Loneliness and Isolation in Older People: *Factsheet*

Tower Hamlets Joint Strategic Needs Assessment

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Executive Summary

Introduction

In an ageing society, loneliness is an area of growing public health concern. The Campaign to End Loneliness, a national collective of charities, has been working to end loneliness and isolation in older people in the United Kingdom. This factsheet draws from much of the work of the campaign and provides a local context in terms of the needs of local older residents in Tower Hamlets.

What is loneliness

Humans are social beings who crave the company of others. Loneliness describes the pain felt when there is a gap between the amount of personal contact desired, compared to that actually received. Loneliness can affect anyone at any age. It can be chronic and enduring, or something experienced temporarily following a significant life event, such as bereavement. External factors, such as where we live, can also impact either positively or negatively on both personal perception and experiences of loneliness. There are those who are at an increased risk of loneliness such as; young care leavers, carers, refugees, people with poor mental health and older people. Older people are at particular risk of loneliness due to an accumulation of risk factors, such as; the loss of friends and family, mobility and income. This factsheet focuses on the needs of older residents in Tower Hamlets aged 65 and over.

What is the impact

Being lonely is very bad for both physical and mental health and wellbeing. Loneliness increases blood pressure and diminishes the ability to refrain from risky behaviour. It can lead to cognitive decline in adults, and is associated with depression. Such is the effect of social relationships on the risk of death it can be compared to that of smoking, and exceeds the effects of obesity. In Tower Hamlets, a higher proportion of older people live alone, are on a low income, report poor health, and are of non-white ethnicity than in England; all factors that were found, through research, to be independently associated with loneliness.

Based on national estimates, approximately 10% of the over 65 population are likely to be lonely 'all or most of the time' referred to as 'chronic' loneliness. Yet, rates of chronic loneliness were found to be higher at 16% in deprived inner city boroughs. Given the characteristics of the Tower Hamlets population, the proportion of older residents who are chronically lonely is likely to reflect the higher rate of 16% equating to about 2,600. This figure excludes those who are lonely some of the time so in essence is likely to be an under estimate.

What is available locally and next steps

There are a wide range of services available locally for older people including, support for individuals as well groups, services that encourage wider community engagement and participation, as well as services that provide information and signpost onto other services, these are discussed in more detail in the factsheet.

Local provision should be further enhanced by understanding how services impact on loneliness. At present

there is no way of knowing if those in greatest need are reached by services. Similarly, whilst there is a good understanding of the risk factors, there is a need to be better informed as to the public's perspective on loneliness. For example, who is lonely and why, what is it about where people live in Tower Hamlets that either contributes toward or mitigates against experiences of loneliness and isolation?

Recommendations

1. To gather public perspectives on loneliness, so that local action aimed at alleviating loneliness, is informed by local need. This can be achieved by empowering local people, through training, to engage within their community to explore local experience and develop local networks. This will succeed in both strengthening the local community, whilst also collecting information on the public perspective.
2. To explore opportunities to enable people working in the public and voluntary sector, to identify people who are lonely and signpost them to wider support services.
3. To explore opportunities to ensure that information about the services available to older people is well publicised and accessible to both staff and residents.
4. To explore opportunities through existing interventions for vulnerable persons, such as the Integrated care Programme and the Carer's Centre, to signpost people towards holistic support services that serve to improve social connectedness, foster peer support and improve health and wellbeing.
5. To include measurable targets and actions for loneliness when the Health and Wellbeing Strategy is next updated, in 2016.
6. Interventions for older people should measure their impact on loneliness to build on the evidence base of what works, alongside equalities data to inform us of any unmet need.
7. We need to understand more about how technology can support older isolated residents to inform the work of the Digital Inclusion Strategy.
8. To explore opportunities to access funding through a SIB on Loneliness and Isolation in Tower Hamlets. https://www.gov.uk/social-impact-bonds
9. To develop a local 'Isolation Index' to pinpoint households at risk for a more targeted approach.
10. To undertake a rapid needs analysis of loneliness and isolation focusing on other areas of the life course such as childhood/ adolescence.

1. What is loneliness?

Loneliness is a subjective response to the perceived gap between the amount of personal contact an individual wants and the amount they have [1]. Isolation describes the absence of social contact, i.e. contact with friends or family, community involvement or access to services[2] The terms 'loneliness' and 'social isolation' are often used interchangeably, whilst they are related they are in fact two distinct concepts.

Loneliness is commonly categorized into two forms, 'social loneliness' and 'emotional loneliness'. Emotional loneliness is described as the absence of a significant other with whom a close emotional attachment is formed (e.g. a partner or best friend)

Social loneliness refers to the absence of a social network consisting of a wide group of friends and neighbours [3]. Loneliness can be both transient i.e. an experience that follows a significant life event [such as the death of a partner], or chronic, an ongoing enduring experience. It is thought that men and women may experience loneliness differently. There is a life-course dimension to loneliness [4], much of the research on loneliness is applicable across the life course. However, the recommendations in this factsheet focus on the needs of the over 65 population to reflect local and national priorities.

1.1. Why is it a public health issue?

Aside from the few who prefer to be alone, human beings are social creatures who tend to crave the company of others. It is thought that loneliness signals a physiological deficit much in the same way as hunger or thirst, suggesting that social relationships are in fact intrinsic to the human experience [5]. Loneliness is also a societal issue. Changes to the landscape of our communities are having an impact upon experiences of loneliness and isolation. 'People are living longer, families are living greater distances from each other, communities are less cohesive, less static and more dynamic with greater mobility between nations. Technology is changing the way we interact with many being left behind [6].

Social Isolation and loneliness impact on quality of life and wellbeing [7]. A meta-analytic review conducted to determine the extent to which social relationships influence risk for mortality, found that persons who experience strong social relationships were likely to remain alive longer than similar individuals with poor or insufficient relationships[8]. Such is the significance of this effect on survival, that it could be compared with quitting smoking, and exceeds many well known risk factors for mortality such as obesity, and physical activity[8]. Being lonely has a significant and lasting effect on blood pressure, with lonely individuals having higher blood pressure than their less lonely peers. Such an effect has been found to be independent of age, gender, race, cardiovascular risk factors (including smoking) medications, health conditions and the effects of depressive symptoms[9].

It has been shown that loneliness makes it harder to regulate behaviour, rendering people more likely to drink excessively, have unhealthy diets or take less exercise [3].

Loneliness is also associated with depression (either as a cause or consequence) as well as higher rates of mortality[10]. Loneliness has also been linked to cognitive decline and dementia in older people [3]. Cognitive decline can also increase the risk of social isolation and loneliness [11].

1.2. *How does it occur?*

Every individual is unique. Experiences of loneliness and social isolation are dependent upon the individual and their personal circumstances.

There are a number of population groups who are particularly vulnerable, such as; young care leavers, carers, refugees, and those with mental health problems [10]. Older people are particularly vulnerable to social isolation and loneliness, owing to loss of friends and family, mobility or income [3].

The Campaign to End Loneliness has identified a range of factors associated with loneliness and isolation for older people.

Personal characteristics: Being aged 75 plus is a risk factor for loneliness[12], being from an ethnic minority community[13]. Research has found rates of loneliness to be higher [between 24-50%] among elders aged 65+ from ethnic minority communities in the UK from China, African, the Caribbean, Pakistan and Bangladesh, [exception of those from Indian subcontinent who reported similar rates to the UK population]. More research is needed to fully understand the results and how this will apply to second, third generation BaME. Being gay or lesbian is a risk factor. Gay and lesbian persons as they age are more likely to live alone or to have less contact

with family [14].

