker: Wave Two Report. Survey Report, Public Health England: London, 2013.

Case study 2: Leeds Seniors Network

The Leeds Seniors Network aims to work with and enhance natural linkages; skilling up local people to be even more effective at making connections, and supporting networks and groups. The overall aim is to support older people to live longer at home, have an active social life and remain integrated in their local community.

It is part of the SeNS European Project (Seniors Network Support) and is based around the idea of developing better networks and connections between older people and their friends/families in local communities. There are two elements to the SeNS project in Leeds:

1 Recruiting Community Connectors through an asset based community development (ABCD) approach in three areas of the city – Calverley, Middleton and Harehills;

2 Linking virtual and actual networks.

1 Community Connectors:
Three third sector Neighbourhood Network Schemes have been commissioned to act as Community Builders to recruit volunteer 'Community Connectors' to identify and connect with people who are not already engaged with groups and activities and to support them to turn their ideas for community activity into actions. These individuals come from a wide range of backgrounds and have a whole range of 'day jobs' – they are selected because of their strong networks in the community and their willingness to help make things happen. Each area has a small amount of seed funding (Small Sparks Fund), to help develop actions.

2 Linking virtual and actual networks:
This programme helps individuals, groups and organisations who work with older people to improve their IT skills, with a view to helping those older people who cannot get out and about to maintain their connections and join groups using the Internet.

The project cost £84k in total, which was 50 per cent funded by the European Union and matched by Leeds City Council. Part of the funding was to cover management of the project, part to award as small grants to seed fund ideas and activities.

The project is being independently evaluated. The learning from the SeNS project will be rolled out as part of Time to Shine, a city wide initiative, being funded as part of the Big Lottery Fund Ageing Better Programme.

'The people I've connected have helped each other. I won't say they've necessarily become close friends, but it's about other people feeling useful and helping them feel useful, that they still have skills... **The thing I feel most proud of is that I got people talking to each other**.'

Community Connector

www.sens-project.eu/index.php/leeds.html

c) Links to the health service

Another approach that is gaining considerable interest is linking up the provision of loneliness interventions to the health service. In effect this combines some of the thinking from approaches (a) and (b) above in that the health system has access to some critical data around risk factors for loneliness – in particular around mental and physical health status – but health professionals are also often among the few individuals with whom lonely individuals have on-going contact.

Approaches are being developed that utilise the knowledge and connections of health professionals to identify potentially lonely individuals and connect them with services. These range from 'Home from Hospital' schemes which aim to identify individuals whose lack of relationships might lead to worsening mental and physical health; through quite informal links between voluntary sector services and GP surgeries; to a range of more formal schemes such as the Community Wellbeing Practices scheme in Halton (see case study 3), social prescribing schemes such as in Rotherham (see case study 4), and integrated care pathways such as in Cornwall (see case study 5 on page 21).

These approaches are often driven by a desire to achieve health-system outcomes – such as reductions in GP visits, or reduced Accident and Emergency admissions – and generally demonstrate positive impacts in these areas. Wellbeing outcomes are often also gathered, but the loneliness impact is not always quantitatively evaluated. However qualitative evaluation regularly highlights reductions in loneliness and isolation among the key impacts.

'Three quarters of family doctors (76 per cent) report that between **one and five patients a day attend their surgery primarily because they are lonely**.' *

* Campaign to End Loneliness/ComRes, November 2013.

Case study 3: Community Wellbeing Practices – Halton

Halton Community Wellbeing Practices (CWP) is a unique health initiative, commissioned by Halton Clinical Commissioning Group (CCG), and delivered by Wellbeing Enterprises CIC. The service supports 17 GP practices in Halton to integrate with wider community-based provision.

The CWP initiative is supported by a team of Community Wellbeing Officers, who provide one-to-one sessions to guide patients through a structured 'Wellbeing Review', which identifies social issues that may be causing or exacerbating physical health problems – e.g. isolation, unemployment or housing problems. Patients are then helped to develop an individualised action plan to overcome challenges, by identifying personal strengths and wider sources of support in the community.

In addition to Wellbeing Reviews the programme offers:

- A comprehensive social prescribing programme, including opportunities for patients to access interest groups, life skills courses, psycho-educational training and self-help groups;
- Asset based community projects, working with individuals and clinicians to co-design and co-produce new opportunities for social connections in the community, e.g. Tango Dancing on Prescription, community garden makeovers and volunteering opportunities;
- Community wellbeing and resilience programmes such as 'Ignite your Life!', 'WOW!' and 'Music and Memories', which provide opportunities to bring together 'at risk' members of the community to work with others to learn skills and form new connections.

The CWP initiative also offers patients who are unable to attend their GP practice or other community venue, a home visiting service, which can link them to support to stay connected at home. Wellbeing Enterprises have collaborated with over 120 partner organisations in the borough to offer additional support to patients.

Wellbeing Enterprises have also established Wellbeing Review clinics with secondary care providers, and are working in partnership with others to provide patients leaving secondary care (e.g. Hospitals and Mental Health providers) with wellbeing and social support.

Clinicians in Halton reported that one of the most frequent issues to emerge from their consultations with patients is loneliness and isolation, and they value having a complementary service into which they can directly refer patients, using their practice's clinical software.

Approximately 4,000 interventions are delivered each year through CWP. Outcomes data from the CWP initiative shows that:

- 64 per cent of participants improved their subjective wellbeing levels after an intervention;
- 55 per cent of participants reported a reduction in depression symptoms after an intervention.

'I firstly joined the Wellbeing Choir, and then after the six week course finished I became a committee member to help sustain the group to carry on running in the longer term – **this was such an uplifting and rewarding experience**!'

Course participant

www.wellbeingenterprises.org.uk

Case study 4: Rotherham Social Prescribing Scheme

The Rotherham Social Prescribing scheme is operated by Voluntary Action Rotherham (VAR) on behalf of NHS Rotherham CCG as part of a wider Integrated Case Management programme in primary care.

VAR employs a Social Prescribing Service project team – a Manager and five Voluntary and Community Sector Advisers.

A risk stratification tool is used by GP practices to identify eligible patients (mainly older people with a variety of long-term conditions). Advisers discuss patients at risk of unplanned hospital admission within the integrated case management teams and patients identified as needing non-clinical means of support to improve their health and wellbeing are referred to the social prescribing scheme. Advisers then carry out a home visit to undertake a social need assessment and link patients into appropriate services in the voluntary and community sector.

Many services are funded under contracts with local voluntary and community sector organisations including the local Age UK, Citizens Advice Bureau, Alzheimer's Society and Sense. Services include befriending and enabling; dementia services; carers' respite; community engagement groups; advice and information; advocacy; sensory services; therapeutic services and community hubs based on an asset based community development (ABCD) model. There is also capacity to spot-purchase solutions for patients whose needs cannot be met by the main providers. Services are time-limited, as a pathway to independence, with an emphasis on enabling patients to take control.

Patients' progress towards social outcomes is measured using a specially developed tool. It has eight measures associated with different aspects of self-management and wellbeing; from sleeping habits and managing symptoms, to work and volunteering, to friends and family.

During the pilot phase of the project (April 2012 to March 2014) 83 per cent of patients experienced positive change in at least one social outcome area. Twenty-seven per cent of patients made progress against the family and friends outcomes, with 69 per cent of those with a low score on this measure at baseline making progress. There were also significant benefits to the NHS, with inpatient admissions reduced by 21 per cent; Accident and Emergency attendances reduced by as much as 20 per cent; and outpatient appointments reduced by as much as 21 per cent.

The pilot phase cost £1.1 million. An independent assessment of the return on investment estimated that the longer-term return on investment could reach £3.38 per pound, if the benefits being achieved by the end of the pilot were sustained over a five year period. In addition the value of patients' wellbeing benefits was estimated as between £819,000 and £920,000 by the end of the pilot. The CCG has re-commissioned the service.

'The only person I talked to was the Tesco delivery driver… One day, feeling my life was totally worthless, I visited my GP. She said she had heard about a new thing called 'social prescribing'… She did not offer me pills. This was great! …Now I have friends, I go out for meals; I've been on day trips to the coast, the animal park and other places. **There's always something to look forward to.**'

Patient testimony

www.varotherham.org.uk

2.2. Talking and understanding – identifying individual needs

The second key issue highlighted by our expert panel was the importance of a personalised response to loneliness, given its nature as a subjective experience based on individual perceptions of the value of different social relationships.[19]

Experts argued that the most effective way of tackling loneliness was to provide a service which could first draw out and then respond to individual needs.

In considering the common features of such approaches, we recognised the importance of services based on what is characterised within the Living Well service (see case study 5) as a 'guided conversation' – a relatively unstructured engagement with an older person in which their circumstances, needs and wishes are explored, leading into a discussion about what might be available to improve their wellbeing.

These in-depth discussions were considered vital in ensuring that the full range of an individual's needs could be recognised and responded to – including requirements for specialist support to overcome barriers to accessibility caused by mobility issues, sensory loss, or cognitive impairment, etc.

Such approaches are sometimes supported by the use of 'First Contact Tools' and checklists,[20] however experts argued that checklists in themselves did not necessarily provide the depth of engagement sufficient to fully draw out an issue as personal as loneliness, or to fully recognise the potential solutions. For example while Village Agents (see case study 6) work with a system akin to a 'First Contact Tool', the ability of an agent to act as a trusted confidant rather than an 'official' is recognised as crucial to the programme's success.[21]

The evidence base for such interventions is small, but growing. Unfortunately it is rare for such interventions to be explicitly evaluated for their impact on loneliness, however we can draw some inferences from the impact on wellbeing and other factors. In addition qualitative evidence supports the widely held view that these services are effective in identifying and responding to loneliness.

Case study 5: Living Well – Cornwall

The Living Well programme aims to help people to build self-confidence and self-reliance by providing practical support, navigation and coordination to those most at risk of increased dependency and hospitalisation.

The programme was developed out of the award-winning Newquay Pathfinder, which was initiated by Age UK Cornwall and Isles of Scilly, NHS Kernow Clinical Commissioning Group, Cornwall Council and local health and social care providers, with funding from Age UK. Living Well staff work in teams including the voluntary sector, district nurses, GPs, community matrons, social workers and mental health nurses to provide wrap-around support.

The intervention starts with a 'guided conversation' between the individual and an Age UK coordinator who is trained in motivational interviewing. This conversation helps individuals to identify their goals and a management plan is developed to support their achievement. Trained volunteers then provide continued support to build individuals' social networks, helping them to connect to their community, and increasing their physical and social activity, which in turn improves their health and wellbeing. Past activities have included everything from helping a previously housebound gentleman to go for a walk on the beach, to supporting a lady to improve her functional ability so that she could walk to the bathroom to wash her hair.

Clients are pro-actively identified using a range of criteria including: having at least two long-term conditions; having a social care package and having recent unplanned hospital admissions.

The core elements of Living Well include:

- Understanding the population – using risk stratification, case finding and local knowledge to identify people at high risk of hospitalisation; recognising social isolation and loneliness as factors that contribute towards a crisis;
- Guided conversation – an unscripted engagement to identify individual needs;
- Community involvement and mapping – through conversation with local leaders to identify existing resources and find the 'community makers';
- Information sharing – sharing data across all sectors, using common protocols and management plans.

The project is currently in a test phase. The cost per person is approximately £400.

Outcomes of the scheme are measured using the Warwick-Edinburgh Mental Wellbeing Scale (see Appendix 3). In the first year of the Newquay scheme clients recorded on average a 23 per cent improvement in their wellbeing scores. An average improvement of 20 per cent has been recorded in the first few months of the West Cornwall scheme.

The evaluation of the pilot in Newquay showed a minimum 29 per cent reduction in the cost of hospital admissions and further cost savings across the health and social care system. A similar trend is being seen in initial data analysis of the West Cornwall cohort. In Newquay there was a 4:1 return on investment.

'It's helping me to push myself to **get back to contacting the world around me**.'
Participant

www.livingwellcornwall.org/knowledgebucket

Case study 6: Village and Community Agents – Gloucestershire

Village and Community Agents are trusted members of the community who provide information and support to local people.

The Gloucestershire scheme was launched in 2006 as part of the LinkAge Plus pilots. Evaluation of the pilot demonstrated that older people perceived that their contact with Agents had improved their quality of life. There are now 39 Village and Community Agents covering the whole of Gloucestershire. Each Agent works part time within a specific geographic area. Two Polish-speaking Agents work with Eastern European migrants and three further Agents work with the African Caribbean, Bengali, and Gujarati communities respectively.

The scheme offers information and support and promotes independence among older people, providing community-based solutions wherever possible. The programme has recently been expanded to provide support to individuals aged over 18 who have a cancer diagnosis, through specially trained agents.

The Agents are employed and managed by Gloucestershire Rural Community Council (GRCC), with funding provided by Gloucestershire County Council and NHS Gloucestershire, and additional funds for the Cancer Specialist Agents provided by Gloucestershire CCG. The total annual funding is £340,000. A cost benefit analysis has been undertaken and is due to be published.

Every contact an Agent makes with a client or community is recorded in a secure online system as a 'gateway'. Where action by another agency is required, a referral is made and Agents later follow up to ensure satisfactory outcomes. However the majority of gateways do not lead to referrals, but to community-led solutions, signposting, information finding, supporting clients, etc.

