Public Health Scotland

DRAFT

Loneliness and Social Isolation

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Contents

1. Introduction

The growing evidence base about social isolation and loneliness, their negative health impacts, ability to impact on anyone at any stage in life, and to further exacerbate existing inequalities[1] has led to their recognition as public health problems and the publication of strategies by both UK and devolved, Scottish, government.[2]

Loneliness and social isolation are differing concepts, widely recognised as significant problems requiring a better collective understanding. The former is a subjective feeling experienced when there is a difference between the social relationships we would like to have and those we have,[3] the latter is where an individual has an objective lack of social relationships, in terms of quality and / or quantity.[4]

The causes of loneliness and isolation are complex, will vary dependent on the life stage; contributory factors might accumulate across the life-course and interact and how they are experienced will differ from person to person. If and how we experience loneliness or isolation will be influenced by factors at the level of the individual including gender, ethnicity, sexuality, personality, resilience levels and personal circumstances such as income, marital or health status and the extent and quality of social connections. The risk of becoming lonely or isolated will be shaped by life events and transitions e.g. unemployment, new parenthood, bereavement, relationship breakdown and retirement. It will also be shaped by the local social and built environment such as poor architecture and planning, poor conditions in the home, limited or expensive transport links, lack of attractive and safe green space as well, as by the wider social, economic, political and cultural context.[5] [6] [7]

Evidence continues to build around the negative health impact of loneliness and isolation, with various theories around potential pathways posited to explain why this might be the case,[8] [9] and points to, for example, loneliness as a risk factor for all-cause mortality,[10] the significant effect of social isolation, loneliness, and living alone on odds of mortality,[11] poor social relationships associated with a higher risk of CHD and stroke,[12] and social isolation, low levels of social activity and poor social networks, significantly associated with poor cognitive function in later life.[13]

In recognition of this, the Scottish social isolation and loneliness strategy seeks to connect communities and individuals and support the development of meaningful relationships for all with objectives set out across:

- Empowering communities and building shared ownership, by devolving more power to communities;

- Promoting positive attitudes and tackling stigma, by building 'kinder' communities and services;
- Creating opportunities for people to connect via physical activity, volunteering or technological solutions; and
- Supporting an infrastructure that fosters connections via strengthening person centred health and social care, local third sector and social economy growth, housing solutions, the community voice in planning decisions, safer communities, and transport.

These are broad, contingent on activity identified across a wide range of policy areas dependent on public, third and private sector partner contributions through the lifetime of the strategy.[14]

2. Aim

It's within this context that the public health and health improvement community, will be further shaping their understanding of loneliness and isolation as well as those they work with and seek to influence.

The aim of this short document, post-publication of the national strategy (although it's a short time since publication) and a 2017 ScotPHN scoping report on loneliness and social isolation that advocated for the public health / health improvement community to develop understanding, identify the lonely or isolated as well as suitable health and social care interventions, is not to restate the nature of the problem. Instead, the aim of this document is to better understand how public health and health improvement responses to loneliness and isolation are developing within the context of the now higher profile agenda.

In spite of the Scottish strategy, and perhaps where there is less clarity is around how we are forging solutions to identify, prevent and mitigate isolation and loneliness and which blend of interventions or activities might work and for whom, across the life course. Perhaps this is unsurprising given the many causes of loneliness and isolation, and the potential 'solutions' aimed at the level of the individual, the community, and the wider socio-economic, political and cultural context delivered by a range of local and national actors.

There are clearly interesting examples provided by the Scottish strategy of how loneliness and isolation might be addressed (and a recent focus on the role of community link working in Scotland for example[15] [16] [17] [18]) as well as international review level evidence. What works to prevent or reduce social isolation and loneliness based on the latter, much of it focused on older people[19] [20] [21] [22] [23] [24]and a

handful of other groups[25] [26] [27] certainly provides some indication of promising activities but findings are also ambiguous.