Personal circumstances such as living alone, it is noteworthy that not all persons who live alone will feel lonely, however, living alone has been associated with loneliness [15] according to a YouGov Poll 62% of persons living alone with a diagnosis of Dementia, reported feelings of loneliness [16]. other risk factors are being single, divorced or never married [12]. Living on a low income [12], or living in residential care [17]. It is thought that as much as 80% of residents living in care homes either have Dementia or significant memory problems[18] □

Health and disability Poor health, immobility, cognitive impairment and sensory impairment, were all found to be significantly associated with loneliness [19]. Sight problems are associated with loneliness [19]. Conditions such as glaucoma, which can result in loss of peripheral vision and depth of perception, are particularly implicated in increased risk of social vulnerability [20].

In a YouGov Poll of over 55's, 38% of persons with Dementia reported feeling lonely compared to 23% of the general adult population surveyed[16]. For Dementia sufferers who speak English as a second language, the ability to recall English diminishes as the illness progresses, the implications of this on loneliness is currently under researched[21].

Falls are a significant cause of injuries, loss of confidence, increased morbidity, institutionalisation and mortality in all older people[22]. In addition research suggests people with dementia recover less well after a fall than those without dementia[22]. It is estimated that between 35% and 40% of pensioners living at home will experience a fall resulting in a deterioration of movement and quality of life, thus increasing risk of social isolation[23].

Transitions Significant life transitions, such as becoming a carer or giving up caring, retirement or bereavement can lead to a loss of social and emotional connections, and lowered resilience. Bereavement can lead to an increased risk of emotional loneliness.

Geography: It is thought that as urban communities have disproportionately high mortality rates (and lower average *life* expectancy) and relatively high rates of migration related population change, all these factors pose a particular risk for older people in terms of loneliness [24]. As such areas with high levels of material deprivation and where crime is an issue are identified risk factors [24]. How older people perceive their neighborhood is important, fear of being a victim of crime can inhibit them from maintaining a 'normal' life [12].

Rates of loneliness are also higher in deprived urban communities that in the country as a whole [25]. Rates have been found to be as much as 16% in a disadvantaged community in Hackney. Similarly, in a study of deprived neighbourhoods in three English cities, severe loneliness was found to be 16% among older people [12].

1.3. What is the impact?

The impact of loneliness and social isolation on an individual's health and wellbeing has cost implications for health and social care services. As already described, loneliness is associated with cognitive decline in adults. Alzheimer's is an illness that is estimated to cost the UK £20billion a year and has an even higher human cost[26]. Loneliness has been independently associated with emergency hospitalisation[27]. The issue of loneliness and isolation are set to increase as an increased number of persons reach old age.

2. What is the policy context?

The *National Services Framework for Older People* published in 2001, first acknowledged isolation in relation to falls and depression [28]. In 2007, *Putting People First* was the government's commitment towards reforming the adult social care system in England, in the context of an ageing society [29]. The agreement highlighted the importance of strong social relationships in reducing dependence upon social care in older age.

The impact of loneliness and social isolation on health inequalities was subsequently reinforced by the *Marmot Review* [30]. These policy changes are reflected by the introduction of the Health and Social Care Act[31] and subsequently the Care Act 2014In 2011/12 the Adult Social Care Outcomes framework (ASCOF) introduced new measures aimed at monitoring levels of social isolation at both the local and national level.

In Tower Hamlets, the '*Older Person Housing Statement*'[32] seeks to enable older people to live independently for as long as possible, and includes a commitment to support older people to maintain and develop social networks, to reduce isolation and to lead more active and healthier lifestyles.

The Better Care Fund aims to bring about changes to the way that health and social care services are provided moving towards greater integration. In Tower Hamlets, the Integrated Care Programme (ICP) was recently introduced which aims to provide more joined up services for vulnerable residents who have multiple long term health issues. This new programme approach provides important opportunities through which issues of social isolation and loneliness could be addressed amongst an at risk population.

The Tower Hamlets Partnership Digital Inclusion Strategy 2015 aims to overcome social isolation and improve wellbeing through the use of digital technology, in particular targeting elderly or disabled residents.

Similarly the Ideas Store Strategy[33], which seeks to improve outcomes for learning, community cohesion, health, as well as economic and social wellbeing, provides potential opportunities to reduce loneliness in the community.

At the national level, it is the Campaign to End Loneliness [a collective of national charities] that is driving the approach towards tackling loneliness and isolation. The Campaign has developed a toolkit to support Health and Wellbeing Boards (HWBs), and has rated HWBs according to how well loneliness and isolation is reflected in their joint strategies. Tower Hamlets is currently ranked as Bronze[34]. To achieve a Gold status, the Tower Hamlets Health and Wellbeing Strategy would need to contain measurable actions and/or targets on loneliness[34].

3. What are the effective interventions?

Those who are isolated usually require practical help or resources, whereas those who are feeling lonely may need emotional or social support, for example, improved access to extended social networks[35].

Loneliness is a multifactorial issue and may not be simply resolved by tackling one aspect alone. The overall evidence for effective interventions is limited[36], but group-based activities and support that provide opportunities for social interaction do demonstrate some promise in addressing social isolation[36]

Group Interventions

Group interventions that provide activities or support demonstrated a reduction in loneliness in three

systematic reviews[37,38,39]. Educational and social activity group interventions that target specific groups of people can alleviate social isolation[37]. Group based exercise programmes targeting inactive older people in the community were found to be effective[39] and targeted support groups and discussion sessions were effective among those with the social skills to participate[38].

Interventions in which older people were the active participants also seemed more likely to be effective[38]. To improve the long term effectiveness of interventions designed to address loneliness, providers should seek to enhance self-esteem and personal control, for example through the provision of skills training, and through involve older people in the planning , development and delivery of activities[36]

One to one interventions Reviews on the evidence for the effectiveness of one-to-one interventions has yielded mixed or inconclusive results. A review concluded that the effectiveness of home visiting and befriending services was unclear[37]. A subsequent review which examined a broader spectrum of outcomes according to social, mental and physical health, similarly concluded that one-to-one interventions were less effective than group interventions[38]. The lack of observed effect may be due to the intervention, but equally the study design or choice of outcome measure[36]. Despite the lack of evidence, these types of interventions, particularly for those who are less able to access group interventions, are considered by experts to play a clear role[40]. In addition, the efficacy of one-to-one interventions could be increased through a variety of ways, such as a befriending service that encourages older people to become befrienders themselves.

Identifying people who are lonely

Wayfinder and Community Navigator interventions are effective in identifying people who are truly socially isolated or lonely[41,42]. General practitioners may be well placed to identify people who are, or who may be at risk of, loneliness and isolation[36].

Interventions involving technology

Interventions that provided both computer and internet training, in either a group or individual basis, did demonstrate a reduction in loneliness compared to controls[43]. A study that examined internet training among community dwelling housebound older people demonstrated a sustained reduction in overall loneliness compared to controls[38]. However, the poor quality of included studies in both instances significantly limits the reliability of the results or the ability to generalise to other settings.

Interventions in practice but not in evidence

Due to the limited and poor quality evidence available for loneliness interventions, The Campaign To End Loneliness developed a guide, bringing together a range of initiatives that show promise in tackling loneliness but may not be reflected in the research literature for example[40]:

- Psychological approaches: For example; supporting people to change their thinking about relationships
- Transport: Transport is vital in keeping older people socially connected, and can be in itself create opportunities for social interaction.
- Asset Based Community Development: . 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’.
- Volunteering: Volunteering should be considered in itself an intervention that directly impacts on

loneliness.