Agents reach out to those who do not socialise regularly through surgeries in community buildings, attending flu clinics in doctor's surgeries, social groups and lunch clubs and by using their local knowledge. Agents are able to visit people at home and spend time finding out about the issues affecting them, and identifying solutions.

'I received a call from a local practitioner concerned about a lady in her 70s living alone. She had recently moved to the area and was having difficulty making contact with people and feeling isolated. I made contact with Mrs A.

After discussing her interests I was able to put her in contact with people attending local chapel. From this contact she joined a knitting group. I also put her in touch with a wellbeing and exercise group. She also enjoyed playing scrabble but had recently lost her fellow players due to illness. I was aware of another single lady living close to Mrs A, who I knew also enjoyed scrabble. With their permission I passed on their contact numbers. Very soon afterwards they arranged to meet and enjoy playing scrabble regularly in one another's homes. I have visited Mrs A several times. **She says she is now much happier**.'

Village Agent

www.villageagents.org.uk

2.3. Supported access

The final approach that experts highlighted was the provision of services to support older people through the process of reconnecting with wider provision in their communities.

Underlying these approaches is a recognition of the damaging effect loneliness can have on individual's confidence and the importance of fear in limiting individuals willingness to engage.[22]

These services link lonely individuals with a trusted 'buddy' or 'mentor', with whom they are able to develop a relationship and who offers practical and emotional support to the individual to support the achievement of specific goals. This role is different to that of an adviser or an assessor, in that the mentor or buddy may well get involved in going along to activities, or in providing other practical and emotional supports to an individual in meeting their goals. However it also differs from the befriending relationship, in that it is normally time-limited and focused on the achievement of very specific objectives which the individual defines and which often relate to connecting to wider services, groups and structures within the community, rather than operating as a long-term support structure or social connection in itself.

Often these approaches are delivered in tandem with services that assess individual needs and support the selection from a menu of local services – for example in the Cornwall Living Well programme individuals are supported by a volunteer beyond the initial assessment of needs to the point of becoming confident to engage independently with wider services.

Some services of this nature have been reviewed for their effectiveness in tackling loneliness, and have been shown to have positive effects.[23] However, in such reviews these services have often been presented as simply another one-to-one intervention, along the lines of befriending. In our discussions with experts it became clear that this does not necessarily accurately reflect the role these services play in relation to a lonely individual. These services should be seen as facilitating and enabling access to direct interventions, rather than offering support in themselves.

Case study 7: Time for Life – Devon

Time for Life (TfL) is a targeted and time-limited, personally tailored, goal oriented community enabling service for people aged 65 and over, aimed at tackling social isolation and consequent exclusion which frequently follow common events in later life, such as bereavement, illness or a disability.

The service is available to people who meet eligibility criteria under Fair Access to Care criteria and delivered across all of Devon (except Torbay and Plymouth) by four consortium members – Westbank, Age UK Devon, Upstream and Age UK Exeter, and is funded by Devon County Council.

Referrals are made into the service from Care Direct (Devon County Council) and on referral a personalised assessment is undertaken by a TfL Enabler who works with the older person to determine their aims and how the TfL enabling service can help them to:

- re-engage in activities which are personally meaningful and enjoyable;
- develop the tools, knowledge and experience to confidently engage in and self-determine their personal and social activities in the future;
- re-engage in the wider community.

The Enabler helps support the participant by using coaching techniques and by accompanying them to any activity they wish to attend, e.g. social groups, activity groups (art and craft, writing), exercise classes/walking groups etc.

Client outcomes are regularly measured using a self-reported outcomes tool developed for the service which measures: Health and wellbeing; Quality of Life; Making a positive contribution within the community; Exercising choice and control; Economic wellbeing; Experiencing personal dignity; and the ability for carers to continue their caring responsibilities. Measures are taken at baseline and after closure and six months after discharge. Clients report significant improvement against all measures with particular improvement in quality of life and making a contribution.

'It's all thanks to you; you gave me the confidence to do this. I got on the bus to Axminster yesterday, walked around and down to the station – I'd not done that before. **It has made such a difference, having you be with me it has really helped – thank you so much**.'

Participant

www.timeforlife.org.uk

Chapter 3: Direct interventions: What's on the menu?

To a large extent the approaches discussed so far in this report rely on the assumption that, in any given community, there are services and supports to which people, once they have been reached, understood and supported, can be referred and into which they can integrate and there develop meaningful relationships.

This section outlines some of the key things that experts believed would be most likely to meet older people's need for meaningful social contact and connection. These services, activities and groups seek to end people's loneliness by doing one of three key things:

- Supporting individuals to reconnect with and/or maintain **existing relationships**
- Fostering and enabling **new connections**
- Helping people to **change their thinking** about their social connections

Below we explore the approaches experts felt were most promising in these three areas.

3.1. Supporting and maintaining existing relationships

Improving access to transport and technology was seen as the primary way in which communities could enable older people's ongoing relationships with existing connections. However these services were also seen as having far wider impact on older people's ability to engage with services, and on communities' ability to provide them. As a result these are discussed in more detail on page 38, in the chapter on 'gateway services'.

3.2. Supporting new social connections

The majority of direct interventions highlighted by experts as promising were those which enabled and supported older people to develop new connections in later life. A wide range of services were discussed, and these fell broadly into two categories – group-based approaches, and one-to-one approaches.

a) Group-based approaches

The most often endorsed approaches were social groups of one form or another, but the majority were groups whose primary 'offer' was not social contact, but something else desirable – e.g. learning, health promotion, support through difficult circumstances etc.

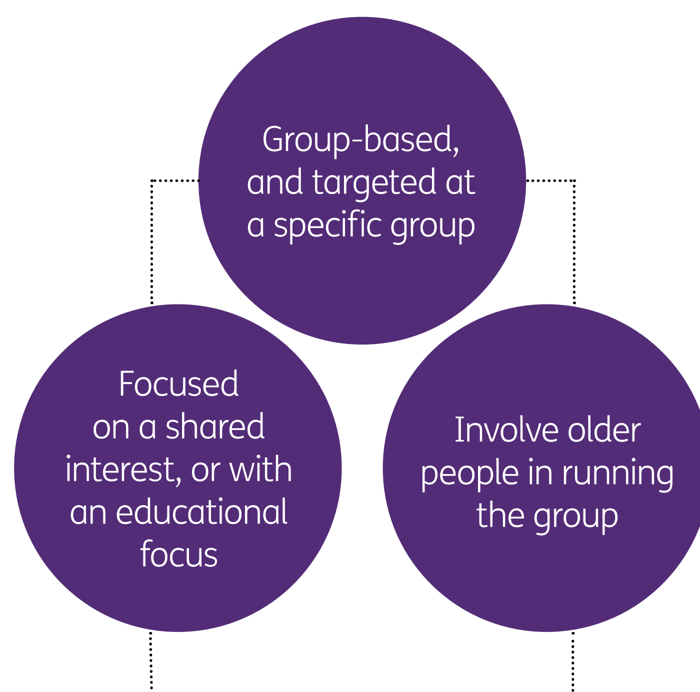
In endorsing these kinds of supports, our experts expressed agreement with the three main criteria identified by Professor Mima Cattan's systematic review of loneliness initiatives[24] – namely that the most effective loneliness interventions are:

- Group-based, and targeted at a specific group
- Focused on a shared interest, or with an educational focus
- Set up to involve older people in running the group

The evidence of effectiveness of such initiatives, as a general type, is therefore relatively strong, and many have gathered their own evidence (of varying quality) to demonstrate their positive impact.

There are numerous initiatives around the country that fit these criteria – from University of the Third Age (U3A) groups to coffee mornings, and from faith groups to community choirs. Experts highlighted in particular the vital role a shared learning experience could provide for giving meaning to social interaction, the particular needs of men for social activity, and the strong bonds that could be forged when individuals came together for the explicit purpose of supporting one another through challenging experiences. Some examples of these schemes are offered in the case studies that follow.

Most effective loneliness interventions according to Professor Mima Cattan



Case study 8: Touchstones – Yorkshire

Touchstones was set up to support bereaved older people to access and learn new practical skills for day-to-day living, and to provide opportunities for older people to get involved in their community through volunteering.

The project was led by Rural Action Yorkshire and the main programme ran from September 2012 to March 2014 in Craven, Harrogate and Wakefield, funded by the Big Lottery Fund Silver Dreams Fund, and delivered through local Age UKs.

Touchstones provided practical skills sessions across rural and small urban communities for bereaved older people provided by people in similar situations. The project set out to offer skills support to 200 beneficiaries over 18 months, delivered by 49 staff and volunteers. Over time 21 beneficiaries became volunteers for Touchstones, supporting skills sessions.

Individual events and training were advertised through local radio and newspapers as well as online via websites and social media. Clients were able to self-refer, and others were referred by GPs, or through Age UK etc. As Touchstones progressed, it identified a wider group of potential beneficiaries including divorced, separated and single people, and those whose partners are suffering from long-term illnesses such as dementia and Alzheimer's disease.

A huge amount of volunteer input helped Touchstones to deliver 120 sessions across the lifespan of the project, equating to 213 hours of skills sessions. Beneficiaries provided the inspiration for the sessions by telling organisers what they wanted to learn or try.

Beneficiary feedback showed:

- 91 per cent felt more involved or connected with their community as a result of Touchstones;
- 86 per cent felt they now had more confidence to get out and meet people.

In Harrogate, Touchstones continues and is going from strength-to-strength as a volunteer-led support group, independent of Rural Action Yorkshire and Age UK. Beneficiaries now contribute a small amount to attend the weekly Friday sessions, and learn different skills and have different themes from week-to-week.

'Losing my husband made me feel very isolated and I lost confidence. Things change when you no longer have someone to do things with. **Having the support of people in the same situation makes life easier**.'

Ann

www.ruralyorkshire.org.uk

Case study 9: Brighton and Hove Carers Centre – Male Carers Support Group

Brighton and Hove Carers Centre Male Carers Support Group was established in May 2009 in recognition of the fact that male carers can have particular support needs and had not been coming along to other groups or coffee mornings run by the Carers Centre.

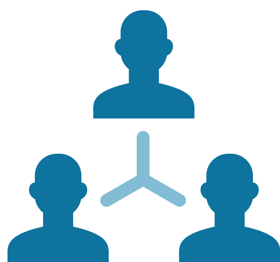
It is funded by Brighton and Hove City Council and run by a Sessional Work Group Coordinator who is employed 10 hours a month by the Carers Centre, and is supported and supervised by a full-time member of the Carers Centre staff.

The group meets twice a month in community settings such as cafés and has established a monthly coffee morning and a monthly social activity. A core group of men come along regularly, most of whom are caring for their partners.

The group is relaxed and has a mainly social focus. The Sessional Work Group Coordinator calls people who are interested in joining the group, and explains that members do not have to talk about their personal life or their caring role if they don't wish to. Outside the group the Coordinator offers one-to-one support and any casework is referred back to the Carers Centre.

At the monthly coffee morning the carers decide on their next activity. All activities are provided free of charge, and in the past these have included bowling, pool, mini-golf, fishing, and cinema trips. Meals are very popular and the group holds an end of year meal and a 'Male Carers Big Breakfast'. When planning activities the group are mindful of carers' own access needs. Evening and weekend activities work best and activities last no more than a couple of hours in the local area, as this is the maximum amount of time most members can take away from their caring role. The Centre pays transport costs for members with mobility difficulties to enable them to access the group.

An evaluation questionnaire is sent out annually to the group's mailing list asking the men to assess the group's usefulness in managing issues like stress, depression, feelings of isolation and ability to cope with the caring role, on a scale of 1–5 (where one represents a low rating and five a high rating). For the period April 1st 2013–March 31st 2014 average scores ranged from 3.75–5.



'Aside from the survey results which are very positive, I am aware that some of the men are forming friendships outside of the group and I have noticed **the quality of the interaction between them has improved greatly**. This is especially true of those members of the group that have been attending for a number of years, they seem to **take pride in the group and are very welcoming and supportive of new members**, it is as if they feel some ownership of the group which is a very positive thing.'

Group Coordinator (April 2011–March 2014)

www.thecarerscentre.org

Case study 10: Fit for the future – Age UK

Fit for the future is a programme involving 11 local Age UKs in England, which supports older people with long-term conditions, and aims to improve their physical and mental wellbeing by delivering real, sustainable change in the provision of integrated services and activities.

It has a person-centred approach, with a trained staff member or volunteer meeting with individual older people to agree a personal, tailored plan to suit their health and wellbeing needs and then supporting them to access relevant services such as exercise groups. Activities available on the project range from dance, cycling and swimming to lessons in cooking, gardening and eating healthily.

The model receives referrals from GPs and healthcare professionals, as well as from friends and relatives, and other local voluntary sector and/or Age UK services. The project's evaluators have found that participants responded positively to invitations to join the project primarily because they wished to meet new people. Age UK provides initial support to attend a group, which might include going along with the participant or assisting with transport arrangements, until the participant is confident to attend independently.

Fit for the future is funded by the Big Lottery as part of its wellbeing portfolio – receiving £2.2m.

A full evaluation of the project will be completed in June 2015. Initial results from surveys carried out among clients at the start of the project and then after several months are demonstrating positive change against a number of measures, including:

- Increase in numbers reporting that they never/hardly ever lack companionship;
- Increase in numbers reporting that they never/hardly ever feel isolated;
- Increase in numbers reporting that they never/hardly ever felt left out.