We need to look beyond this evidence however to think more broadly about the types of interventions, for all age groups, that could address loneliness or isolation, even if set up to achieve other outcomes (as is evident in the Scottish strategy). As Public Health England have advocated for example, interventions to address social isolation for example might include supporting women and couples during pregnancy to build supportive networks, supporting families to build good quality relationships, preventing school bullying, providing support for young carers, making environmental changes to encourage play, developing increased employment or networking building opportunities for working age adults, and providing tailored support for ex-offenders.[28]
The nature and scope of the activity therefore that will be required to prevent or reduce loneliness or isolation directly or indirectly is bound to be wide. However by capturing information from public health and health improvement colleagues about local approaches to prevent, reduce or mitigate loneliness and isolation, even if that provides a very brief overview of some local activity or of experiences solely from one perspective, it means that we can share that information with the aim of generating further interest, to shape further questions, generate discussion and to push the agenda on.

3. Method

This report asked local health boards to nominate one representative, health improvement senior / manager or public health senior, to take part in a telephone based semi-structured interview. The interview guide is available in Appendix 1.

The question set sought to identify:

- If loneliness and social isolation has been prioritised, and by whom;
- if loneliness and social isolation has been measured locally and the tools used;
- the nature of public health and health improvement led activities, interventions, or partnership working;
- the role of primary care;
- the role of social services and social care activity; and
- if loneliness and social isolation is embedded in activity around local infrastructure.

The approach was iterative, and as data was gathered from interviewees this further shaped understanding and context, although all respondents were asked the same

set of questions, with additional questions posed, where appropriate. NVIVO (v12)13[29] was used to manage and code interview data.

Question responses, as will be shown below are variable, unsurprising given the complexity of the theme, and they reflect variation in experience of working to address loneliness and social isolation, but some common themes arise too.

All interviewees were able to provide a response to most or all of the questions although given that the questions were expansive and asked participants to comment on activity out with their immediate NHS role (including in relation to GP, local authority and CPP, social service and social care led activity), respondents weren't always able to shed light on this. This is a limitation of this work as given limited time and resources, the views of those working in these sectors, such as social care, social services, HSCPs, local authorities and primary care staff, have not been sought.

4. Limitations

There are various caveats attached to the use of an approach that uses a very small sample of respondents to generate a better understanding about a complex, Scotland-wide problem, shaped by various factors, experienced by a wide range of population groups and that may be prevented, mitigated and addressed in manifold ways.

Clearly a limited pool of respondents precludes the generation of anything approaching a clear outline of the range of specific and generic factors that might shape loneliness and isolation locally (this would be a significant task), and how potentially worthwhile solutions, delivered across the public, third and private sectors, pitched both directly and indirectly at loneliness and isolation, might be being forged across all of the factors that shape loneliness and isolation, and population groups who experience it.

Therefore this short document can only seek to identify how public health and health improvement colleagues may be defining and constructing their own responses to loneliness and isolation and of their experiences, and observations, of how wider partners might be seeking to do the same.

5. Prioritisation

Participants were asked to comment on if, locally, loneliness and social isolation has been identified as a public health priority, and not solely by public health and health improvement teams and if so, was this generating activity within the NHS and among wider partners including HSCPs, IJBs, CPPs, local authorities and the third sector.

The responses are mixed, and we need to recognise that interpretations of what may be described as a 'priority' will differ, but in general the responses were positive and indicate that loneliness and isolation have been prioritised to some extent for public health and health improvement / promotion teams and for wider partners, or if not, loneliness and isolation are at least headed up the agenda.

Most interview participants thought that loneliness and isolation had been prioritised by their teams / departments (one felt that they were at the beginning of the process given current limited staff capacity[30]) and / or wider partners although for one, 'social connectedness' had in their opinion always been a priority, and so loneliness and isolation was simply a rebadging of this work to some extent.[31] For another, even if loneliness and isolation was not set down as a local public health 'priority' it was nevertheless featuring across a number of projects and programmes, proposed activity and public health intelligence work, and had been of interest well before the development of the national strategy but badged as developing communities and community capacity.[32]

In terms of how it might be prioritised by public health, health improvement / promotion teams, responses indicate that loneliness and isolation feature in a range of local activity for example around local mental well-being or mental health priorities,[33] [34] [35] the development of a local social prescribing framework, to provide definition and ensure service consistency[36] and in having developed local responses to the national loneliness strategy consultation, with the opportunities for engagement and influence this provided.[37] [38] In one area, the public health team are in the process of developing a local strategy.[39]

Dedicated work time for one participant and a colleague has provided the opportunity to prioritise the issue via contribution to the development of one HSCP nine year strategy and implementation plan. Its focus, initially on older people, with a 3 year LOIP priority around this, is to prevent, identify where lonely and isolated people might present themselves in the community, design responses such as signposting to re-connect individuals back into the community, and gauge what activity is already taking place to achieve this.[40]

Prioritisation is also clearly identifiable in several DPH annual reports. For example the 2016 DPH report for a large rural board, with a focus on loneliness and older

people, led to a series of recommendations, around building capacity in the third sector, identifying good local practice, the need for community transport, service co-production and social prescribing.