- Age positive approaches: that helps to foster a positive mentality on aging among a wide range of key organisations and institutions within a local area.

Gaps in research evidence:

There are significant gaps in evidence on the impact of loneliness initiatives in minority communities such as LGBT and BME older people, and older people who live in care homes. Although initiatives may exist that serve these populations, the data to support their effectiveness is not yet available. Providers need to ensure that the needs of minority communities are built into their service planning, and that efforts are made to effectively evaluate outcomes[40]

SCIE highlight the importance of an effective relationship between health and social care, and continued investment in preventative services delivered by the voluntary sector[10].

4. What is the local picture?

Loneliness across the life-course

Loneliness is present across the life course. A cohort study following children from ages 5 through to 17 identified characteristics in early childhood such as low self-worth and low trust, that predicted relatively high stable loneliness and depressive symptoms at age 17[44]. Early reviews have stated that loneliness tends to peak during early adolescence, drops between young adulthood and middle age, and then rises again in old age[44]. This is closely associated with mental wellbeing. Preventative and mitigating action across the life-course is discussed in some detail in the Mental Wellbeing JSNA factsheet.

The next section examines the estimated prevalence of loneliness among residents in Tower Hamlets aged 65+.

Prevalence of loneliness

Tower Hamlets has a relatively small proportion of residents aged over 65 accounting for just 5.9% of the overall population[45], compared to 17.4% in the overall UK population[46].

A national study of ageing among persons aged 52+ reported a prevalence rate of feeling lonely 'often' (chronic loneliness) as 9%, with reported loneliness being highest among those aged 80+ at 17% [47]. Surveys have consistently shown that around 6-13 per cent of older people report that they are often or always lonely[6]. Based on national estimates 10% of the over 65 population to be lonely 'all or most of the time'.

Yet, research has estimated rates of chronic loneliness to be far higher in inner city boroughs (16%). Given the characteristics of the Tower Hamlets population and levels of deprivation rates of loneliness are likely to reflect this higher rate of 16%, which would equate to approximately 2,560 persons. It is important to consider that this figure *excludes* those who are lonely some of the time.

A model that estimates subjective loneliness at borough, middle and lower super output areas, ranks Tower Hamlets as 1 out of 33 for London and 1 out of 326 for England, meaning that persons aged over 65 living in Tower Hamlets are predicted to be among the loneliest in both London and England. The model uses data from both the English Longitudinal Survey for Ageing (ELSA) and small area data from the Census based on

characteristics that are significantly associated with loneliness. Being in poor health was by far the biggest factor associated with chronic loneliness, followed by widowhood and living alone[48]. It is the high levels of poor self-reported health in the borough that accounts for much of the weighting in the model that predicts Tower Hamlets to be the loneliest borough. The relationship between poor self-reported health and loneliness is explored in section 1.2 (Risk factors for loneliness). The GLA state that the model is intended as a means of examining variation between areas than as a true estimate of the prevalence of loneliness in a given area[49]. There are limitations most notably that ethnicity was not included as a variable due to limited available data for England and it excludes elderly persons living in care homes and institutions. For more information see[48]

The prevalence of severe loneliness among older people living in care homes is at least double that of the community dwelling population between 22-42% [50]. In Tower Hamlets, there are a small but significant number of people living in elderly care approximately 300 persons.

1.1. Self-reported social isolation

There are no routine population measures for loneliness at the national or local level. There are plans to include a measure for loneliness in the Adult Social Care Survey (ASCS).

The ASCS measures social isolation among adult (18+) users of social care services (including carer's) by assessing levels of social contact. The survey informs the Adult Social Care Outcomes Framework (ASCOF)[51] and the Public Health Outcomes Framework[51]. Whilst social isolation is a proxy measure for loneliness, it does provide some insight into local experience.

The data on social isolation is presented on the Public Health Outcomes Framework. In 2014/15 users of Adult Social Care, agreed significantly less with the statement that 'they have as much contact as they would like' 39.8% compared to England 44.8%, but this was similar to the regional average at 41.8%.

The ASCOF also measure levels of social isolation among adult carer's. In 2014/15 the local rate was 36.2% which was not found to be significantly different to regional or national averages. See section 4 Impact on indicators to observe the trend data on social isolation. For more detailed information about the ASCOF Measures on social isolation please refer to the HSCIC website[1]

1.2. Risk factors for loneliness

This next section explores the risk factors for social isolation and loneliness in the Tower Hamlets population.

The following table on the next page provides a summary of the risk factors associated with loneliness[52] and the proportion of the over 65 population in Tower Hamlets affected. These results have been compared both regionally and nationally. The numbers represented are independent of each other, so should not be used to calculate a total. A more detailed breakdown of some of these headline figures are provided in the following section.

1 https://nascis.hscic.gov.uk/Portal/Reports/Pdf.ashx?r=N008_711_01_2016.pdf&t=PublishedReport&type=standardreports

TABLE 1: SUMMARY OF RISK FACTORS FOR SOCIAL ISOLATION AND LONELINESS

Loneliness risk factor for people aged over 65 living in Tower Hamlets	Tower Hamlets			London		England		
	Risk greater /lower in TH	%	(n)	%	(n)	%	(n)	Data available
Being on a low income (Indices of deprivation age 60+)	↑	51.9	214472	23.8	1201424	18.2	11327617	These are population weighted averages of LSOA values for IDAOPI score 2010 (times 100)
The proportion of the TH population Aged 75 and over	↓	47.5	7401	47.7	431691	47.4	4108246	KS102EW -Census 2011
Living alone	↑	38.8	6038	34.5	312022	31.5	2725596	DC1109EW -Census 2011
Single	↑	12.2	1896	10.12	91534	5.54	479434	DC1107EW -Census 2011
Widowed	↑	32.99	5137	28.6	258643	28.7	2483352	DC1107EW -Census 2011
Divorced (includes same sex and civil)	↑	11.83	1842	10.8	98049	8.68	751894	DC1107EW -Census 2011
Non white	↑	35.5	5529	21.9	198521	4.7	410025	DC2101EW -Census 2011
Limiting long-term bad health (self-reported)	↑	29.4	4581	17.2	155708	15.3	1325172	DC3201EW -Census 2011
Moderate to Severe Visual Impairment	↓	8.9	1389	9.1	82295	9.2	794029	Based on POPPI estimate for 2012. Uses national prevalence 5.6% 65-74yrs 12.4% 75 and over
Dementia	↓	7.0	1088	7.3	66043	7.3	636099	Based on POPPI estimate for 2012. Uses national prevalence rates by age and `sex from Dementia UK
Depression	↓	8.6	1345	8.9	80909	9.0	781879	Based on POPPI estimate for 2012. Uses national prevalence rates by age and sex from McDougall et al 2007

Looking at the statistical significance in difference between Tower Hamlets and England, significantly more persons in Tower Hamlets live alone, are on a low income, are single widowed or divorced, report poor health, and are from an ethnic minority.

Some important characteristics of the Tower Hamlets population on risk factors for loneliness and social isolation are reflected on here.

Personal characteristics

- The above table indicates that 35.5% of the over 65 population are non-white which is far higher than nationally. Across all ages 65% of the Tower Hamlet population is non-white. The ethnic distribution in the over 65 population will change over time.