The final evaluation will capture any reductions in the number of unplanned GP or hospital visits. Surveys so far have captured promising data, including a small reduction in the numbers of people experiencing a fall or loss of balance.

'Gets me out of the house and **talking to people** that I wouldn't normally get the chance.'

Participant

www.ageuk.org.uk/health-wellbeing/fit-as-a-fiddle/fit-for-the-future

Case study 11: Open Age – London

Open Age is a charity operating primarily in the Royal Borough of Kensington and Chelsea (RBKC), Westminster, and Hammersmith and Fulham to create chances for older Londoners to work, learn, take part and stay healthy in body and mind. The project provides almost 400 weekly activities across community venues and its own activity centres and hubs.

In addition to the huge range of creative and performing arts opportunities, computer and iPad classes, dance and physical activity sessions, social groups, lunch groups and trips, Open Age also provide facilitated phone activities for those who are housebound, activities for carers and special daily men's sessions.

Open Age place a heavy emphasis on the provision of activity and learning, rather than social contact in itself, as they find that this creates a more attractive offer to older people. The Charity's activities are led by the interests of older members, who are actively involved in leading the organisation.

It is free to join Open Age and classes normally cost £1 an hour and are pay-per-session and drop-in. Sessions are run by independent paid tutors or volunteers. Most of the staff are outreach workers setting up the activities and trying to find those most in need by working with a variety of stakeholders. For example, in RBKC Link-up workers make home visits to older people who are referred through health professionals and others, to help break down barriers preventing participation (e.g. loss of confidence through bereavement, frailty etc) and to support older people to attend new sessions for the first few times.

Open Age has multiple funders including local authorities, Public Health, Clinical Commissioning Groups, Skills Funding Agency, as well as Trusts and Foundations and the Big Lottery Fund.

In a recent evaluation survey by the charity 85 per cent of the 1,366 members who responded said that they had made new friends and had a social life through attending Open Age.

'**I am isolated in my flat** and the session gives me a chance to socialise, meet people from different backgrounds, interact with different people and **finally, lifts my spirits**.'

Men's group participant

www.openage.org.uk

Case study 12: Men's Sheds /Tools Company – Age UK Exeter

Age UK Exeter's Men in Sheds scheme was set up to offer a facility for men aged over 50 to meet for a few hours a week in the familiar environment of a shed or workshop.

The men come together to socialise over refurbishing and renovating tools and garden equipment to be donated to charities and organisations in the UK and Africa, or to be sold to raise money for Age UK Exeter.

The scheme operates four days a week. For two days a week the project is open to men who can manage the work and environment independently and on the other two days the Shed offers a more managed environment so that men with physical disabilities and/or mental health needs can safely enjoy the shed – this is Tools Company.

Through this programme regular shed attendees act as 'Buddies' for older men who would not otherwise be able to access the Shed, who are known as 'Chaps'. The scheme was initially funded by a £10,000 grant from Nesta as part of the Ageing Well Challenge Prize. During the grant period the Shed supported 19 Chaps to attend the Shed regularly.

Now that the Nesta grant has come to an end the scheme is funded by a number of trusts and foundations, and benefits from in-kind donations of tools and training from corporate supporters. The project as a whole costs approximately £32k per annum, with salary costs making up around 80 per cent of the costs (to ensure appropriate risk and safety levels on all four days).

The scheme is widely advertised through posters and local media etc. 'Chaps' are referred to the scheme by Mental Health teams, Social Services, Age UK Exeter and the Royal Devon and Exeter Hospital. The scheme also accepts self-referrals. It has attracted men who have not attended and do not want to attend day centres, clubs and other activities where the primary focus is on chat.

Evaluation of impact over the six month period supported by Nesta demonstrated that participation in Tools Company resulted in:

- An increase in the amount of time in which older men were engaged in meaningful activities each week;
- A reduction in feelings of loneliness and isolation among all participants;
- Increased social contact and lasting friendships between older men.

Age UK Exeter have produced a short guide entitled 'Create Your Own Tools Company' to support other organisations to replicate their model in other areas.

'**I love the company**. Because of my depression I'm not very sociable so I come for the company. There are people here with lots of skills and I'm still learning skills and I'm still learning things. **I know what we are doing is helping other people**.'

Michael, aged 65

www.ageuk.org.uk/exeter/our-services/men-in-sheds/

b) One-to-one approaches

Experts were clear that for some people the potential for reconnecting with existing contacts was limited, and that while the ideal model for creating new connections was through interventions that enable people to move back into the wider community, for some the practical barriers to 'getting out' were too great.

Experts believed that for this group long-term one-to-one friendship provision at home was the only practical solution – the most common form of this being traditional 'befriending' services, through which an older person is matched with a worker or volunteer who visits or telephones them on a regular basis.

Mima Cattan's 2005 systematic review of loneliness interventions concluded that the evidence on one-to-one befriending was too weak to be able to state that these initiatives are effective in reducing loneliness, however she noted that such services were highly valued.[25]

Other studies, before and since, have produced different conclusions. However this may in part be explained by the fact that often these studies categorise a wide range of interventions under the heading of 'one-to-one' interventions, conflating those services which offer a one-to-one relationship as the end-game, with those which connect or reconnect individuals to wider social contacts through an (often time-limited) one-to-one enabling, mentoring, or other supportive intervention.

Notwithstanding the lack of evidence, the experts we consulted made clear their belief that, particularly for those for whom practical barriers such as disability made getting out and about difficult, and in a context in which social care provision was simply insufficient to overcome these barriers, one-to-one befriending services could play an extremely positive role.

Furthermore experts highlighted the efforts being made to build on the 'traditional' befriending model, to increase its efficacy, in a range of ways, including offering older people the opportunity to become involved as befrienders themselves, and supporting older people to engage in activities outside the home. Others have developed specialist models of befriending to meet the needs of particularly at risk groups who may struggle to engage with wider provision.

Case study 13: Dorset Befriending Service – Royal Voluntary Service

The Dorset Befriending Service is run by the Royal Voluntary Service and offers home visiting and support to older people across the county of Dorset.

The scheme was initially set up in response to concern by a local GP that a number of older patients were making repeated trips to the GP and to Accident and Emergency, for reasons which were primarily to do with their isolation.

The scheme is available on a referral or self-referral basis to older people throughout the county. Older people who are referred to the scheme are assessed by the coordinator or a customer support volunteer, in order to work out what kind of support will best meet their needs and wishes.

The scheme offers a range of options including:

- Home visits
- Accompanied and wheelchair walks
- Shopping and general errands
- Sitting to relieve a carer
- Dog walking
- Card and board games
- Trips out and socialising
- Reading and help with correspondence.

Support is available on an on-going basis, for as long as older people want to receive it.

The scheme is funded by donations and fundraising. It was initially set up using legacy funds. The scheme costs around £7,000 per annum to run (excluding costs for the service manager), and is coordinated and delivered entirely by volunteers who are supported by the part-time service manager. The scheme has 110 clients, with the majority aged between 80–94 years old. All overheads included, it costs just £3.50 per person each week to provide companionship, encouragement and a supported sense of wellbeing.

'My volunteer is a very nice lady and **I look forward to her visits**. Sometimes we play scrabble and she has taken me shopping, and offered to take me to other places where I might like to go. I count myself lucky to have been given the opportunity to receive visits from a volunteer, **it certainly has made a difference to my life**.'
Client

www.royalvoluntaryservice.org.uk/service/1271-dorset-and-wiltshire

Case study 14: Dementia Friendship Scheme – Age UK Coventry

Age UK Coventry runs a Dementia Friendship Scheme for older people with early stage dementia, which aims to support people who live alone to maintain a hobby, or activity within their local community.

Specially trained volunteers visit clients once a week for a minimum of two hours and can either spend time in the home or accompany the older person to an activity. Clients choose what they would like to do with the time, and activities include anything from tea and chat; to attending a friendship group or craft activity; to going to lunch or for a walk; to doing some baking. The overall aim of the scheme is to support people to live well with dementia.

Referrals are received from a variety of sources including older people and family members, as well as Alzheimer's Society, local Memory Services team; Social Services and other teams at Age UK Coventry.

The project was initially funded by NHS Coventry, but this finished in 2012. Since then it has been funded through a legacy and money from the Big Lottery Fund's Awards for All scheme. The scheme is volunteer-led and overseen by the Friendship Development Officer. A rough estimate of the cost of an hourly home visit is £10.

The scheme collects feedback from clients each year and the pilot phase of the project was subject to both internal and external evaluations, which found that clients reported a range of outcomes related to improved social contact, increased activity, and improved wellbeing.

'**We can talk about anything**, football, boxing and he helps me out with things, he made me a telephone list so that I can see it and he helps me sort out my appointments, I can't remember them, but **he helps me, he explains it to me, and that helps**.'

Client

www.ageukcoventry.org.uk

Case study 15: The Silver Line Helpline

The Silver Line is the only 24-hours-a-day free and confidential helpline which offers information, friendship and advice to older people. The Silver Line also offers telephone and letter based befriending by volunteers known as 'Silver Line Friends'.

Calls to the helpline are answered by professional advisers who are specially trained and available to answer questions, to refer older people to sources of specialist advice, or to simply have a chat.

Most older people call in the evenings, at night and weekends for company when other services may not be available, particularly around times of transition – such as following a bereavement.

Older people who want regular conversations with the same person are invited to be matched to a volunteer 'Silver Line Friend'. While waiting for a match they receive a regular 'wellbeing call' from helpline staff to check how things are and have a chat. Once matched they receive a weekly phone call, at an agreed time, to build up a friendship. The Silver Line also facilitates 'Silver Circles' which are telephone groups, facilitated by a volunteer, and offers befriending by email and letter. Silver Letters' are popular with older people with hearing loss.

While the Silver Line is happy to speak to people over the phone for as long as they want, they also explore people's interest in getting involved with face-to-face social opportunities. The Charity has forged collaborative relationships with other voluntary sector agencies and offers signposting to Age UK, the University of the Third Age and Contact the Elderly, among others, to support face-to-face connections in local communities.

The Silver Line also seeks to encourage people who receive calls from the 'friends' scheme to become volunteers themselves, or to get involved with Silver Circles, as a way of helping people to find a new sense of purpose and widen their social circles.

The Silver Line is funded by a range of trusts and foundations including the Big Lottery Fund, as well as corporate partners including BT.

A pilot phase of the helpline was evaluated by the Centre for Social Justice, which reported that 'in the many cases where loneliness had been a driver in them calling or asking for a friend, people referred to how it had enabled them to become reconnected, whether to other services or simply to another person'. An ongoing evaluation is underway in partnership with Anglia Ruskin University, and will produce quantitative as well as qualitative evidence of impact.

'It's very difficult when you haven't got children and you are not working... you are lost... I am now involved with a Silver Circle... **We chat to one another, we know one another**. They are my friends... You give us confidence to go forth... I am now going to be a facilitator. I'm going to have my own [Circle] and, if I'm allowed, I'll take over the place.'

Jean

www.thesilverline.org.uk/

3.3. Psychological approaches

The third category of direct interventions identified by experts as showing promise was focused on supporting people to **change their thinking** about their relationships. Experts believed that there was significant potential for growth in this area, and many of the most lonely and isolated older people would be in need of such services if their loneliness were to be addressed effectively.

Experts were interested in the findings of a recent meta-analysis of loneliness interventions by Masi et al, which found that the greatest effect on loneliness was seen within interventions that addressed what they called 'maladaptive social cognition'.[26] In essence these were psychological approaches to loneliness, based on systems such as Cognitive Behavioural Therapy (CBT) and Mindfulness.

However experts recognised that services of this nature were in their infancy in the UK. Mindfulness and CBT are currently recommended for use among individuals suffering from depression,[27] and there is good evidence of their efficacy in addressing loneliness,[28] however few organisations offer psychological services as a loneliness intervention at present.

In Warwickshire (see case study 16) a menu of psychological services is made available to older people who are experiencing a range of mental health issues, with positive impacts on older people's wellbeing. However, while the linkages between these mental health issues and loneliness and isolation are recognised, the more intensive services are only available to those with other mental health diagnoses.

It is clear that there is still room for further consideration of the role psychological interventions might play in work among lonely individuals, particularly given the relatively strong evidence available in this field.

Case study 16: Psychological Support Services – Age UK Warwickshire

Age UK Warwickshire's Psychological Support Services is a county-wide scheme offering a range of interventions aimed at improving wellbeing and supporting older people.

A counselling service is available to clients who are aged over 55, or who are caring for someone aged over 55, offering up to 25 sessions with a trained counsellor who provides emotional support, confidential, non-judgemental listening, and help to work through difficulties. Sessions are generally held in individuals' own homes, and referrals are accepted from a wide range of agencies. Self-referrals are also taken. The scheme is funded through a combination of grants from trusts, core funding and individual client donations.

The service has recently started to gather impact data using the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS – see Appendix 3) with measures taken during the initial assessment phase and then after the final counselling session. To date a mean increase of six points on the WEMWBS has been recorded among clients undergoing counselling.

