Lot 3e Preventing and Reducing Social Isolation and Loneliness Service Outline

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Priority Area – Tackling Vulnerability

- Preventing and reducing incidences of social isolation and loneliness in people aged 16+

Introduction

The National Campaign to End Loneliness provides the following definition for Loneliness and Isolation

"Loneliness can be defined as a subjective, unwelcome feeling of lack or loss of companionship. It happens when we have a mismatch between the quantity and quality of social relationships that we have, and those that we want."

Types of loneliness include:

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

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

Loneliness is not just an issue restricted to older people, but can have an impact on individuals across the life course. However the risk factors for loneliness may increase as we get older. The following risk factors for loneliness have been identified:

- Poor health (physical and mental wellbeing)
- Sensory loss
- Loss of mobility
- Low income
- Living alone

- Living in isolated rural areas
- Living in deprived urban communities
- Retirement
- Becoming a carer
- Lack of transport
- Housing
- Fear of crime
- Older age

There is a strong evidence base to support the prevention of social isolation as an intervention for improved health, wellbeing and independence. The national review of health inequities provides evidence that social networks, friendships and connections have an impact on reducing the risk of mortality (death), morbidity (developing certain diseases), and can also help individuals recover from illness.

Research shows that loneliness and isolation is a significant risk factor for poor health, wellbeing and independence. The following evidence collated by the National Campaign to End Loneliness highlights some of these risks:

- The effect of loneliness and isolation on mortality is greater than the impact of well-known risk factors such as **obesity**, **physical inactivity** and has a similar influence as cigarette **smoking**. Lacking social connections is as damaging to our health as smoking 15 cigarettes a day

- Loneliness has been shown to increase the risk of high **blood pressure**

- Lonely individuals are also at higher risk of the onset of **disability**

- Loneliness puts individuals at greater risk of **cognitive decline**

- Lonely people have a 64% increased chance of developing clinical **dementia**

- Lonely individuals are more prone to **depression**

Lonely individuals are more likely to:

- **Visit their GP**, have higher use of **medication**, higher incidence of **falls** and increased risk factors for long term care
- Undergo early entry into **residential or nursing care**
- Use **accident and emergency** services independent of chronic illness

The total funding available for this priority is £17,500. We are inviting proposals of a minimum of £3,000 and up to a maximum of £17,500.

Brief description of service(s) required	We acknowledge that interventions to tackle social isolation such as befriending, mentoring, luncheon clubs, community services and social group schemes can help individuals increase their social interaction and community involvement. This provides opportunities to take up or go back to hobbies and participate in wider community activities. Such services provide social support, self-help, friendship and flexible creative activities that may be peer-led or provided by an organisation. Individuals can be empowered to be more independent. These services can prevent, or at least delay, the deterioration of wellbeing that can result from ageing, illness or disability and the need for more costly and intensive services. We are seeking innovative proposals that will effectively seek to limit the incidence of Social Isolation and Loneliness and to redress the negative impact of this on individuals aged **16 years plus**. It is anticipated that bids may include (**NB** this list is not exhaustive): **Befriending Schemes** Including one to one befriending, group befriending, and telephone befriending. Bids for innovative befriending schemes will be welcomed and may, for example, include; i) using social media technology such as Skype, Facetime, etc. to enable electronic face to face befriending to be experienced by a wider community on a more frequent basis ii) bereavement befriending whereby both practical assistance and emotional support are available following

bereavement

iii) intermediate care befriending whereby time limited support is made available to individual's when they leave hospital, for instance, after a fall or hip replacement operation

iv) care and repair befriending to enable befriending opportunities as part of a practical service designed to provide help with 'odd jobs'

v) rural specific befriending

vi) end of life befriending

Lunch Clubs

These may include a nutritional healthy meal (breakfast, lunch or dinner etc.), or tea parties taken in a wide variety of locations and establishments such as high street restaurants, public houses, areas of natural beauty, National Trust venues, community bake houses, garden centres, museums, libraries, etc.

Befriending and Lunch Club

Innovative bids which enable befriending and nutritional meal taking to be combined all or some of the time will be welcomed.

Social Group Schemes

These aim to increase and improve the individual's social circle and may include one or more educational, leisure or physical activity for example.