Personal circumstances

- In Tower Hamlets, 51.9% of pensioners live on a low income, putting them at risk of social exclusion and potentially limiting their ability to fulfill key social functions[53].
- Of those who live alone they are more likely to be female[54]. A greater proportion of Tower Hamlets residents live in 'age mixed households' than for England 40.2% vs 22.2%[15].

Health and disability

- According to 2011 Census, many pensioners self-report poor health. Poor self-reported health has been independently associated with loneliness. When calculating the relative risk by ethnicity, those aged over 65 who identify as Asian/Asian-British were 3 times more likely to report their health as 'bad' or 'very bad' than nationally. [the risk was 4 times higher among those aged 50-64] (Table 5) & (
- Table 6).
- Older residents in Tower Hamlets are more likely to report lower wellbeing than younger adults[55].
- Tower Hamlets pensioners are also at greater risk of falls than for England 2,013/100,000, vs 1,665, for further information refer to the Falls Review[56].

Transitions

- Of the 32.9% of residents over 65 who are widowed, 80% are female (Table 4). As described by a Tower Hamlets Homes resident, the loss of her husband was like a 'double loss' as losing him also meant losing the support of the one who 'used to deal with everything around the house'[57].
- 22% of our pensioners are providing some form of unpaid care, with over half of these providing that care for 50+ hours of week. This is significant given the relationship between hours spent caring and reported experiences of social isolation in the ASCS[58].

2. What is being done locally to address this issue?

The intervention framework by the Campaign to End Loneliness[59] (CTEL) has been used to assess local provision, this encompasses:

- Support for individuals
- Group Interventions social and cultural and health promoting
- Wider community engagement
- Information and signposting services

In Tower Hamlets many of the services are delivered and funded via the statutory sector Local Authority (LA) and the Clinical Commissioning Group (CCG) or through charitable funding pulled in by the voluntary sector.

An influential service for older people (50+) in Tower Hamlets is **Linkage Plus**, [funded by the LBTH][2]. Linkage is a borough wide service delivered through a range of voluntary sector providers.

The next section demonstrates the range of services provided.

[2] Linkage services spans the entire borough, and is delivered by five voluntary sector agencies operating as 'Linkage Network Hubs' namely; Age UK, Neighbours in Poplar (NIP), Toynbee Hall, St Hilda's Community Centre and Peabody.

Support for Individuals i.e. befriending, mentoring, Wayfinders etc.

- Befriending services are delivered by more than one provider in Tower Hamlets; THFN[3] providing befriending services as well as extended support for housebound residents which include holistic care such as reflexology. Neighbours in Poplar (NIP) a Linkage member, provide support by telephone or in person including escorted outings. Befriending services for Toynbee are provided by the Community Advice and Support Scheme (CASS) In addition, The City and East London Bereavement Service (CELBS) provide befriending or counselling as part of their service.
- Outreach Workers (similar to Wayfinders) seek to attract new members into Linkage. Outreach is achieved by holding pop up stalls at venues frequented by older people such as One Stop Shops, Ideas Store, and General Practices[4].
- Tower Hamlets Homes (THH) have a safe and secure scheme, whereby staff frequently call residents considered vulnerable. Any staff member can refer a resident to be assessed against the 'getting to know you' criteria.

Group Intervention – social, cultural and health promoting

There are a wide range of group interventions provided locally:

- Lunch Clubs funded by the Local Authority[5].
- There is a Dementia Café that provides support to persons with Dementia and their carer's.
- Some voluntary sector providers offer social activities and day trips through Age UK, NIP have two minibuses and are supported by 40 Active Volunteers.
- There are culturally specific group activities for Bangladeshi Elders such as those provided by Toynbee Hall, or the ALFIE Club. Each Linkage hub provides a wide range of activities based upon interest.
- There are also health promotional activities such as 50+ Keep Fit, seated exercise some of which are aimed at specific older groups i.e. 'The Men's Club' at Sundial Centre, or Green Candle dance company which provide seated sessions in care homes (funded through the mainstream grant).
- Golden Time Group[6] is provided space in the Ideas Store to run both informal and formal sessions for older people based upon what the group identify as a need i.e. using the computer to trace the family tree.
- There is also a mainstream grants scheme that funds pensioner groups to support social activities which includes an objective to reduce social isolation and increase independence. In October 2013 there were 53 pensioners groups funded through the small grants programme, ranging from £300 to £500.

Wider community engagement and participation

- Time Banking such as that provided by the BBBC, is a community initiative where residents of any age can

3 Tower Hamlets Friends and Neighbours (THFN) currently supports over 300 older people with regular visits, advice, advocacy and outings, and has been supporting vulnerable and isolated older people for 60+ years

4 Public Health are supporting the OW by providing training to enable them to directly deliver health and wellbeing advice and support.

5 The lunch clubs are currently under review to establish how well these meet and reflect the needs of older people in the most optimum way, but also to understand better their impact upon social isolation.

6 The Ideas Store provides access to a shared non-clinical community space, seven days a week. They work closely with a range of providers to achieve the aims set out in their health strategy

volunteer their time, and receive credits in kind. This initiative helps to build social networks and boost wellbeing.

- Local groups involving older people include the Involving Older People Project (Age UK), Housebound Older People's Reference Group, and Healthwatch.
- Tower Hamlets Homes (THH) have the following initiatives aimed at increasing participation of their older residents.
    - OP Champions are trained alongside YP Ambassadors represent tenants of their respective age groups, which provide opportunities for intergenerational projects between these two groups.
    - TH Homes have opened up their paid apprenticeship programme with Decent Homes [an initiative to refurbish council property] to residents of all ages, and are actively promoting the opportunity to residents aged 50+.

Information and signposting to services, such as telephone helplines, directories.

- Information, Advice and Advocacy (IAA) a 'one stop shop' borough wide information advice and advocacy service.
- A borough wide social prescribing pilot funded by the CCG, to be known as the 'Tower Hamlets Wellbeing Service' is due to be launched in 2016[7].

3. What evidence is there that we are making a difference?

None of the evidenced based services (befriending, Linkage Outreach, tailored creative group sessions) routinely collect outcomes data on loneliness and/or isolation.

What is presented in the following table, are the available evaluations of some of the interventions that have been highlighted in the factsheet. Other than an evaluation of the Linkage Plus service in 2011 there is limited outcomes data available.

Most of the available evidence relates to outputs drawn from monitoring returns and have been summarised in the table below:

Project/intervention	Input	Output	Outcomes
Social Prescribing Project Bromley by Bow MEEBbB scheme funded by TH-CCG[60] Cover five GP practices	Annual Funding £30K from CCG & £20K from MEEBBB network	Apr 14/Mar 15 • 694 patients engaged (approx. 8% aged 65+) • Healthcare Professional cited 'social isolation' as the need for referral in 99 cases, and CMD in 134. [8]	• Referred to 37 different organisations
Linkage Plus		2013-14 monitoring:[9] • 1,156 new clients • 1,039 (89%) were screened for falls risk	Linkage evaluation 2011 Apr – Sep. Cross sectional survey 262 members (opportunistic) • EQ-5D - Quality of Life - 0.58 to 0.66

[7] Public health are working with the CCG on the specification for the borough wide social prescribing pilot and it is intended that the pilots impact on loneliness will be measured.

[8] Social Isolation is cited throughout the report as a significant issue for patients requiring extra support from the social prescribing service. However, this pilot project did not measure the impact the intervention had on levels of social isolation or loneliness.