Also available is a scheme called 'Support, Time and Recovery', which focuses on improving wellbeing, increasing self-management skills and reducing isolation. The service is funded by Warwickshire County Council and through client donations and is available to clients aged over 55 who have a diagnosis of depression, stress or anxiety. The scheme offers up to 25 sessions with a volunteer who helps clients work towards identified goals and to take steps to improve their wellbeing.

Although the service often deals with issues of isolation and loneliness, it is not available to those whose only request is to reduce isolation, and self-referrals are not accepted. Referrals are accepted from GPs, Community Mental Health team and other mental health service providers. Regular reviews and on-going monitoring are carried out, to identify any changes in client needs. These clients can then transition to different parts of the Psychological Support Service, for example counselling or CBT, with little delay. Similarly clients who have had 25 sessions and made improvements, but who are not ready for discharge, can be provided with lower intensity services.

Evaluation shows that clients make a mean improvement of 20.2 points on the WEMWBS scale, following involvement with the 'Support, Time and Recovery' programme.

Lower level interventions offered by the service include 'Wellbeing in a Box', which enables individuals to learn techniques to increase confidence and find ways to manage low mood or improve sleep. This is a short-term intervention involving the provision of self-help guides or 1–5 low level sessions. It is funded by Warwickshire County Council. The organisation's befriending service also forms part of the Psychological Support Service.

'**I couldn't have asked for anyone better**, she has made such a difference – **giving me more confidence** and listening without pressure. To have someone to talk to and know you can say anything at all and in confidence is wonderful.'

Support, Time and Recovery Client

www.ageuk.org.uk/warwickshire/our-services/psychological-support-service/

Chapter 4: Gateway services

Throughout discussions with our expert panel, the role that access to transport and technology plays in addressing loneliness was repeatedly highlighted.

Both were felt to be vital to enabling social connection, not only in supporting older people to maintain their existing relationships, but also in enabling services that support the development of new connections. Experts also emphasised that lack of availability of, and access to, these services could be a serious barrier to social connection.

Experts noted that these enabling services were so highly valued that often simply offering these services could act as an enticement and catalyst to engagement with the wider community – so that older people who might reject explicit offers of support with social connection, might accept transport or technology-based services which offered social connection 'on the side'.

4.1. Technology

The impact of technology on loneliness among older people has been hotly disputed, with some arguing that the increasing use of technology has exacerbated the exclusion of older people, and others pointing to the vital role that technology can play in enabling older people to maintain (and, to a lesser extent, develop) their social connections.[29]

A recent systematic review by Hagan et al found that technology based initiatives were among the most effective of all studied interventions in tackling loneliness.[30] However it should be noted that in only one of the studies which informed this conclusion was technology itself the source of a new relationship, in other cases the technology either enabled, or created the catalyst for, new social connections, and indeed in some cases the provision of technology created the 'excuse' for new face-to-face relationships – e.g. in the provision of IT training.

In discussion with experts it was acknowledged that, alongside the role of technology in helping older people to maintain connections with existing contacts, it also offered a cost-effective way of providing wider services and supports to social connection. It was recognised that technology-based provision may sometimes represent the 'best case scenario' in a time of limited resources, even though face-to-face provision may be preferred.

Experts also argued that while some technologies may currently be inaccessible and unpalatable to older people, others – such as the telephone – are now commonly accepted and accessible to older people. It was noted that these accessible technologies could play a particularly important role in supporting the delivery of services (as in Age UK's Call in Time programme – see case study 17) and that over time, as new cohorts age, the range of commonly accepted and accessible technologies may widen, opening up new possibilities for technology-based loneliness solutions.

The case studies below demonstrate the role of technology both as an enabler of social connection in itself, and in making the provision of social support more cost effective and easy to deliver.

Case study 17: Call in Time – Age UK

Call in Time is a national telephone befriending service provided by Age UK, which is based on a corporate volunteering model.

Organisations that sign up to Call in Time allow their staff to volunteer, usually during working hours, for half-an-hour a week to befriend an older person.

Age UK recognise that most older people would prefer to receive a face-to-face befriending service, so Call in Time tends to serve clients in areas where no face-to-face services are available due to lack of funding, or difficulties recruiting volunteers. Because Call in Time is delivered over the telephone, with the support of employers, Age UK is able to deliver a cost effective service and reports few problems attracting volunteers.

The scheme accepts self-referrals and receives referrals from a wide range of agencies. Upon referral individuals are contacted by the central Call in Time team who assess their suitability and offer a brief 'good day' call once or twice a week for a period of around six to eight weeks. These calls allow staff to find out more about the individual, so that they can be appropriately matched to a befriender. This is also an opportunity for individuals for whom the scheme may not be suitable, due to mental health or other issues, to be identified and referred to a more appropriate service.

Once referred to a volunteer, individuals receive a weekly call for friendship and chat. Befrienders are trained to be able to identify and refer any emerging issues or concerns. They have access to a live email 'alert' system, through which they can flag any urgent issues to the Call in Time team who ensure an appropriate response.

The scheme is largely funded by its corporate partners who pay for their staff to be part of the scheme on a per-head basis. This funding gives them a complete package of support including training and volunteer matching.

An independent evaluation of the pilot phase of the project found that 'perceived wellbeing and mood improved and activity levels increased among telephone befriending service recipients, including those suffering from chronic depression. Many reported a reduction in loneliness.'

The team are now developing new methods for gathering impact data, relating to both participants and volunteers within the project.

'**I was very, very, very lonely, and very, very, very sad**. …I couldn't tell you how I felt, numb. I really didn't have any feelings. That's what frightened me in a way. …The **Call in Time service has helped me dramatically**, because I know that the call is coming. If I'm upset I've got someone to talk to me, and if I'm happy I've got someone to share that with.'

Barbara, 82, lost her husband and daughter in close succession

www.ageuk.org.uk/health-wellbeing/relationships-and-family/telephone-befriending/

Case study 18: Active Online – Viridian Housing

Active Online is Viridian Housing's free Internet training scheme for residents aged 50 and over. The scheme provides free one-to-one training sessions in individual's own homes, and no computer equipment or Internet connection is needed to participate, as trainers bring tablets with them.

The project started with a pilot, which tested both one-to-one and group-based models of training, and trained 80 residents aged 50 and above. This has now been rolled out, across the UK, to all areas in which Viridian works. Two hundred and fifty residents have signed up since January 2014, and the target is to have 300 residents signed up by January 2015. The scheme now operates on a one-to-one basis only, as the pilot showed that this model worked better both for Viridian and its residents. Viridian works with two trainers: Student@Home (who provide the majority of the sessions) and UCanDoIT (who provide specialist support and technology for residents with additional needs, such as visual impairments, learning disabilities or dementia).

The scheme is advertised widely through Viridian's newsletters and website, and through housing officers and scheme managers. Residents can also self-refer. Student@Home run 'taster sessions' at retirement schemes, and residents aged over 50 who do not live in retirement schemes are called directly to offer training.

Viridian is committed to ensuring all customers have access to the training and therefore has invested in the Active Online project. The average cost per person during the pilot phase was £373, with an extra £90 per resident spent on purchasing a tablet. However the scheme no longer provides free tablets or Internet connection as it was found that after training, most residents were happy to buy their own equipment.

The pilot phase of the project was fully evaluated and found that:

- 76 per cent of residents found a tablet easy to use;
- 61 per cent felt more in touch with the world around them;
- 80 per cent of the participants found their new skills valuable;
- Residents enjoyed using online games as it kept their minds active;
- Residents used Skype to stay in touch with family and friends.

'**I just click on and I can Skype Greece where my other family is**. I can Skype them and see them, you know, it is out of this world.'

Participant

www.viridianhousing.org.uk/residentsandcommunities/activeonline

4.2. Transport

It is clear that transport is vital in keeping older people socially connected.[31] Research demonstrates the importance of good transport in enabling people to keep up connections with existing family and friends.

Lack of appropriate transport can be a major barrier not just to the maintenance of existing social connections, but also to the successful operation of services designed to reduce social isolation. In recognition of this, many loneliness initiatives, such as Contact the Elderly (see case study 19) provide transport to their activities as part of the service. However experts highlighted that this can be extremely costly and complex, and concerns were expressed about the ongoing lack of appropriate transport in some areas, and the far-reaching implications of this gap in provision in terms of older people's health and wellbeing.

Experts also argued that sometimes the provision of transport can in itself create opportunities for social interaction, the great advantage of these casual social interactions being that there is no stigma to taking up the service in the first place. Initiatives like Age UK Kensington and Chelsea's shopping service (see case study 20) have hung opportunities for social interaction around the provision of an accessible and affordable transport service to groups who are unable to use public transport.

Unfortunately these transport initiatives have not been evaluated as part of the literature on loneliness, and so the evidence base in this area remains relatively limited. This gap is recognised and increasingly of interest.[32]

'In urban areas 95 per cent of people live within 13 minutes of a regular (hourly) bus, but **in rural areas this falls to 61 per cent**'.*

* National Travel Survey, 2012.

Case study 19: Contact the Elderly Tea Parties

Contact the Elderly organises free monthly Sunday afternoon tea parties for people aged 75 and over, who live alone and have limited support from family and friends.

The provision of transport is integral to the model as guests are collected from home and driven to tea parties by a regular volunteer driver. There are currently over 7,300 volunteers supporting over 4,500 older people in 560 groups across England, Scotland and Wales.

Each tea party group is formed of 6–8 older guests, 3–4 volunteer drivers, a bank of volunteer hosts and a volunteer coordinator. The group visits a different host each month but the volunteer drivers stay the same, ensuring that friendships are formed over time.

Older people are allocated to a local group on completion of an application form. The charity accepts referrals from third parties including other charities, healthcare professionals (including GPs and Occupational Therapists), long distance friends and family. The groups are promoted through local print media, by existing volunteers and guests, social services and with leaflets and posters. More recently the charity has been working with the emergency services (particularly the Fire Service) and GPs to reach out to some of the most isolated older people.

The charity is funded primarily by trusts (48 per cent) and corporate supporters (27 per cent). The remainder is made up of grants (10 per cent), individual and community giving (11 per cent) and legacies (three per cent). To launch a new Contact the Elderly group and support it for 12 months costs the charity around £5,200; maintaining an existing group costs around £620 per year. Contact the Elderly calculates that if volunteers were replaced by staff the cost of running each group would be approximately £7,000 per year.

In May 2014 a survey of 1,200 guests highlighted the profound difference tea parties make:

- 96 per cent of guests say the tea parties give them something to look forward to;
- Almost 90 per cent have made friends with volunteers;
- Over 80 per cent have made friends with other guests;
- 80 per cent of guests feel happier as a result of joining a group;
- Almost 80 per cent feel less lonely since joining a group.

'**The volunteers are absolutely wonderful**, wonderful people. You can't find any better people. They have a smile on their face every time they pick you up, a smile on their face every time they drop you off. Nothing is too much for them. **It's made my life more than sitting at home all day**.'

Harry, 90, London

www.contact-the-elderly.org.uk/

Case study 20: Shopping Service – Age UK Kensington and Chelsea

Age UK Kensington and Chelsea's shopping service enables older residents of the borough who are unable to use public transport to do their shopping, while also providing an opportunity to socialise.

Older people are transported to a local supermarket, for an extended trip over lunchtime, to shop, have a meal and socialise.

Referrals to the scheme come from a range of sources including social services, friends, family and self-referrals. Following referral a home visit is undertaken to ensure that the individual meets the criteria for the service. Once accepted, clients are free to ring and request a place on the trips.

There are two trips per week and places are allocated largely on a first-come-first-served basis, although other factors – such as time since last trip and level of support needed – are taken into account. No advance bookings are taken, and clients are advised that generally speaking they will be allocated a place no more than once a fortnight.

Older people are collected at their homes by volunteers using a minibus from Westway Community Transport, and are taken to one of the local supermarkets, according to a rota. Volunteers support shoppers from the moment they leave their houses to their return – while some clients need to be pushed in a wheelchair, others simply need help carrying shopping to the kitchen.

The service is funded by the local authority the Royal Borough of Kensington and Chelsea and the money goes towards the cost of the transport and the coordination of the service. Clients make a £1.50 contribution towards the costs.

Age UK Kensington and Chelsea have calculated that the cost of the trips is around £15, or £4 per hour, per client – a substantial saving on the cost of using a home care service. In addition the service provides additional benefits in ensuring client can choose their own shopping and get cash back, are able to leave the house, and can have a cooked meal and socialise with others they feel comfortable with.

The service produced an internal evaluation in 2012, based on members' survey, which emphasised the value shoppers placed on the social contact provided by the service.

'The only day I leave the house is Wednesday when I go to the shops with Age UK Kensington and Chelsea. **It is great to meet other shoppers**. Everyone is very friendly and you always feel welcome to the group. Volunteers will push my chair around the shop and will assist me to get on and off the bus. I have carers who come daily to help me at home but it is good to leave the house and meet other people. I particularly enjoy the time we spend at the restaurant when **we chat and have a meal together**.'

Service User

www.aukc.org.uk

Chapter 5: Structural enablers

The final category of approaches identified by experts was what we have termed 'structural enablers'. These are broad approaches to the delivery of interventions, which are focused not on 'what' is delivered but on 'how' services are delivered.

Experts were clear that taking these approaches – often in combination – was the best way to ensure that the kind of services which could ultimately reduce loneliness were 'on the menu'. However they also highlighted the fact that the particular characteristics of these approaches – their ethos and methodologies – meant that they made it more likely that communities which used these approaches would be successful in tackling loneliness.