Community Navigating

Community Navigators are usually volunteers who provide people with emotional, practical and social support. They essentially act as an interface between the community and public services and help individuals to find appropriate means of support. Community Navigators offer home-based visits, enabling often frail older people to discuss concerns and helping them to look into which service or community provision may be beneficial. Community Navigators have been shown to be effective in identifying isolated individuals and then signposting them to appropriate services and

	support. **Peer Support Projects** One of the most difficult things about having a disability, whether physical, sensory or a learning disability, being an older person or having a mental health issue is the fact that people you meet don't really understand what it is like to be in your situation. Peer support is social and/or emotional support (frequently coupled with practical support) provided by people who have disabilities/mental health issues to others who have similar conditions or experiences. The goal is to bring about a desired social or personal change. Peer support can be provided via one-to-one connections, networks and self-help groups. A 'peer' is someone that has "been there, done that" and can relate to others who are now in a similar situation. It is anticipated that organisations will identify further innovative schemes in addition to those listed above and will scope the barriers of implementation, providing examples of overcoming such barriers within their application.
National and Local Context	**Loneliness and Social Isolation – The National Picture** Loneliness and Isolation has been highlighted nationally through the National Campaign to End Loneliness which has identified the following national data: • Between 6% and 13% of people aged over 65 say they feel always or very lonely • 17% of older people are in contact with family, friends and neighbours less than once a week and 11% are in contact less than once a month • Over half (51%) of all people aged 75 and over live alone • 63% of adults aged 52 or over who have been widowed, and 51% of the same group who are separated or divorced report, feeling lonely some of the time or often

- 59% of adults aged over 52 who report poor health say they feel lonely some of the time or often, compared to 21% who say they are in excellent health
- A higher percentage of women than men report feeling lonely some of the time or often

Social Isolation and Loneliness in Staffordshire

Key Facts:

- There are 165,300 **older people aged 65 years** and over in Staffordshire, which is higher than the national average. Research suggests that between 6% and 13% of older people aged 65 years and over say that they feel lonely. Therefore, in Staffordshire there are between 9,918 (6%) and 21,489 (13%) older people aged 65 and over who feel lonely.
- There are 355,300 people and 44,770 older people aged 65 years and over who **live alone** in Staffordshire. There are 12.6% of people in Staffordshire who live alone and at risk of social isolation and loneliness compared to 12.4% nationally.
- There are 162,600 people in Staffordshire with a **limiting long-term illness**, which is higher than the national average, therefore resulting in a higher risk of loneliness due to ill health in Staffordshire.
- There is a higher risk of social isolation and loneliness in Staffordshire due to retirement with 852,100 people in Staffordshire who are **retired**, which is significantly higher than the national average.
- In Staffordshire there are more people living on **low income** than the national average, resulting in 852,100 people at higher risk of loneliness.
- Further analysis is required to ascertain the impact of mental health, caring, immobility and cognitive decline on loneliness and social isolation. This work is ongoing in Staffordshire

The County is also more ethnically diverse, with an increase in the black and minority ethnic population, which now

includes around 86,500 people, roughly 10% of the total.

Staffordshire is a large, predominantly rural county covering 2,623sq.km interspersed by five major towns and a network of market towns and villages. Staffordshire does not experience concentrated areas of deprivation, although some pockets do exist in urban areas. The more remote rural areas in the county have their own issues with hidden deprivation, particularly around access to services.

Mental Health and Dementia

Most mental ill health is mild and self-limiting and does not reach the level of diagnosis of a disorder. However, a significant proportion is chronic and causes moderate disability while a small number of people suffer life-long severely disabling illness. Anxiety and depression affect the largest number of people and often occurs in conjunction with relationship and social problems, substance misuse or physical illness. At least one in four people will experience a mental health problem at some point in their life and one in six adults have a mental health problem at any one time.

In 2011/12 there were over 5,000 people registered with a severe mental illness on GP registers across Staffordshire and 4,350 people with dementia**.** Levels of people with severe mental illness are lower than the England average. Levels of dementia overall in Staffordshire are similar to England. However levels in Newcastle-under-Lyme are significantly higher than England, which may be due to a combination of differences in case finding and recording on GP disease registers, as well as real differences in prevalence due to demographic and risk factors between areas, for example more older people.

Within Staffordshire we are aware Stafford and Newcastle have the highest numbers of people diagnosed, whereas Tamworth and Lichfield have the lowest.

Loneliness is a difficulty for many people with dementia. In the Alzheimer's Society's Dementia 2012 report on how well people are living with dementia, more than half (55%) of people with dementia reported feeling lonely some of the time.

The risks of social isolation and loneliness are more profound in people with dementia. Studies have highlighted several personal characteristics which influence whether a person is lonely or not – many of which are common among people with dementia. Living alone (de Jong Gierveld et al, 2011) or living in residential care (The Residents and

Relatives Association, 2010) are factors which are associated with loneliness. Poor health (Victor C et al, 2005), reduced mobility (Tijhus MAR et al, 1999) and cognitive impairment (Victor C et al, 2005) all increase in line with an older person's chances of being lonely.

There is some evidence which suggests that the risk of Alzheimer's disease more than doubles in older people experiencing loneliness (Wilson et al, 2007).