[9] For more detailed performance information for Linkage Plus, please refer to the Falls JSNA

		• 1067 people attended general physical activity (walks & chair based fitness) sessions • 217 attended Tai Chi and Yoga sessions. • Social and recreational activities were attended by 1190 people 782 people were given advice and/or attended learning sessions.	• Slight increase in wellbeing WEMWBS (not significant)
Tower Hamlets Friends and Neighbours 2011-12		(n) 440 supported older, isolated and vulnerable people, (n) 300 regularly visited in their own home.	

THFN qualitative feedback taken from their 'tea and chat' report into their befriending service 2012 [61]

"It helps me feel not so lonely". *"It gives me hope to carry on going."* *"To hear another voice; to break the loneliness."* *"Somebody friendly coming in to see people like me who don't see anybody."* *"Helps to keep in touch with the outside."*	*I can talk to you and feel better."* *" It means giving me an outlook on the world outside by having somebody to come."* *"A friendly face visiting every week.* *I look forward to her visit."*	*" It's been nice to have a visitor as I'm on my own."* *" I would miss you if you didn't come – you can't talk to the telly."* *" Something I look forward to every week."* *" The day drags when you're on your own – having P come round cheers me up."* *" I like it when you come."*

4. Impact on indicators

The Public Health Outcomes Framework (PHOF) sets out the desired outcomes and indicators that assess how well the public health is being improved and protected. The outcomes reflect on how long people live, as well as how well they live at different stages of life.

There are two indicators included in the PHOF to monitor levels of social isolation among 'users of social care services' and 'carers' via an annual survey the Adult Social Care Survey (ASCOF). Below are the trend tables for these indicators comparing Tower Hamlets to the regional and England average.

(Figure 1) The trend data on reported social isolation among users of social care shows us that in 2014/15 Tower Hamlets is significantly worse than England but similar to London. Whereas in previous years the difference was not significant.

(Figure 2) The trend data on carers reveals that there is no significant difference between London and England in 2014/15. In 2012/13 it may have been significantly worse but data quality issues limit the reliability of this result.

FIGURE 1

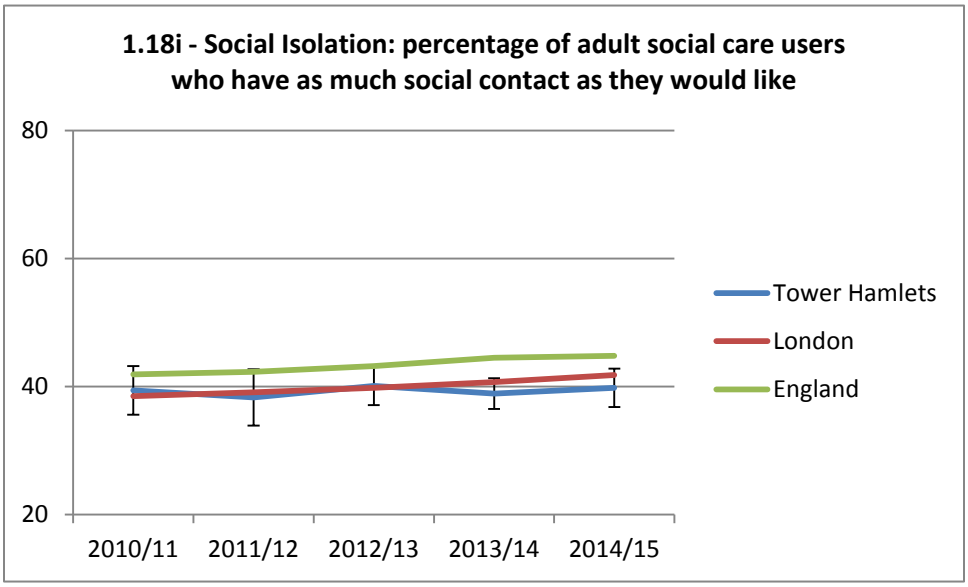

TABLE 2: 1.18II % OF ADULT SOCIAL CARE USERS WHO HAVE AS MUCH SOCIAL CONTACT AS THEY WOULD LIKE

Period		Value	Lower CI	Upper CI	London	England
2010/11		39.4	35.6	43.2	38.5	41.9
2011/12		38.3	33.9	42.7	39.1	42.3
2012/13		40.1	37.1	43.1	39.8	43.2
2013/14		38.9	36.5	41.3	40.7	44.5
2014/15		39.8	36.8	42.8	41.8	44.8

FIGURE 2

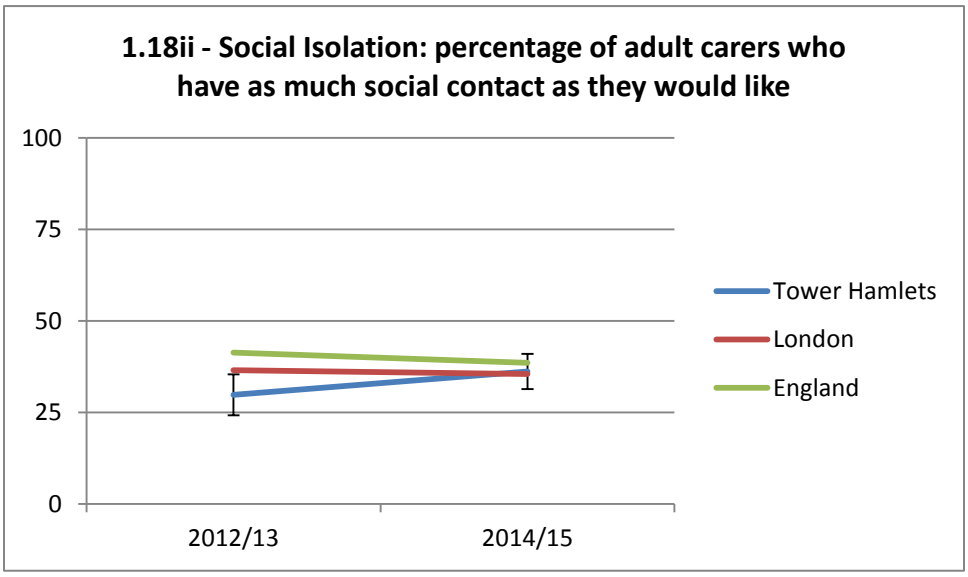

TABLE 3: 1.18II % OF ADULT CARERS WHO HAVE AS MUCH SOCIAL CONTACT AS THEY WOULD LIKE

Period		Value	Lower CI	Upper CI	London	England
2012/13		29.8*	24.2	35.4	36.5	41.3
2014/15		36.2	31.4	41	35.5	38.5

*There is a note on data quality against the indicator 1.18ii

5. What is the perspective of the public?

There is limited data on the public's perspective of loneliness and isolation. It would be useful to obtain the public's views on what it is that they consider to be the factors that either contribute toward, or alleviate loneliness.

Healthwatch[10] commissioned a serious of community intelligence bursary projects, three of which consulted on the views of older people[11]. In a report that contained the views of about 50 residents[62] , issues of social isolation and loneliness were cited frequently. For example, one resident expressed concern over threats to funding for a social club for older men. Other residents spoke of becoming isolated following bereavement, and issues of loneliness linked to anxiety and depression. The value of community services was highlighted.

In 2014, six local volunteers working directly with older people in Tower Hamlets were consulted with regarding this factsheet. These conversations help generate hypotheses which would need to be tested through more extensive dialogue. The key points identified were:

- The causes of loneliness were cited as: 'bowel and bladder weakness' inhibiting participation in trips, 'territorial behavior' against new members in established groups, and sensory problems. Pain was cited as a problem made worse without other distractions. Not having someone to talk to was considered to be damaging to both physical and mental health.