5.1. Neighbourhood approaches

Many experts believed that interventions to address loneliness were most effectively driven from the neighbourhood level.

Research demonstrates that older people spend more time in their immediate neighbourhood and often feel a higher degree of commitment to their neighbourhood, making the immediate locality an extremely significant influence on their wellbeing.[33] There is, therefore, a clear logic behind the selection of the neighbourhood as the locus for action on loneliness. There are also practical benefits to tackling loneliness neighbourhood by neighbourhood, as breaking areas down into more manageable chunks allows more effective targeting of initiatives and enables outreach efforts.

The Neighbourhood Networks in Leeds have led the way in establishing a neighbourhood-based approach to ageing issues more generally, and have gathered some evidence about the impact of engagement with neighbourhood networks on feelings of connectedness and wellbeing, using the older people's Outcomes Star™ (see Appendix 3). However the evidence to support neighbourhood approaches above other approaches has yet to be developed.

'**Almost one million people** over 75 do not know their nearest neighbours.'*

* Royal Voluntary Service, Loneliness survey, October 2013.

Case study 21: Leeds Neighbourhood Networks

The Leeds Neighbourhood Network contract is delivered by 37 locally based schemes, run by committees that are representative of the communities they serve, with the aim of enabling older people to feel included in their local community and to have choice and control over their lives.

A five-year contract for Neighbourhood Networks was signed in 2010 with 35 different local third sector organisations (covering 37 areas). The contract specified four key outcomes for the Neighbourhood Network Schemes (NNS): increasing contribution and involvement; improving choice and control; improving wellbeing and healthier life choices; and reducing social isolation.

Each of the 37 schemes delivers a range of services, shaped by local people to meet these outcomes, including health related activities, digital inclusion, social groups, outings and trips, information and advice and practical support. These services are largely delivered by volunteers, many of whom are older people.

Self-referral is the most common way into to the NNS, but agency referrals are taken. The majority of schemes provide services to people aged 60 and over, though there is flexibility to allow friends, family and carers to benefit. In 2013/14 it is estimated that there were a total of 110,019 contacts between users and the NNS, across a total estimated membership of 22,000 people.

In 2014/15 the total annual cost to Leeds City Council (including the Public Health contribution) of the NNS was £2,437,702. This includes a core contract and additional funding which NNS have won to extend their work – e.g. in providing dementia cafés, Social Prescribing schemes, and innovative ideas to tackle social isolation. On top of this Neighbourhood Networks bring in their own funding from a range of sources.

NNS collect data using the Older People's Outcome Star for a proportion of their members as part of their ongoing monitoring. Data compiled between October 2012 and September 2013 across 31 schemes showed positive shifts across all the outcomes measured. In particular positive results were demonstrated against the outcomes of 'keeping in touch' and 'feeling positive'.

'I was at the end of my tether, when a friend advised me to get in touch with Caring Together. **What a lifeline it has been**. I can give a bit of my time and also have access to fun events and activities.'

70-year old female

www.leeds.gov.uk/betterlives

5.2. Asset based community development

Many experts endorsed an 'asset based community development' (ABCD) approach to tackling loneliness as most likely to deliver results. ABCD is an approach based on the principle of identifying and mobilising individual and community 'assets', rather than focusing on problems and needs, or 'deficits'.

Experts argued that taking an ABCD approach to tackling loneliness would be likely to yield effective results within a community as this approach was the most likely to deliver a range of services for older people that met three key criteria:

- Being what local older people want
- Involving older people
- Being sustainable

The evidence base on ABCD approaches, and their impact on loneliness specifically, is in its infancy.[34, 35] However it seems likely that an approach based around citizen involvement and assets would result in the development of the kind of groups, activities and services which have been shown to be effective in tackling loneliness (see case study 22).[36]

Many experts also highlighted the significance of **intergenerational contact** as a key feature of successful interventions. In the recent Joseph Rowntree Foundation programme Neighbourhood approaches to loneliness, we saw that when loneliness was addressed at a neighbourhood level without reference to age, it naturally brought about services and support structures which had an intergenerational element.[37] Similarly in Klee's review of ABCD approaches among older people intergenerational projects were a common result.[38]

5.3. Volunteering

The central importance of volunteering, as both an enabler of effective loneliness interventions and a way of directly preventing and alleviating loneliness, was also highlighted by our experts. Studies of volunteering have tended to emphasise the positive impacts it has on volunteers' own wellbeing and social connection, however the evidence for volunteering as a loneliness intervention remains under-developed.[39]

Nonetheless experts argued that, given what we know about the importance of meaningful relationships in reducing loneliness, volunteering should be seen not just as a way of reducing the cost of delivering interventions, but as part of the solution to loneliness in itself (see case study 23).

Case study 22: LinkAge Bristol – Involve, Inspire, Enjoy

LinkAge is a local charity that works with people aged 55 and over and local communities to facilitate inspiring social activities that enrich lives, reduce isolation and loneliness and promote active participation and positive ageing.

It is run, and funded, by a partnership of Bristol City Council, St Monica Trust, the Anchor Society, Bristol and Anchor Almshouse Trust and Redcliffe Care. The organisation takes a community development approach to its work, raising the profile of what is already taking place within communities and helping to make it successful and sustainable, as well as operating as a broker and a catalyst to fill gaps in provision.

LinkAge works through community hubs, each of which has a local Advisory Group of people aged over 55 who decide on what activities to develop, informed by feedback from the wider community at open days and wellbeing days where people can contribute their ideas and suggestions. LinkAge will provide support in getting new groups off the ground, negotiating deals on venues etc, but aims for activities to become self-sustaining with participants taking on organisation and contributing to costs.

Throughout the city, hubs offer a wide range of activities including archery, choirs, cooking, holistic therapies, golf, IT, ping pong, walking football, and yoga. Local What's On guides are used to show people what is available in their community. LinkAge also supports the development of more friendly, cohesive and empathetic communities through its intergenerational work, by celebrating cultural diversity and by challenging age stereotypes. Volunteers are the keystone of the organisation and LinkAge has seen 'virtuous circles of volunteering' where people start by attending activities, but later become volunteers.

LinkAge works hard to reach out to lonely and isolated older people and receives referrals from a wide range of individuals and agencies. The organisation has recently taken on management of the ACE Project (Active, Connected, Engaged Communities), developed by Bath University, which matches lonely older people with older volunteers who find out their interests and support them to get involved with a range of activities, building confidence and self-esteem.

An independent evaluation of LinkAge by the University of the West of England concluded that: LinkAge meets the agendas established by the Marmot Review–Fair Society Healthy Lives. Its outreach work draws people in that may feel isolated in their community. Through activities LinkAge helps people feel more socially connected, improves wellbeing and happiness (on the ONS Happiness Index) and increases physical activity.

In 2012 a Social Return on Investment Calculation was completed on the Whitehall and St. George LinkAge hub and found that for every £1 invested there was a SROI of at least £1.20. LinkAge believes this represents a substantial underestimate as, since 2012, the organisation has increased its public profile, expanded its referral network and is now drawing in more lonely and isolated individuals – supporting them with befriending and through the ACE project.

'If it wasn't for LinkAge things would be entirely different and I don't quite know what would have happened. It's made life bearable. Well, more than bearable **it's made it life again**.'

Lyn

www.LinkAgeBristol.org.uk

Case study 23: Royal Voluntary Service

The Royal Voluntary Service currently works with more than 35,000 volunteers throughout the UK, many of whom are older people.

Volunteers have the opportunity to work locally and on a wide variety of tasks. Rather than being recruited to specific jobs, Royal Voluntary Service ask people to tell them what time they have to help out locally, what interests them and what skills they have, and then create volunteering opportunities that are tailored to their volunteers. Volunteer roles vary widely and include visiting people at home, driving people to and from events, helping run activities, taking someone to the shops or giving them a hand in the garden.

All volunteers receive a thorough induction before they start work, and are given a named supervisor with whom they can discuss their volunteering experience and share any issues or problems they're facing. They are provided with out of pocket expenses, and are fully insured for any authorised work carried out by them in a volunteer capacity.

Royal Voluntary Service believes that volunteering has a range of positive impacts for the volunteer particularly on their own wellbeing. A report commissioned by Royal Voluntary Service in 2012 from Professor James Nazroo and Katey Matthews, entitled *The impact of volunteering in later life*, found that 'for each of the wellbeing outcomes there is a strong positive effect of volunteering on subsequent wellbeing (the decline in the depression and social isolation scores reflect improvement, as do the increases in quality of life and life satisfaction scores), and this effect remains after adjusting for demographic factors.'

Royal Voluntary Service often find that older people who are initially referred to them as potential service recipients are willing to become volunteers and find the role extremely fulfilling.

Case history

Clive lives in a very rural location in Wales and suffers from diabetes, which means he has limited mobility. He started out as a customer of Royal Voluntary Service's Meals on Wheels service, which he still receives, but he now also works as a volunteer to update the Royal Voluntary Service Ceredigion and Powys Facebook and Twitter pages.

Clive says that after Royal Voluntary Service had given him so much help he wanted to give something back as a volunteer. He had been suffering from feelings of loneliness and isolation but **feels much more involved with his community since starting volunteering**. Clive has grown in confidence and recently spoke at an event in Cardiff about his experiences with Royal Voluntary Service. He is now planning to try volunteering as a befriender.

www.royalvoluntaryservice.org.uk/

5.4. Age positive approaches

Another key structural enabler identified by experts was an age-positive approach to demographic change, through which local authorities and other commissioners place an emphasis on healthy and active ageing in their policy and practice, and reject negative stereotypes of later life. Experts noted that such approaches are often exemplified by the pursuit of such initiatives as Age Friendly[40] or Dementia Friendly[41] Communities.

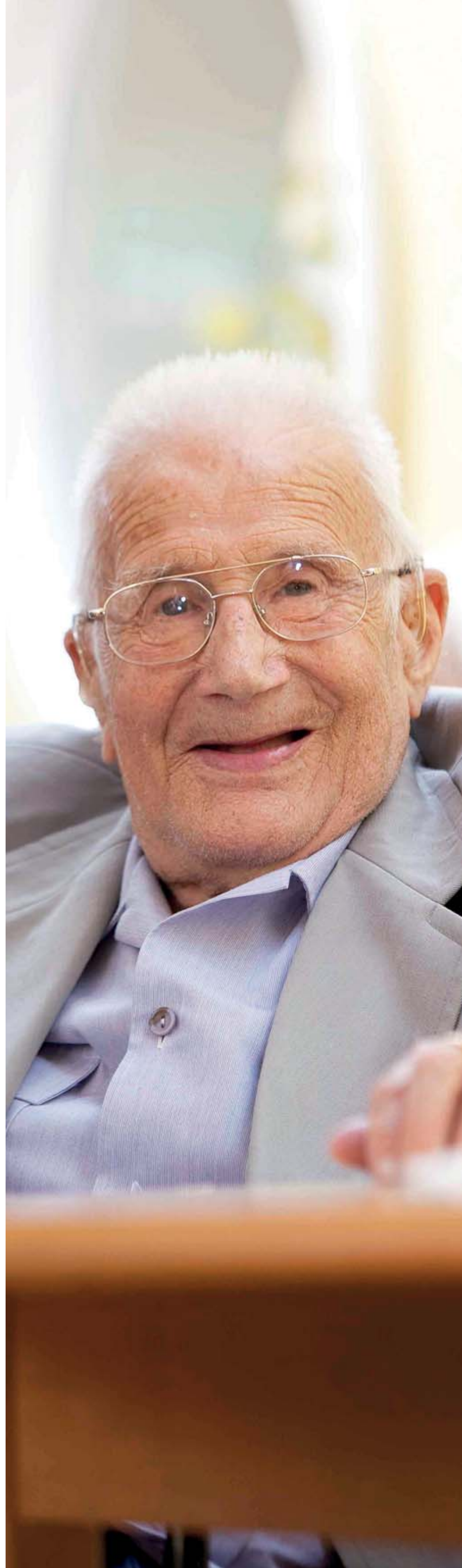
Experts argue that 'age friendly' approaches help to foster a positive mentality among a wide range of key organisations and institutions within a local area. This, in turn, encourages more creative thinking about how to ensure services and facilities enable older people to remain socially connected – supporting the development of a wider 'menu' of services in the community, and ensuring that proactive steps are taken to make these services available to older people.

In 2010 Manchester became the UK's first Age Friendly City, and is part of a growing global network supported by the World Health Organization. Initiatives such as the 'Culture Champions' programme (see case study 24) are held up as examples of the wide range of organisations that can be drawn into efforts to tackle isolation when communities take positive approach to ageing at a strategic level.

Unfortunately, while social connection is intended to be a key consideration in those areas seeking age friendly or dementia friendly status, the evidence that the adoption of such initiatives has a direct impact on loneliness among older people living in these areas is not yet developed. However, research demonstrates that negative attitudes to ageing can present a barrier to older people taking up support available to enable social connection, so efforts to address these attitudes within a community are likely to be part of the solution.[42]

'An environment that suits an older person with **limited mobility is also likely to help someone pushing a pram**.'*

* Age UK Agenda for Later Life, 2014.