Further information can be found at http://www.alzheimers.org.uk/dementia2013

Learning disabilities

Learning disability is one of the most common forms of disability and is a lifelong condition. It is acquired before, during or soon after birth and affects an individual's ability to learn. People with learning disabilities may face challenges and prejudice every day, for example:

• Half of all families with children with a learning disability live in poverty.
• Less than one in five people with a learning disability work, although at least 65% of people with a learning disability want to work. Of those people with a learning disability that do work, most only work part time and are low paid.
• Just one in three people with a learning disability take part in some form of education or training.
• At least half of all adults with a learning disability live in the family home - meaning that many do not get the same chances as other people to gain independence, learn key skills and make choices about their own lives.
• People with a learning disability are 58 times more likely to die aged under 50 than other people.
• Less than a third of people with a learning disability have some choice of who they live with, and less than half have some choice over where they live.

The expected prevalence of learning disability suggests that there may be significant numbers of people undiagnosed or unrecorded on GP registers in Staffordshire. It is estimated that there are nearly 14,000 people aged 18 and over who have a learning disability, but the actual number of people on GP registers is much lower (nearly 3,000). The numbers of adults with learning disabilities is projected to remain similar over the next 15 years.

Long Term Conditions

	It is estimated that around one in five people in Staffordshire have a limiting long term condition which increases significantly with age. Data from a sample of practices revealed that at least one in four people have a registered disease with one tenth of the population having more than one condition. Almost a third of all patients with a specified registered disease are also obese, around 14% are smokers and 19% are ex-smokers. Expected prevalence shows that significant numbers of people with long term conditions may be undiagnosed or unrecorded on GP disease registers with the largest under-recording seen in chronic kidney disease, hypertension, COPD and dementia. With an ageing population, Staffordshire is also predicted to see an increase in numbers of long term conditions, placing an increasing burden on available health and social care resources.
Any other relevant information e.g. key partners	Successful applicants will be expected to work collaboratively with existing partners and commissioners. Target groups, communities, service users and their parents/carers should be involved in the design and evaluation of the programme
Service availability (Days/Hours per week)	It is expected that interventions engage with local communities and that activities are provided in accessible and appropriate venues (where a venue is required) which maximise the use of existing local assets. Availability is to be flexible in order to meet the needs of target groups, people aged 16+.
Service Information	
Details on geographical delivery area	Projects need to be delivered within the local authority boundary of Newcastle-under-Lyme, with a particular emphasis on vulnerable groups and communities to tackle inequalities
Details of any specific target groups	Young People and Adults aged 16+
Details of eligibility criteria	N/A
Indication of volume/numbers accessing the service	Dependent on the intervention, and tailored to meet needs and approach. It is expected that all efforts are made to maximise uptake by vulnerable groups and communities, and that the proposal represents value for money.

<table>
<tr><td>Details of referral process</td><td>Open Access</td></tr>
<tr><td>Planned start date</td><td>1st November 2015</td></tr>
<tr><td>End date</td><td>31st October 2016</td></tr>
<tr><td colspan="2">Specific Service Standards & Monitoring</td></tr>
<tr><td>What outcomes are to be achieved</td><td>The outcomes we wish to achieve are detailed below:
<table>
<tr><td>Prevent the onset of social isolation and loneliness for people age 16+</td><td>• Increase the social connectedness of vulnerable groups such as older people and people with additional needs
• Increase in awareness for the general public of the factors which may lead to social isolation and loneliness</td></tr>
<tr><td>For people experiencing social isolation and loneliness reduce and limit the incidences of occurrence</td><td>• Increase in social connectedness through a variety of means such as social media, befriending, etc.
• Increase in social participation
• Increase the diversity of social networks
• Decrease in individual experiences of social isolation and loneliness</td></tr>
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<tr><td>What are the target outputs to be achieved</td><td>85% of service users state that they are satisfied/very satisfied with the programme.</td></tr>
<tr><td>Performance Indicators: expected qualitative and quantitative data</td><td>To be negotiated as part of contract negotiation.</td></tr>
<tr><td colspan="2">Contract Period:</td></tr>
<tr><td>Indicative Contract period:</td><td>The maximum contract period will be 17 months. This will consist of an initial contract for 12 months and extension for a further 5 months (where possible and appropriate subject to performance and available funding).</td></tr>
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Budget:	
Available Indicative Budget for service delivery:	Funding available up to £17,500 per annum. The Partnership shall reserve the right to increase or decrease the total funding subject to availability. The Newcastle Partnership does not accept year on year inflationary increases.
Contract Payment:	
Contract Payment:	Contract payments will be made quarterly in arrears (following receipt of quarterly monitoring information and satisfactory review by responsible Officer).