'*Some of the old folk living in flats all they see is those four walls day in day out with only the tele for company*'

- Lots of issues cited with Homecare services which mainly centered on workers not having enough time to engage meaningfully with the older person.

"*Carers tend to be agency, they do their duties but they don't talk to the people, sometimes that is the only contact that person has all day*".

- Similarly issues cited with the district nursing services, frequent use of agency staff.

'*One of our men he used to be the life and soul, – he got prostate cancer, became reliant on carers and district nurses, he is stuck indoors and has said to me "you might as well shoot me". He is depressed now,*

[10] Healthwatch are an independent charity that gives a voice to the community on local services. Recommendations from Healthwatch CIB report currently unpublished, contact to obtain further information.

[11] Link to the Healthwatch information page on the community intelligence bursary Link to Community Intelligence Bursary Reports

they put him on anti-depressants'.

- Cultural issues such as pride preventing take up of services, privacy and stigma in the Bengali community (admitting that their families are unsupportive). Not to just 'assume that South Asian community is looking after their elders'. Younger BaME families moving out leaving old folks behind with poor English.

Transport issues [highlighted by Healthwatch] including bus safety highlighted for frail older people. Lack of available parking for Blue Badge Holders also an issue, particularly around leisure areas such as markets. Dial A Ride – difficult to access and the service is available when you need it.

A report by Tower Hamlets Homes [57] identified the following issues for older people[12].

- Many older residents described feelings of isolation, and of not having opportunities to meet their neighbours.
- 15% stated there were not enough opportunities to meet other people in their area.
- A significant minority reported feelings of loneliness, isolation and depression, after the death of a partner.
- Vulnerable groups were considered to be older Somali women who experienced language barriers and a lack of opportunities to socialise, and residents who identified themselves as LGBT, stating that fear of homophobia and stigma led to isolation.

[12] Tower Hamlets Homes provides social housing on behalf of the Council, over one third of its tenants are aged over 60, 50% are White, and over half experience some form of mobility issue. Mobility issues they report are common among adults aged 50-59 (pre-retirement age), caused by living on a low income.

6. What more do we need to know?

This section sets out the need for further information about loneliness and isolation in Tower Hamlets.

1. There is a need to engage the public to understand more about who is lonely in Tower Hamlets, what contributes towards or alleviates loneliness and how these experiences may differ between neighbourhoods.
2. There is a need to understand more about how to identify people who are lonely who are not currently known to services. Similarly, to understand more about how our statutory, provider and voluntary services can identify people who are lonely – not only those who are known to services but also those that are not yet known to services, and to encourage engagement with local interventions that suit their particular needs.
3. There is a need to understand and address the needs of populations at high risk of loneliness, such as carer's, elderly people living in care homes, persons with mental ill health and other at risk populations. Addressing the needs of residents with a long term limiting health problem would be an appropriate step towards addressing loneliness and/or isolation. The 'Integrated Care Programme' is a key service through which persons at risk could be identified.
4. There is a need to understand if there is a knowledge gap among key frontline staff of the impact of loneliness, and if it would be beneficial to raise awareness of the impact of loneliness on health and wellbeing and what they could do to help alleviate it. The need for this could be explored through point 1.
5. We need to understand how effective the interventions we provide are in alleviating loneliness, particularly those specifically designed to address loneliness [i.e. befriending]. No intervention in Tower Hamlets is currently measuring their impact upon loneliness[13].
6. We need to understand more about how technology can support older isolated residents to inform the work of the Digital Inclusion Strategy.
7. we should explore the potential of the Social Impact Bond (SIB) to fund local intervention(s) to address loneliness and isolation
8. It may be beneficial to use data to identify particular households who may be at risk. For example by adopting the 'Isolation Index' developed by Essex County Council, which used commercial demographic (Mosaic) to identify risk at the household level http://campaigntoendloneliness.org/toolkit/casestudy/essex-isolation-index
9. Loneliness is a life course issue; it would be beneficial to examine how to prevent the long term impacts of loneliness on health and wellbeing to inform local intervention.

[13] Scales develop to assess levels of loneliness in the population tend to be unsuitable for use in many interventions given the range of settings and the emotive nature of the items included. The Campaign is working with a range of partners, including Linkage in Tower Hamlets, to develop a new measure that should be available in 2015. See the link for further information http://www.campaigntoendloneliness.org/measuring-loneliness-interventions.

7. What are the priorities for improvement?

The following table outlines the priorities for improvement that have been identified. Tackling loneliness and reducing isolation among our older residents is a Mayoral priority.

Current State	Evidence for Effective Intervention	Recommendation
We have limited data on the public perspective as to the impact of loneliness and isolation.	Participatory Research method can be useful in capturing lived experience. PA enables local people to explore and share knowledge of life and local conditions as well make decisions, so the outcomes are owned and shared by the community. The process also upskills and empowers those participating in the process.	To gather more insight into the public perspective, to understand what contributes towards or alleviates loneliness and isolation for Tower Hamlets residents.
Frontline staff do not routinely identify an older person who is lonely and signpost them appropriately.	Exploratory area. • Training of frontline staff to identify and signpost i.e. through the MECC • A tool to assess risk of loneliness linked to local services/interventions that may assist.	To explore options for how to enable frontline staff to identify people who are lonely and signpost onto appropriate services, to be implemented across the statutory and voluntary sector.
The council, CCG and voluntary sector currently fund/provide a wide range of services that can support older people to be less lonely.	A comprehensive and accessible well promoted information service is needed to ensure both frontline staff and the public are aware of the services available and how to access them.	To explore opportunities to ensure that the public and staff alike are able to easily identify local services both online and offline.
There are no interventions in place that directly aim to address loneliness and isolation among high risk groups.	There are certain population groups that are at high risk of loneliness such as young care leavers, carers, refugees, and those with mental health problems	To explore opportunities through existing interventions for vulnerable persons, such as through the Integrated Care Programme or the Carer's Centre, to signpost people towards holistic support services that serve to improve social connectedness, foster peer support and improve health and wellbeing.
The Campaign to End Loneliness rated Tower Hamlets as Bronze. This rating reflects that the Tower Hamlets Health and Wellbeing Strategy acknowledge loneliness as a serious issue but did not identify any measurable targets.	To achieve a Gold status, the Tower Hamlets Health and Wellbeing Strategy would need to contain measurable actions and/or targets on loneliness	When the Health and Wellbeing Strategy is updated in 2016, to ensure that it contains measurable actions and/or targets on loneliness, including activities that aim to strengthen social networks.
We are currently unaware of the impact that our local interventions have on loneliness, i.e. befriending services, time banking, social prescribing.	Tower Hamlets Linkage Plus piloted a new measure for loneliness for use in interventions. The Campaign subsequently developed guidelines on how to measure loneliness. http://www.campaigntoendloneliness.org/frequently-asked-	Interventions for older people should measure their impact on loneliness to build on the evidence base of what works, alongside equality data.