Case study 24: Culture Champions – Age Friendly Manchester

The Age Friendly Manchester Culture Champions scheme is part of the wider Age Friendly Manchester Cultural Offer programme which was established in 2007 to extend the reach of the city's world-class arts and culture to older people in Manchester.

The Cultural Offer programme is run by Age Friendly Manchester, with a working group of 19 cultural organisations from Manchester and Salford including the Hallé Orchestra, People's History Museum, Royal Exchange Theatre and the Whitworth. It focuses on encouraging arts engagement among older people and using arts in health/social care for older people. The project is funded by Age Friendly Manchester – part of Public Health Manchester.

The Culture Champions scheme was launched in 2011 following research and consultation, which recommended that developing 'gatekeepers' in local communities to act as 'ambassadors' for the arts and culture in the city should be a priority.

Older people from communities throughout Manchester were invited to become 'Culture Champions'. Champions are given a wide range of information about arts and culture events in the City, receive offers such as discounted tickets, and are invited to contribute to projects at specific cultural venues, e.g. volunteering at the Chinese Arts Centre. Their role is then to share their insights, experiences and knowledge of the cultural programmes in Manchester with their friends, networks and local community and, where possible, to encourage and even support visits to the organisations involved in the project.

Champions have been involved in co-programming themed 'After Hours' events at galleries for older audiences, participating in specially designed Culture tours, and testing experimental theatre projects. They are a powerful resource for mobilising older people and stimulating interest in the cultural offer. An evaluation of the project found that involvement in the scheme had made Champions feel more confident, connected, informed and inspired.

One Culture Champion said of their experience of introducing others to the arts:

'It was so thrilling to see them thrilled. **I felt so inspired and privileged!**'

www.manchesterculturalpartnership.org/wp-content/files_mf/vopculturechampionsevaluation.pdf

Chapter 6: Gaps and areas for development

While our discussions with experts demonstrated the breadth of activities going on to combat loneliness and isolation, there remain some notable gaps in our understanding about how best to address the needs of some sub-groups within the older community. Some of the key gaps identified are discussed below.

6.1. Loneliness within care settings

There is a growing understanding that communal living is not an effective antidote to loneliness, and that, in fact, older people in residential care demonstrate worrying levels of loneliness and isolation.[43]

Experts acknowledged this issue, and recognised that the vast majority of current initiatives were aimed at older people living in the community.

Some experts argued that the limitations on opportunities for social interaction among those in care settings were primarily a product of the barriers created by the high levels of physical disability and cognitive impairment that exist among most residents of residential care. However others perceived additional barriers created by a culture of risk adversity among care home owners and a failure by practitioners and commissioners to recognise the need for individuals in care home to maintain social connections beyond their interactions with other residents.

Although the literature on how best to tackle loneliness and isolation in care settings is not well-developed, there are some initiatives which have been evaluated and seem to demonstrate beneficial effects.

Common approaches include those involving companion animals of one form or other, both as a loneliness alleviation in themselves and as a means of fostering and catalysing social connections between residents and others; also common are schemes that attempt to break down the barriers between care residents and the wider community – often operating on an intergenerational basis, e.g. by linking care homes and schools.

Experts also highlighted the efforts being made in some care homes to create environments conducive to 'normal' social interaction, such as the arrangement of chairs into smaller groups to foster a 'cosier' environment, and even the creation, in some care homes, of spaces that look like pubs and cafés, which were thought to be particularly helpful in encouraging men to interact.

However research in extra care housing has demonstrated the potential limitations of the new connections developed between residents of communal living schemes – showing that the relationships that had most meaning to older people in these settings remained those that they had developed before entering the schemes.[44]

It is clear this is an area ripe for further investigation.

Case study 25: My Home Life – Community Visitors

The Community Visitors project is run by the My Home Life Essex Community Association (MHLECA) and is designed to offer a new way for volunteers to work in care homes and to develop relationships with their residents, families, staff and managers.

Volunteer Community Visitors (CVs) are linked up with local homes, and have a remit to offer support to, and facilitate communication between, the different members of the care home community, to act as a critical friend to the home, and to become an integral part of the care home team. CVs have been able to help residents make known concerns that are important to them, but which they had hesitated to mention to staff. This has led to action to improve matters both for individuals and for other residents.

CVs visit homes once a week for a couple of hours and undertake a range of tasks including getting to know residents and spending time with them; supporting residents to voice their concerns; helping with, or organising activities; acting as a link with families; facilitating residents' and families' meetings; and identifying community resources that may benefit residents.

The project is delivered at minimal cost, due to a high level of voluntary input, both from the CVs, and in the management of the project. The main expenditure has been on recruitment, training, support and supervision of the CVs, with minor costs arising from CV expenses (mainly for travel), production of induction packs, ID materials etc. and incidental costs for refreshments at meetings etc. In addition MHLECA makes occasional 'one-off' payments to bring in trainers. The pilot recruited five CVs to go into three homes – supporting around 80 residents in total. Initial funding came from the Essex Community Foundation, Age UK and MHLECA's reserves, however the project has now attracted additional funding from Essex County Council.

The Joseph Rowntree Foundation funded an evaluation of the pilot phase, by Essex University, which found substantial evidence that as a result of the project:

- Older people were less isolated and had greater opportunities to develop friendships, and have company;
- Older people had access to, and took part in a greater range of activities;
- Older people had more opportunities to take part in activities beyond the home;
- Older people received support and guidance when joining the home.

MHLECA has now embarked upon a wider programme, funded for three years by Essex County Council, called 'FaNs' – Friends and Neighbours – which will enable the expansion of the CV project.

A man's daughter was away for 10 weeks in New Zealand and unable to visit. The CV made a point of visiting the man. Afterwards the daughter remarked to the manager that what the CV had done had been very valuable. Later, as the rapport between CV and the older person developed, he told her about his various medical problems. The CV sensed his growing depression, and a sense that he was giving up on life. She was able to talk to the manager about this, which enabled them to develop approaches to build his resilience.

www.mhlec.org/about/community-visitors

Case study 26: HenPower

HenPower brings together older people living in care settings, artists and hen-keeping to combat loneliness and depression and improve wellbeing.

Currently based in the North East, with a national roll out in progress, HenPower helps vulnerable older people gain a sense of purpose and being part of something worthwhile. It isn't just about looking after hens. Hen-keeping is the catalyst for further creative and meaningful engagement between active older people, care setting staff and residents and schools.

The scheme works by enabling care settings and sheltered housing schemes to become HenPowered Homes. Supported by Equal Arts they receive guidance from the project leads on the practical side of hen-keeping as well as how best involve residents and others in the daily activities. This process offers skill transfer with care staff and builds project sustainability. With the hens as a focus Equal Arts then develops a creative programme with residents and people living with dementia. The project is an excellent opportunity to engage with those at risk of loneliness, care home residents, their families and friends.

A number of residents from HenPowered Homes have been engaged in taking the hens on out 'Roadshows' taking hens out to schools and other care settings.

An initial pilot in 2012 was carried out with Big Lottery Silver Dreams funding of £164,000. HenPower received £34,100 from the Heritage Lottery Fund from January 2013 to July 2015 and in May 2014 was awarded £1m from the Big Lottery Silver Dreams Flagship fund till March 2018.

Northumbria University conducted a 12-month independent evaluation of HenPower in 2013. Using recognised health scales it found that HenPower:

- Significantly improves the health and wellbeing of older people;
- Significantly reduces depression among older people;
- Reduces loneliness among older people;
- Reduces the need for anti-psychotic medication.

HenPower aims to be part of older people's lives in over 100 care homes across the UK by 2017.

Tommy Appleby, 89, cared for his wife for 25 years. After her death he felt he'd become isolated from society. He said:

'I've made some great friends through HenPower. **What I like about HenPower is that you're not entertained, you're involved.** You make decisions for yourself and you work as a group. I love to tell people how it's changed my life, about how it's changing older people's lives.'

www.equalarts.org.uk

6.2. Black and Minority Ethnic groups

In discussion experts highlighted a range of initiatives, of which they were aware, that aimed to support social interaction between older people from Black and Minority Ethnic (BME) communities. Most of these groups were community-specific social activities – e.g. lunch clubs and reminiscence groups.

However experts acknowledged that the evidence base on the most effective ways to address loneliness and isolation among these communities was still underdeveloped.

Research has demonstrated that loneliness is significantly higher among some, but not all, older people from minority ethnic communities, however much less is known about the most appropriate interventions to respond to this issue.[45]

A key issue, among experts, was the uncertainty as to whether community-specific interventions were really the best way to address loneliness among BME older people. Many experts highlighted examples of community-specific provision proving counterproductive to efforts to reduce loneliness, due to its failure to support community cohesion. However it was acknowledged that language and cultural requirements sometimes meant community-specific interventions were necessary. It was noted that these needs could be particularly acute among those with dementia, as this is often accompanied by a loss of ability with second languages.

Many experts argued that, in considering which groups had the greatest need for specific provision to address loneliness and isolation, we should consider issues of ethnicity less and focus more on migration status, as it was first generation migrants who struggled most to access mainstream provision (see case study 27).

Thus far the evidence on BME interventions is too weak to determine what forms of approach are most effective, and for whom. Clearly more robust evaluation of community specific initiatives, and of mainstream initiatives, is needed to determine their effectiveness among BME communities.

Case study 27: New Beginnings – Migrant and Refugee Communities Forum (The Forum)

The New Beginnings project was established by the Forum in 2008 to support isolated refugees, migrants and asylum seekers, of all ages, who need extra support to build up their confidence, access services and develop new skills.

Many of the clients are new arrivals to the UK and lack knowledge about mainstream support services and are unable to support themselves. They often come from countries with conflict situations and have mental health issues due to the trauma they have experienced.

The project offers tailored and sustained support from trained volunteer mentors. The mentors provide practical and emotional support to direct people to relevant services and to enable them to access them. New Beginnings also offers educational, social and cultural activities, and casework and advocacy support to help refugees and asylum seekers integrate into British society.

Research undertaken by the Forum (published in September 2014 and entitled '*This is how it feels to be lonely*') found that loneliness was the biggest challenge mentees face.

Participant feedback demonstrated the value of a safe space where migrants could interact with people and learn new skills. Project staff have been overwhelmed by project participants' willingness to keep in touch, give back and volunteer after their mentoring relationship was closed. Ten mentors have stayed with the project since its inception while 15 mentees have now become mentors. Twenty-four volunteers and ex-mentees have given their time to help with workshops, events, fundraising and blogs.

The cost per person is £500 per year, which includes an average of 10 information, advice and advocacy sessions; 20 one-to-one meetings with a volunteer mentor who supports their mentee to create social networks in the community; and participation to one or more weekly educational activities at the Forum for at least eight weeks. The project also helps to make connections between the different professionals involved with clients.

'The activities at the Forum, and the mentoring project especially, really make people feel less lonely and are of **great support for their lives in the UK**.'

Safia

migrantforum.org.uk

6.3. Lesbian, Gay, Bisexual and Trans older people

There was a similar dearth of knowledge around the need for specific interventions for Lesbian, Gay, Bisexual and Trans (LGBT) older people. Experts argued that while some older LGBT people may wish to develop connections with other LGBT people, others would prefer to receive mainstream provision that was sensitive to their needs.

Surveys suggest loneliness can be particularly acute among older lesbian and gay people, and the limited evidence available suggests that these groups experience problems in accessing mainstream provision, and lack confidence that these services will meet their needs.[46] It is clear that more research will be needed to understand how best to meet the needs of LGBT people as they age.

'41 per cent of Lesbian, Gay and Bisexual people aged 55 and over live alone (compared to 28 per cent of heterosexual people).'*

* Guasp, A (2011) *Lesbian, Gay and Bisexual People in Later Life*, Stonewall.

Case study 28: Opening Doors London

Opening Doors London (ODL) is a programme run by Age UK Camden which works to support a membership of almost 1000 Lesbian, Gay, Bisexual and Trans Londoners – through social activities, one-to-one befriending, information and advice and active campaigns work.

ODL's social groups and befriending operate in London boroughs north of the Thames, and it campaigns London-wide. The majority of members self-refer after hearing about ODL from someone involved, or seeing literature in a local library, or GP office etc. However, referrals from external agencies (particularly adult social services) have increased following the delivery of training to front line staff. ODL is funded by the Big Lottery Fund (Reaching Communities), City Bridge Trust, the Trust for London and through donations and occasional legacies. In a survey of members in 2013/2014:

- 91 per cent said at ODL they felt they could be themselves without fear of being judged by others;
- 81 per cent said they felt more connected to the LGBT community because of their involvement with ODL;
- 73 per cent said they felt more comfortable attending ODL groups/events than other mainstream services;
- 71 per cent said that ODL has made them feel less isolated;
- 55 per cent felt that ODL has benefitted their mental health;
- 70 per cent said ODL has benefitted their social wellbeing.

ODL has supported other organisations to establish similar models – most notably Age UK Tunbridge Wells' OLGBT Befriending service, which was launched last summer. They also plan to roll out their services in South London in 2015.

Case history

Brian became extremely withdrawn when his partner of 45 years died. He was being treated for severe depression by a hospital psychologist, who saw an advert for the Opening Doors London Befriending Scheme and made a referral. When the Befriending coordinator first visited, Brian did not feel that he could be helped, but after regular visits from the coordinator over several months he was persuaded to meet a volunteer befriender.

Brian's befriender is retired and has dedicated a lot of time to getting to know him. They have formed a strong friendship, and meet up at least three times a week, taking trips to concerts, social events and other activities. They attend Opening Doors London social groups together and friendships with other members have blossomed Brian said, '**look how happy I am now, I never stop smiling**.'

openingdoorslondon.org.uk

Conclusions and recommendations

This guide has demonstrated the breadth and depth of initiatives currently being undertaken to tackle loneliness and isolation in communities throughout England, and has proposed a new framework for understanding how these initiatives interact with, and support, one another.

It is clear that as we take forward our efforts to reduce loneliness, action should primarily be driven by **local authorities**. It is therefore vital that local authorities – and particularly those with responsibility for health and wellbeing – take up the challenge of tackling loneliness and ensuring adequate services and supports are in place.

The role of Health and Wellbeing Boards in bringing together some of the key organisations whose efforts are needed to provide an effective response to loneliness has been emphasised in a number of recent reports,[47] and over 50 per cent of Boards have explicitly recognised the size of the challenge.[48] However acting on these aspirations will require leadership from a range of key individuals and organisations including Council Leaders and Chief Executives, Directors of Public Health, members of Clinical Commissioning Groups as well as those with responsibility for commissioning across local authorities and particularly in adult social care. A '**whole system**' response to loneliness is required, and this must lead to a proactive approach to commissioning effective interventions.

Based on our discussions with experts, subsequent work to trawl the academic and other evidence relating to the effectiveness of loneliness interventions, and to gather examples of good practice around the country, we make the following recommendations.

Recommendations for **service providers**

Those involved with **service provision** must:

- Make their own **connections**: As this research has shown few, if any, organisations are able to provide the full range of supports and services that are needed to effectively tackle loneliness in our communities. Providers need to assess what contribution they make to the overall framework of loneliness interventions and build the necessary partnerships to deliver more effectively with other providers.
- Play their part in **building the evidence**: As long as there is a shortage of evidence of the impact of loneliness initiatives, there will always be an excuse not to fund this vital work. External evaluations are costly, but all organisations can build into their programmes the opportunity to gather data about their impact. By using recognised and accredited tools, even if only with a sample of services users, we can start to create a reservoir of comparable data, improving the evidence base and building a clearer picture of which initiatives work best and why. Measurement does not have to be an onerous process. **Simple-to-use resources** – like the Campaign to End Loneliness's forthcoming impact measurement tool – are increasingly being made available.
- Act on the **gaps**: There is a huge shortage of evidence of the impact of loneliness initiatives on minority communities, such as LGBT and BME older people, and older people who live in care homes. This is not necessarily because initiatives do not serve these communities, but because providers have not yet gathered the data that proves that they do, and we do not know enough to be able to work out which approaches work best. Providers need to make sure that the needs of these minority communities are built into service planning, and that efforts are made to evaluate the impact on these groups in particular. This is not just a moral imperative, but particularly where supported by public bodies, it is also a requirement under the duties set out the Equality Act 2010.

Recommendations for **commissioners**

Those responsible for **commissioning** services must:

- Support promising approaches to tackling loneliness – as this report demonstrates, our understanding about how to effectively tackle loneliness is growing and developing all the time. Commissioners should support the replication of approaches that show promise, and the continued development of the evidence base to back them. Many of the approaches highlighted in this report work with the grain of broader initiatives being implemented to meet the needs of ageing populations. However, in order to be most effective, those commissioning these approaches should make tackling loneliness a core outcome so that sensitivity to the particular challenges of reaching, understanding and supporting lonely older people can be built into service design.
- Ensure access to the **full range** of loneliness interventions. Commissioners need to recognise the role different types of services play in responding to the complex and individual experience of loneliness. One size will not fit all, so to be effective in tackling loneliness communities need:

  (1) Foundation services: i.e services that:
  - Reach lonely individuals;
  - Understand and respond to the specific circumstances of an individual's loneliness – rather than offering a 'one-size-fits-all' response; and
  - Support individuals to take up the services that would help them make meaningful connections.

  These services will be vital to ensure that individuals who are experiencing, or at risk of, loneliness can make use of the full range of services and support structures available in their communities, in a way that makes sense and works for them.

  (2) Gateway services:
  - Transport
  - Technology

  These services can be the glue that keeps people active and engaged, and makes it possible for communities to come together. But if they are used inappropriately, or if they become inaccessible to older people, the problems of loneliness and isolation will only worsen.

  (3) Direct interventions including services that help people to:
  - reconnect with and/or maintain existing connections;
  - develop new connections;
  - change their thinking about their relationships.

  Loneliness is personal and so one size will never fit all. Communities will need a range of services and supports including group-based and one-to-one activities to suit a range of tastes, and psychological support for those who need it.

- In developing these services commissioners should consider what **structural supports** are needed in their communities to create the right conditions for ending loneliness.

  This report identifies the following **Structural Enablers**:
  - Asset based community development (ABCD)
  - Neighbourhood approaches
  - Volunteering
  - Positive Ageing

  By supporting one or more of these approaches within a whole community, or in individual localities, community leaders can catalyse new action on loneliness – including the development of effective and sustainable foundation services and direct interventions.

- Commit to **evaluating impact**: The evidence presented in this reports demonstrates a number of approaches that show promise in tackling loneliness, and many also demonstrate the potential for cost savings. However the evidence base remains patchy. Commissioners must commit to playing their part in building the evidence base in this territory, by requiring and funding providers to measure their impact on loneliness, using recognised tools that facilitate comparison between initiatives – for example the forthcoming impact measurement tool being developed by the Campaign to End Loneliness.

Recommendations for those involved with **research**

All those involved with **research** must support the development of more and better evidence of the impact of loneliness initiatives. For this to happen:

- **Commissioners and funders** should support the development of evidence, by funding evaluation and encouraging the use of recognised and robust tools for impact measurement so that comparisons can be made between initiatives.
- **Service delivery organisations** must commit to measuring the impact of their services on loneliness specifically rather than relying on proxy measures.
- **The research community** must ensure the right tools are available to effectively assess the work that is being done. This will require a more sophisticated understanding of the role different interventions are playing in addressing the problem of loneliness, and in this regard we hope that our new **framework** set out in Chapter 1 will help. We may also need **new tools** to measure the impact of initiatives that are preventative, and to measure the success of foundation services, which do not ultimately seek to address loneliness but rather to reach, understand and support individuals to access services that do.

Appendix 1: Members of the expert panel

NB – Experts offered comments in their personal capacity. Organisations are listed for information only.

Alex Burn	Hampshire County Council
Paul Cann	Age UK Oxfordshire
Ken Clemens	Age UK Cheshire
Chris Commerford	Age UK
Jonathan Eastwood	Big Lottery Fund
Johanna Goll	University College London
Anna Goodman	Campaign to End Loneliness
Martin Green OBE	Care England
Dr Robert Hagan	University of Ulster
Andrea Hare	Public Health England Cheshire and Merseyside
Lucy Harmer	Independent Age
Alan Hatton-Yeo	Communities for All Ages
Shelagh Marshall OBE	Age Action Alliance
David McCullough	Royal Voluntary Service
Paul McGarry	Manchester City Council
Roz Morris	Experts by Experience
Guy Robertson	Positive Ageing Associates
David Scott	Experts by Experience
Antonio Silva	Behavioural Insights Team
Philip Talbot	Age UK Herefordshire and Worcestershire
Claire Turner	Joseph Rowntree Foundation
Professor Christina Victor	Brunel University
Mick Ward	Leeds City Council
Jonathan Whitehead	Age UK

Appendix 2: Standards of evidence

Evaluation is vital to understanding how a service works and how successful it is in achieving its aims. Without such evidence it is difficult to know whether the service being delivered is effective or not, or indeed whether it is having a detrimental impact.

High quality evaluation requires that those carrying out an evaluation can produce independent and objective reports (this is known as the independence principle), and that the methodology and findings are accessible and available to all (this is known as the transparency principle). High quality evaluation also requires the appropriate use of control groups to have confidence in the changes that can be attributed to the service.

However in practical terms it is not always possible to have control groups for every evaluation, and therefore the quality of the evidence produced by different evaluations varies. Often these differing standards of evidence mirror the development of services from scoping to scaling-up.

There are a number of different levels of evidence:

- Level one – using existing evidence and research a theory of change or logic model is developed that provides a coherent and convincing description of how and why a service will have the desired impact.
- Level two – builds on this theoretical framework with promising results, usually collected by pre and post (or regular interval) surveys or cohort studies.
- Level three – involves the use of control groups and provides a level of confidence to the extent that it can be claimed that the service causes changes. The creation of control groups is dependent on the design of the service and can include randomised control rials, matched control groups or difference-in-difference approaches.
- Level four – complements the previous level by including evidence that provides a clear explanation of how changes attributed the service happen.
- Level five – includes evidence that demonstrates that the service can be scaled-up and operated elsewhere whilst continuing to have the positive outcomes demonstrated.

Appendix 3: Measurement scales and tools

Older Person's Outcomes Star™

The Older Person's Outcomes Star™ was developed by the consultancy organisation Triangle in consultation with service providers and commissioners from Camden, Westminster, Brent and Hammersmith and Fulham, as one of a series of Outcomes Stars™ which are intended to both measure and support progress for service users towards a range of goals.

The Stars are designed to be completed collaboratively as an integral part of key work. Each version consists of a number of scales which are mapped on a Star Chart onto which the service user and worker plot where the service user is on their journey.

The outcomes for the Older Person's Star are:

- Staying as well as you can (physical and mental health)
- Keeping in touch (use of time and social networks)
- Feeling positive (motivation and managing change)
- Being treated with dignity (choice and control)
- Looking after yourself (self care and mobility)
- Staying safe (safety)
- Managing money (economic wellbeing)

The Outcomes Star™ for older people has a focus on re-enablement and measures progress towards maximising independence and wellbeing. The model of change is from 'cause for concern' to 'as good as it can be', so all older people can reach '10' and the Star captures the difference that services make.

For more information see: **www.outcomesstar.org.uk/older-people/**

Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)

The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) is a scale of 14 positively worded items, with five response categories, for assessing a population´s mental wellbeing.

Individuals are read a series of statements about their feelings and thoughts and asked whether these have been their experience over the past two weeks – with a scale ranging from 'none of the time' through to 'all of the time'.

The Scale was funded by the Scottish Executive National Programme for improving mental health and wellbeing, commissioned by NHS Health Scotland, developed by the University of Warwick and the University of Edinburgh, and is jointly owned by NHS Health Scotland, the University of Warwick and the University of Edinburgh.

For more information see: **www.healthscotland.com/scotlands-health/population/Measuring-positive-mental-health.aspx**

Appendix 4: Case study contact information

1 **Springboard – Cheshire**
Ken Clemens, Chief Executive, Age UK Cheshire
Tel: **01606 305030**
Email: **ken.clemens@ageukcheshire.org.uk**

2 **Leeds Seniors Network**
Trudie Canavan, Enterprise Development Officer
Leeds City Council
Tel: **0113 224 3418**
Email: **trudie.canavan@leeds.gov.uk**

3 **Community Wellbeing Practices – Halton**
Wellbeing Enterprises
Tel: **01928 589799**
Email: **info@wellbeingenterprises.org.uk**

4 **Rotherham Social Prescribing Scheme**
Barry Knowles, Project Manager
Voluntary Action Rotherham
Tel: **01709 723098**
Email: **barry.knowles@varotherham.org.uk**

5 **Living Well – Cornwall**
Rachel Murray, Strategy and Planning Team, NHS Kernow
Tel: **01209 886636** Email: **rachelmurray1@nhs.net**

6 **Village and Community Agents – Gloucestershire**
Kate Darch, GRCC Lead for Older People's Projects
Gloucestershire Village and Community, Agent Manager
Tel: **01452 528491** Email: **kated@grcc.org.uk**

7 **Time for Life – Devon**
Debbie Avery, Time for Life Manager, Westbank
Tel: **01392 824752** – select option five
Email: **d.avery@westbankfriends.org**

8 **Touchstones – Yorkshire**
Leah Swain, Rural Action Yorkshire
Tel: **0845 313 0270**
Email: **leah.swain@ruralyorkshire.org.uk**

9 **Brighton and Hove Carers Centre – Male Carers' Social Support Group**
The Carers Centre for Brighton and Hove
Tel: **01273 746222** Email: **info@thecarerscentre.org**

10 **Fit for the Future – Age UK**
David Terrace, Programme Manager – Prevention, Age UK
Tel: **020 3033 1374**
Email: **david.terrace@ageuk.org.uk**

11 **Open Age – London**
Helen Leech, Open Age
Tel: **020 8962 5585** or **0208 962 4141**
Email: **hleech@openage.org.uk**

12 **Men's Sheds/Tools Company – Age UK Exeter**
Nichola Weate, Age UK Exeter
Tel: **01392 202092**

13 **Dorset Befriending Services – Royal Voluntary Service**
Tina Damon, Befriending Service Manager
Tel: **01305 23 66 66**
Email: **tina.damon@royalvoluntaryservice.org.uk**
or **dorsetwiltshirehub@royalvoluntaryservice.org.uk**

14 **Dementia Friendship Scheme – Age UK Coventry**
Nichola Lavin
Friendship Development Officer, Age UK Coventry
Tel: **02476 433977**
Email: **nichola.lavin@ageukcoventry.org.uk**