	questions/measuring-loneliness/	
Analysis of the risk factors does not reveal to us where to target interventions.	Isolation Index' developed by Essex County Council.	To develop a local 'Isolation Index' to pinpoint households at risk for a more targeted approach.
In May 2014 the council explored opportunities for a Social Impact Bond to fund intervention(s) for loneliness and isolation. It was concluded at that time that more information was needed before progressing.	'Social Finance' have details of a SIB in Hertfordshire and Worcester for loneliness and isolation that provides detailed information for testing locally.	Tower Hamlets should explore opportunities to access funding through a SIB on Loneliness and Isolation in Tower Hamlets. https://www.gov.uk/social-impact-bonds
A Digital Inclusion Strategy was published in 2015 which contains objectives to tackle social isolation through the use of technology, with a particular focus on the elderly and disabled.	Despite the lack of empirical evidence, technology will be used to address isolation and loneliness. Where there is a lack of empirical evidence, there are useful examples/case studies available in this rapidly evolving area of social support[40].	To undertake a review of evidence to inform and support the work in Tower Hamlets to reduce isolation among vulnerable groups through the use of technology.
We need to understand more about loneliness among those aged under 65.	Research has identified that long term loneliness can be predicted in childhood and that loneliness is linked to depression and unhealthy lifestyle behavior's at age 17[44]	To examine the factors associated with loneliness in childhood to inform local interventions

8. Contacts / Stakeholder Involvement

Contacts

Stakeholders from a range of internal departments in the London Borough of Tower Hamlets have been involved in the development of the factsheet including policy and strategy and performance, strategic commissioning and Corporate Research Unit and Public Health.

Voluntary Sector engagement included:

Name	Job Title	Organisation
Dave Bernard	Older People's Transformation Manager	Toynbee Hall (Lead Organisation Linkage Plus)
Zeki Du-ale	Outreach Workers Lead	Toynbee Hall
Sister Christine Francis	Programme Manager	Neighbour's in Poplar
Various	NIP Volunteers	Neighbour's in Poplar
Liz Pope	Chief Executive	Tower Hamlets Friends and Neighbours
Aliyr Rahman,	Chief Executive (former)	Tower Hamlets Friends and Neighbours
Christine Sheppard	Involving Older People's Lead (former)	Age UK
Rose Fraser	Community Development Worker	Bromley By Bow

External organisations

The Campaign to End Loneliness

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With special thanks to Maju Miah for his input into producing this factsheet

Appendix 1

TABLE 4: MARITAL STATUS CENSUS 2011 TOWER HAMLETS RESIDENTS 65+

	Persons				Females				Males			
Status	**Eng**	**prop**	**TH**	**Prop**	**Eng**	**%**	**TH**	**%**	**Eng**	**%**	**TH**	**%**
Civil Partner	9236	0.11	38	0.24	3082	0.06	9	0.11	6154	0.16	29	0.41
Separated*	103885	1.20	521	3.35	48053	1.00	215	2.54	55832	1.45	306	4.31
Single	479434	5.54	1896	12.18	233648	4.85	796	9.41	245786	6.39	1100	15.48
Divorced*	751894	8.68	1842	11.83	434727	9.03	988	11.67	317167	8.25	854	12.02
Widowed*	2483352	28.67	5137	32.99	1930820	40.09	4187	49.47	552532	14.37	950	13.37
Married	4832728	55.80	6136	39.41	2165360	44.96	2268	26.80	2667368	69.38	3868	54.43

**includes data for same sex and civil partnerships*

TABLE 5: CENSUS 2011 - SELF REPORTED SICKNESS AND RELATIVE RISK BY ETHNIC GROUP

Census 2011 -Self reported sickness by ethnic group in Tower Hamlets Relative Risk -Actual divided by expected at England rates for age/sex group (values over 2 highlighted in red, 1.5 to 2 in red text)		
	Bad or very bad health	
	Age 50 to 64	**Age 65 and over**
Asian/Asian British	**3.53**	**2.87**
Black/African/Caribbean/Black British	**1.61**	**1.79**
Mixed/multiple ethnic group	**2.14**	**1.36**
Other ethnic group	**2.88**	**2.20**
White	**1.86**	**1.58**
All ethnicities	**2.32**	**1.92**

TABLE 6: CENSUS 2011 - PERCENTAGE OF SELF-REPORTED SICKNESS BY ETHIC GROUP

% persons with 'bad or 'very bad health' in Tower Hamlets		
	Age 50 to 64	**Age 65 and over**
Asian/Asian British	30.8%	43.8%
Black/African/Caribbean/Black British	14.0%	27.3%
Mixed/multiple ethnic group	18.6%	20.7%
Other ethnic group	25.2%	33.5%
White	16.3%	24.2%
All ethnicities	20.3%	29.4%

Appendix 2

. Tijhuis M, Jong-Gierveld J De. Changes in and factors related to loneliness in older men. The Zutphen Elderly Study. *Age …*. 1999.

2. Bolton M. *Loneliness the State We're in – a Report of Evidence Compiled for the Campaign to End Loneliness*. Oxon; 2012.

3. Cann P, Joplin K. *Safeguarding the convoy.A Call to Action from the Campaign to End Loneliness*. Oxon; 2011.

4. Scott J. Loneliness. *Lancet*. 2011;377:812.

5. Cattan M. *Alleviating Social Isolation and Loneliness in Older People. Cited in: Safeguarding the Convoy. A Call to Action from the Campaign to End Loneliness*. Oxon; 2011.

6. Cann, P and Joplin K. *The Challenge. Cited in: Safeguarding the Convoy. A Call to Action from the Campaign to End Loneliness*. Oxon; 2011.

7. CATTAN M, WHITE M, BOND J, LEARMOUTH A. Preventing social isolation and loneliness among older people: a systematic review of health promotion interventions. *Health (Irvine Calif)*. 2002.

8. Holt-Lunstad J, Smith T, Layton J. Social relationships and mortality risk: a meta-analytic review. *PLoS Med*. 2010;7(7). http://dx.plos.org/10.1371/journal.pmed.1000316.g006. Accessed June 5, 2014.

9. Hawkley L, Thisted R, Masi C, Cacioppo J. Loneliness Predicts Increased Blood Pressure: 5-Year Cross-Lagged Analyses in Middle-Aged and Older Adults. *psychology.uchicago.edu*. http://psychology.uchicago.edu/people/faculty/cacioppo/htmc2010.pdf. Accessed June 12, 2014.

10. Windle K, Francis J, Coomber C. Preventing loneliness and social isolation: Interventions and outcomes. *SCIE Res Brief 39*. 2011.

11. Victor C, Scambler S. The prevalence of, and risk factors for, loneliness in later life: a survey of older people in Great Britain. *Ageing …*. 2005. http://journals.cambridge.org/production/action/cjoGetFulltext?fulltextid=299569. Accessed June 5, 2014.

12. Scharf T. Growing older in socially deprived areas: Social exclusion in later life. 2002.

13. Victor CR, Burholt V, Martin W. Loneliness and ethnic minority elders in Great Britain: an exploratory study. *J Cross Cult Gerontol*. 2012;27(1):65-78. doi:10.1007/s10823-012-9161-6.

14. Stonewell. *Lesbian, Gay and Bisexual in Later Life*. http://www.stonewall.org.uk/media/current_releases/6433.asp. Accessed June 12, 2014.

15. Office of National Statistics. Measuring National Well-being. 2013.

16. Alzheimer's Society. *Dementia 2013. The Hidden Voice of Loneliness*.; 2013.

17. The Relatives and Residents Associated. *Together but Alone - Isolation Older People in Care*.; 2010.

18. Alzheimer's Society. *Low Expectations Attitudes on Choice, Care and Community for People with*

Dementia in Care Homes (Executive Summary). Alzheimer's Society; 2013.

19. Victor C, Scambler S, Bowling A, Bond. The prevalence of, and risk factors for, loneliness in later life: a survey of older people in Great Britain. *Ageing Soc*. 2005;25(3). http://journals.cambridge.org/production/action/cjoGetFulltext?fulltextid=299569. Accessed June 5, 2014.

20. Sense. *Seeing Me: Guidance on Sight and Hearing Difficulties for Staff Who Care for Older People*.; 2011.

21. Mendez MF, Perryman KM, PontÓn MO, Cummings JL. Bilingualism and Dementia. *J Neuropsychiatry Clin Neurosci*. 1999;11(3):411-412. http://journals.psychiatryonline.org/article.aspx?articleid=100420. Accessed June 5, 2014.

22. Allan L, Ballard C, Rowan E, Kenny R, Baune B. Incidence and Prediction of Falls in Dementia: A Prospective Study in Older People. *PLoS One*. 2009. http://www.tara.tcd.ie/bitstream/2262/31986/1/PLoSOne 09 Allan L.pdf. Accessed June 12, 2014.

23. London Borough of Tower Hamlets. *Tower Hamlets Joint Strategic Needs Assessment 2009/10 -2.11 Older Peoples Needs Assessment*.; 2009.

24. Scharf T. *Loneliness - an Urban Perspective. Cited in Safeguarding the Convoy: A Call to Action from the Campaign to End Lonelines*. Oxon; 2011.

25. Bowling A. Life satisfaction and associations with social network and support variables in three samples of elderly people. *Int J …*. 1991. http://onlinelibrary.wiley.com/doi/10.1002/gps.930060803/full. Accessed June 12, 2014.

26. Social Care Institute for Excellence. *At a Glance 60 - Preventing Loneliness and Social Isolation among Older People*. London; 2012.

27. Molloy GJ, McGee HM, O'Neill D, Conroy RM. Loneliness and emergency and planned hospitalizations in a community sample of older adults. *J Am Geriatr Soc*. 2010;58(8):1538-1541. doi:10.1111/j.1532-5415.2010.02960.x.

28. Department of Health. *National Service Framework: Older People - Publications - GOV.UK*.; 2001. https://www.gov.uk/government/publications/quality-standards-for-care-services-for-older-people. Accessed June 12, 2014.

29. Department of Health. *Putting People First: A Shared Vision and Commitment to Transformation of Adult Social Care*.; 2007.

30. Marmot M. *Fair Society, Healthy Lives, The Marmot Review*.; 2010.

31. Department of Health. *Health and Social Care Act*.; 2012.

32. London Borough of Tower Hamlets. *Older Persons Housing Statement 2013-2015*.; 2013.

33. Hamlets LB of T. *Ideas Store, Health Strategy – Medicine for the Soul*.; 2009.

34. Cupitt S. *The Campaign to End Loneliness Evaluation: Health and Wellbeing Boards' Uptake of Campaign Messages*.; 2013.

35. Cattan M. *Supporting Older People to Overcome Social Isolation and Loneliness*.; 2001.

36. Centre for Reviews and Disseminatin. *Interventions for Loneliness and Social Isolation*.; 2014. https://www.york.ac.uk/media/crd/Loneliness and social isolation.pdf.

37. Cattan M, White M, Bond J, Learmouth A. Preventing social isolation and loneliness among older people: A systematic review of health promotion interventions. *Ageing Soc*. 2005. http://doi.apa.org/?uid=2005-01957-003. Accessed June 12, 2014.

38. Dickens AP, Richards SH, Greaves CJ, Campbell JL. Interventions targeting social isolation in older people: a systematic review. *BMC Public Health*. 2011;11(1):647. http://www.biomedcentral.com/1471-2458/11/647. Accessed September 4, 2015.

39. Medical Advisory Secretariat. Social isolation in community-dwelling seniors: an evidence-based analysis. *Ont Health Technol Assess Ser*. 2008;8(5):1-49. http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3377559&tool=pmcentrez&rendertype=abstract. Accessed October 16, 2015.

40. Jopling K. *Promising Approaches to Reducing Loneliness and Isolation*.; 2015. http://www.campaigntoendloneliness.org/blog/promising-approaches/. Accessed January 29, 2015.

41. Findlay R. Interventions to reduce social isolation amongst older people: where is the evidence? *Ageing Soc*. 2003. http://espace.library.uq.edu.au/view/UQ:67956. Accessed June 12, 2014.

42. Knapp M, Bauer A, Perkins M, Snell T. Building community capacity: making an economic case. 2010. http://eprints.lse.ac.uk/33163/1/dp2772.pdf. Accessed June 12, 2014.

43. Choi M, Kong S, Jung D. Computer and Internet Interventions for Loneliness and Depression in Older Adults: A Meta-Analysis. *Healthc Inform Res*. 2012;18(3):191. http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3483477&tool=pmcentrez&rendertype=abstract. Accessed October 22, 2015.

44. Qualter P, Brown SL, Rotenberg KJ, et al. Trajectories of loneliness during childhood and adolescence: predictors and health outcomes. *J Adolesc*. 2013;36(6):1283-1293. http://www.sciencedirect.com/science/article/pii/S0140197113000122. Accessed July 2, 2015.

45. Greater London Authority. London Borough Profiles Census 2011.

46. Office of National Statistics. *Annual Mid-Year Population Estimates, 2013*. London; 2014.

47. Beaumont J. *Measuring National Well-Being - Older People and Loneliness*.; 2013.

48. Iparraguirre J. Predicting the prevalence of loneliness at older ages (January 2016). 2016. http://www.ageuk.org.uk/professional-resources-home/research/reports/health-wellbeing/predicting-the-prevalence-of-loneliness-at-older-ages/. Accessed February 23, 2016.

49. London Datastore. http://data.london.gov.uk/dataset/probability-of-loneliness-for-those-aged-65-and-over. Accessed February 23, 2016.

50. Victor CR. Loneliness in care homes: a neglected area of research? *Aging health*. 2012;8(6):637-646.

doi:10.2217/ahe.12.65.

51. Department of Health. Adult Social Care Framework 2014-15. 2013.

52. Campaign to End Loneliness. Loneliness and Isolation a toolguide for health and wellbeing boards. Factsheet. Risk Factors. 2013.

53. Scharf T, Phillipson C, Smith A., Kingston P. *Older People in Deprived Neighbourhoods, Social Exclusion and Quality of Life in Old Age. Full Report of Research Activities and Results.*; 2002.

54. Nomis. Census 2011 - DC1109EW - Household composition by age by sex.

55. Ipsos Mori. *Health and Lifestyle Survey Tower Hamlets*. London; 2009.

56. Lopez S. *FINAL- TH Falls PreventionServices Review Report*. London: London Borough of Tower Hamlets; 2014.

57. London Borough of Tower Hamlets. *Homes for Life An Inquiry Into Ageing*.; 2013.

58. Nomis. Census 2011 - LC3301EW - Provision of unpaid care by general health by sex by age.

59. Campaign to End Loneliness. Briefing note : Services to reduce loneliness and isolation amongst older people. 2013:1.

60. Fraser AR, Coan J. *BROMLEY BY BOW SOCIAL PRESCRIBING SERVICE YEAR-END REPORT APRIL 2014 – MARCH 2015*.; 2015.

61. Report: More than just tea and a chat - Tower Hamlets Friends and Neighbours -- Befriending Networks. http://www.befriending.co.uk/befriendingpublication.php?type=1&id=53. Accessed October 15, 2014.

62. Davis C, Falconer Roberts J, Pritchard E. *How Do You Want to Live When You're 100?*; 2015.