15 **The Silver Line Helpline**
Sarah Caplin, Director of Development and Communications, The Silver Line
Tel: **020 7224 2020** DL: **020 7224 2729**
Email: **sarah.caplin@thesilverline.org.uk**

16 **Psychological Support Services – Age UK Warwickshire**
Kate Richmond, Manager of Psychological Support Service
Age UK Warwickshire
Tel: **01926 458114** Email: **kate@ageukwarks.org.uk**

17 **Call in Time – Age UK**
Jan Williams, National Development Manager, Age UK
Tel: **020 3033 1054** Email: **jan.williams@ageuk.org.uk**

18 **Active Online – Viridian Housing**
Ed Wallace, Research & Innovation Manager Viridian Housing
Tel: **0330 123 0220**
Email: **ed.wallace@viridianhousing.org.uk**

19 **Contact the Elderly Tea Parties**
Contact the Elderly
Freephone: **0800 716543** Office: **020 7240 0630**
Email: **info@contact-the-elderly.org.uk**

20 **Shopping Service – Age UK Kensington and Chelsea**
Tasio Cabello, Volunteer and Community Services Manager
Age UK Kensington and Chelsea
Tel: **020 8969 9105** Email: **tcabello@aukc.org.uk**

21 **Leeds Neighbourhood Networks**
Michelle Atkinson
Older People's Commissioning Manager, Leeds City Council
Tel: **0113 2474939**
Email: **michelle.l.atkinson@leeds.gov.uk**

David Peel, Commissioning Officer
Email: **david.peel@leeds.gov.uk**

22 **LinkAge Bristol**
Tel: **0117 3533042**
Email: **admin@linkagewestofengland.org.uk**

23 **Royal Voluntary Service**
Tel: **0845 608 0122**
Email: **enquiries@royalvoluntaryservice.org.uk**

24 **Culture Champions – Age Friendly Manchester**
Sherry de Wynter
Age Friendly Manchester, Cultural Programme Manager
Tel: **0161 234 2962**
Email: **sherry.dewynter@theaudienceagency.org**

25 **My Home Life – Community Visitors**
Janet Russell, My Home Life Essex Community Association
Tel: **01621 868984** Email: **janet@mhlec.org**

26 **HenPower**
Equal Arts
Tel: **0191 477 5775**
Email: **information@equalarts.org.uk**

27 **New Beginnings – Migrant and Refugee Communities Forum (The Forum)**
Francesca Valerio
New Beginnings project coordinator
Migrant and Refugee Communities Forum (The Forum)
Tel: **020 8962 3048** Email: **francesca@mrcf.org.uk**

28 **Opening Doors London**
Stacey Halls, Project Manager, Age UK Camden
Tel: **020 7239 0400**
Email: **stacey.halls@ageukcamden.org.uk**

References

1 Perlman, D, Peplau L. (1981) *Toward a Social Psychology of Loneliness*. Personal Relationships 3: Personal Relationships in Disorder, Pp. 31–43.

2 Victor, C. (2011). *Loneliness in old age: the UK perspective.* Safeguarding the Convoy: a call to action from the Campaign to End Loneliness. Age UK Oxfordshire.

3 www.campaigntoendloneliness.org/threat-to-health

4 www.campaigntoendloneliness.org/wp-content/uploads/downloads/2013/11/FINAL-Still-ignoring-the-health-risks-an-update-to-our-June-2013-review-of-HWBs4.pdf

5 Cann, P, Jopling, K. *Safeguarding the Convoy: a call to action from the Campaign to End Loneliness*, Age UK Oxfordshire, pp23.

6 Bolton, M. *Loneliness the State We're In* Age UK Oxfordshire.

7 www.ageuk.org.uk/documents/en-gb/for-professionals/evidence_review_loneliness_and_isolation.pdf

8 Findlay, R (2003). *Interventions to reduce social isolation amongst older people: where is the evidence?* Ageing and Society, 23, pp 647–658; Cattan, C, White, M, Bond, J, Learmouth, A (2005). *Preventing social isolation and loneliness among older people: a systematic review of health promotion interventions.* Ageing and Society, 25, pp 41–67; Fokkema, T, Van Tilburg, T. (2007) *Loneliness interventions among older adults: sense or nonsense?* – Netherlands Interdisciplinary Demographic Institute; Masi,C, Chen, H, Hawkley L, and Cacioppo T. (2011) *A Meta-Analysis of Interventions to Reduce Loneliness* Pers Soc Psychol Rev. 2011 August ; 15(3): Dickens et al (2011) *Interventions targeting social isolation in older people: a systematic review.* BMC Public Health 2011, 11:647; Hagan, R, Manktelow, R, Taylor, B, Mallet J. (2014) *Reducing loneliness amongst older people: a systematic search and narrative review,* Aging and Mental Health, 18:6, pp 683–693.

9 de Jong Gierveld, J, Fokkema, T, Van Tilburg, T. (2011) *Alleviating loneliness among older adults: possibilities and constraints of interventions*. Safeguarding the convoy: a call to action from the Campaign to End Loneliness. Age UK Oxfordshire. pp 41.

10 Cattan, C, White, M, Bond, J, Learmouth, A (2005). *Preventing social isolation and loneliness among older people: a systematic review of health promotion interventions*. Ageing and Society, 25, pp 41–67.

11 E.g. www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/; www.gov.uk/government/uploads/system/uploads/attachment_data/file/304139/Transforming_primary_care.pdf; www.gov.uk/government/publications/care-act-2014-part-1-factsheets

12 Victor, C, Scambler, S, Bond, J. (2009). *The social world of older people: Understanding Loneliness and Social Isolation in Later Life*. OUP table 5.5 pp. 199.

13 Griffin, J. 2010 *The Lonely Society,* Mental Health Foundation

14 Masi,C, Chen, H, Hawkley L, and Cacioppo T. *A Meta-Analysis of Interventions to Reduce Loneliness* Pers Soc Psychol Rev. 2011 August ; 15(3):

15 Victor, C, Scambler, S, Bowling, A, Bond, J, (2005). *The prevalence of, and risk factors for, loneliness in later life: a survey of older people in Great Britain.* Ageing and Society, 25, pp 357–375.

16 Victor, C, Scambler, S, Bond, J. (2009). *The social world of older people: Understanding Loneliness and Social Isolation in Later Life* OUP ch 5.

17 Florio, E, Raschko, R (1998) *The Gatekeeper Model*, Journal of Aging and Social Policy, 10:1, 1–19.

18 Bartsch, D, Rodgers, V, Strong D.(2013) *Outcomes of Senior Reach Gatekeeper Referrals: Comparison of the Spokane Gatekeeper Program, Colorado Senior Reach, and Mid-Kansas Senior Outreach,* Care Management Journals Volume 14, Number 1.

19 Perlman, D, Peplau L. (1981) *Toward a Social Psychology of Loneliness*. Personal Relationships 3: Personal Relationships in Disorder, Pp. 31–43.

20 ageactionalliance.org/wordpress/wp-content/uploads/2013/07/firstcontactreportEdition1_201307012.pdf

21 Wilson L., Crow A., Willis M. (2008). *LinkAge Plus Project: Village Agents*: Gloucestershire County Council in partnership with Gloucestershire Rural Community Council: Overall Evaluation Report, INLOGOV, School of Government and Society, the University of Birmingham.

22 Goll JC, Scior K, Charlesworth G and Stott J. (in press) *Barriers to social participation among lonely older adults: the influence of social fears and identity.*

23 Windle, K, Francis, J, Coomber, C (2011) *Preventing loneliness and social isolation: interventions and outcomes* – Social Care Institute for Excellence.

24 Cattan, C, White, M, Bond, J, Learmouth, A (2005). *Preventing social isolation and loneliness among older people: a systematic review of health promotion interventions*. Ageing and Society, 25, pp 41–67.

25 Cattan, C, White, M, Bond, J, Learmouth, A (2005). *Preventing social isolation and loneliness among older people: a systematic review of health promotion interventions*. Ageing and Society, 25, pp 41–67.

26 Masi,C, Chen, H, Hawkley L, and Cacioppo T. *A Meta-Analysis of Interventions to Reduce Loneliness* Pers Soc Psychol Rev. 2011 August ; 15(3):

27 www.nice.org.uk/guidance/cg90/

28 Creswell, JD, Irwin, M, Burklund L, Lieberman, M, Arevalo, Ma, J, Breen, E, Cole, S. (2012). *Mindfulness-Based Stress Reduction training reduces loneliness and pro-inflammatory gene expression in older adults: A small randomized controlled trial* Brain, Behavior, and Immunity 26, pp1095–1101.

29 www.campaigntoendloneliness.org/blog/technology-loneliness-fix/

30 Hagan, R, Manktelow, R, Taylor, B, Mallet J. (2014) *Reducing loneliness amongst older people: a systematic search and narrative review,* Aging and Mental Health, 18:6, pp 683–693.

31 webarchive.nationalarchives.gov.uk/20091003125851/ http://www.dft.gov.uk/pgr/scienceresearch/social/olderaspirations?page=9

32 Cattan,M (2011) *Alleviating social isolation and loneliness in older people* Safeguarding the Convoy: A call to action from the Campaign to End Loneliness, Age UK Oxfordshire pp 50.

33 Phillipson, C., Bernard, M., Phillips, J. and Ogg, J. (2000) F*amily and Community Life of Older People*, Routledge, London.

34 Collins, A, Wrigley, J (2014) *Can a Neighbourhood Approach to Loneliness Contribute to People's Well-being?* Joseph Rowntree Foundation.

35 Klee, D, Mordey, M, Phuare, D, Russell, C. (2014), *Asset based community development – enriching the lives of older citizens*, Working with Older People, Vol. 18 Iss 3 pp. 111–119.

36 Cattan, C, White, M, Bond, J, Learmouth, A (2005). *Preventing social isolation and loneliness among older people: a systematic review of health promotion interventions*. Ageing and Society, 25, pp 41–67.

37 Collins, A, Wrigley, J (2014) *Can a Neighbourhood Approach to Loneliness Contribute to People's Well-being?* Joseph Rowntree Foundation.

38 Klee, D, Mordey, M, Phuare, D, Russell, C. (2014), *Asset based community development – enriching the lives of older citizens*, Working with Older People, Vol. 18 Iss 3 pp. 111–119.

39 www.biglotteryfund.org.uk/-/media/Files/Publication%20 Documents/rl_well_being_impact_volunteering_factsheet.pdf

40 World Health Organization. *Global Age-Friendly Cities: a guide*. France: WHO; 2007.

41 Alzheimer's Society (2013), *Building dementia-friendly communities: A priority for everyone*, Alzheimer's Society.

42 Goll JC, Scior K, Charlesworth G and Stott J. (in press) *Barriers to social participation among lonely older adults: the influence of social fears and identity.*

43 Victor, C (2012) *Loneliness in care homes: a neglected area of research?* – Aging Health, Vol. 8, No. 6 , Pages 637–646.

44 Burholt, V., Nash, P. and Philips, J. (2013). *The impact of supported living environments on social resources and the experience of loneliness for older widows living in Wales: An exploratory mediation analysis* Family Science 4(1): 121–132.

45 Victor CR[1], Burholt V, Martin W. (2012) *Loneliness and ethnic minority elders in Great Britain: an exploratory study.* J Cross Cult Gerontol. 2012 Mar; 27(1):65–78.

46 Guasp, A (2011) *Lesbian, Gay and Bisexual People in Later Life*, Stonewall.

47 Kempton, J, Tomlin, S (2014) *Ageing Alone: Loneliness and the Oldest Old, CentreForum; Watson J, Sinclair D (2014) Community Matters: Making our Communities Ready for Ageing – a call to action,* ILC-UK.

48 www.campaigntoendloneliness.org/wp-content/uploads/downloads/2013/11/FINAL-Still-ignoring-the-health-risks-an-update-to-our-June-2013-review-of-HWBs4.pdf

About this report

Over recent years there has been growing public attention to loneliness in later life and this has been accompanied by a shift in our understanding of its impact – and in particular its implications for mental and physical health. Research suggests that the effect of loneliness and isolation can be as harmful to health as smoking 15 cigarettes a day, and is more damaging than obesity.

This report seeks to shine a light on what can be done to reduce loneliness, drawing on the expertise and experience of leading figures in the field, as well as on the academic and other available evidence. It aims to reflect the full range of initiatives being undertaken which show promise in tackling this serious public health issue. It is intended to:

- **Guide commissioners and funders of services that support older people** – including adult social care, clinical commissioning groups and public health teams – to identify the areas of need in their communities;
- **Support service providers** in the delivery of more effective loneliness interventions; and
- **Shape future research** so that our understanding of loneliness, and how it can be addressed, continues to grow.

Tavis House
1–6 Tavistock Square
London WC1H 9NA
0800 169 80 80
www.ageuk.org.uk

Campaign to End Loneliness
3 Rufus Street
London N1 6PE
020 7012 1409
www.campaigntoendloneliness.org

Age UK is a charitable company limited by guarantee and registered in England and Wales (registered charity number 1128267 and registered company number 6825798). The registered address is Tavis House, 1–6 Tavistock Square, London WC1H 9NA. Age UK and its subsidiary companies and charities form the Age UK Group, dedicated to helping more people love later life. ID202422 01/15