The perception is that the report, and subsequent promotion, raised awareness and acted as a catalyst for discussion among wider partners, the NHS, and the local authority and the CPP for example picked up loneliness and isolation to develop activity around. Engagement with the local media pushed loneliness and isolation up the agenda from a low base, and led to an incorporation of this awareness into various strands of work. Importantly, the focus on a local take on the problem in the report, e.g. by surveying a local sample to provide some indication of the prevalence of loneliness in older people, provided an opportunity for a local interpretation of the problem, deemed more useful than a national overview in generating interest.[41]

Elsewhere, loneliness and isolation form part of local public health priorities around mental well-being, as evidenced by inclusion as a priority within the 2018 DPH report, for a predominantly rural board, with a communication and engagement plan developed around this theme to generate momentum.[42]

How far loneliness and isolation are prioritised by wider partners and are generating activity, participant responses indicate that there are variable levels of engagement at least within wider partner plans and strategies (we need to acknowledge that the identification of activity around loneliness and isolation or proxies such as 'connectedness', across all plans and strategies, may not be feasible for participants to identify) as well as differences in emphasis in how these might be defined (isolation and loneliness might not be the only terms used) and addressed.

The clearest evidence of engagement with the problem, in one local authority area, as noted above, is a HSCP strategy and implementation plan, which sets out a range of actions to run to 2021, with some further activity noted by the participant in another local authority area including development of an action plan by a CPP, work with the Carnegie Trust[43] around kindness by another CPP, and some focus on the problem of loneliness and isolation in another HSCP strategy, with links now made with the interview participant to develop activity further.[44]

A further interview participant felt that loneliness and isolation were viewed as a priority and recognised as a key issue by the HSCP, learning community partnerships, and CPP area partnerships, even if activity was not thought to be particularly well joined up, with variability in the terminology used. Activity was identified as including multi-agency work to raise the issue, HSCP link worker provision, the provision of three local 'healthy living networks' based in deprived areas thought to have a focus on loneliness and isolation as well as local authority

provision of a ‘community capacity building’ team set up to link older people to community activities.[45]

In another board area, one LOIP (for one large town) was prioritising the issue with emphasis on intergenerational activities and physical activity to generate opportunities for social interaction, with several (limited) references to the problem across various HSCP plans and strategies in another urban area. There had been however in one city, CPP activity, including a dedicated multi-agency event with a network thought to be developed from this, and use of the Reshaping Care / Integrated Care Fund, to support delivery of projects to e.g. get the over 65s mobile via provision of community cars, to develop engagement opportunities, a men’s shed and LGBT focused work. There are aspirations in the same city to better link the wide range of services that support people, even if not directly focused on loneliness and isolation, to strengthen community involvement and consideration of e.g. participatory budgeting, tests of change and use of innovative technology.[46]

An HSCP strategic plan was identified by a further participant as seeking to reduce isolation by working with partners on developing community transport, while the LOIP is seeking to identify factors linked to loneliness and isolation, those at risk, and an agreed measure of and baseline estimate for isolation and loneliness.[47]

In other responses, participants can certainly point to an interest in loneliness or isolation by wider partners such as in the form of: reference to the problem in HSCP strategic plans and some LOIPs[48]; the enthusiasm of a CPP senior officer to include loneliness and isolation in the CPP strategic plan which is in development[49]; local authority interest, with brief references to loneliness and isolation in the LOIP, some locality plans, HSCP and local authority plans[50]; growing interest with three of four LOIPs making some reference to the issue, with others not necessarily making explicit reference to loneliness or isolation[51]; interest in loneliness and isolation but not explicitly,[52] and for one participant a sense that there was general engagement and conversation, but nothing specific going on around the problem.[53]

6. Public health and health improvement activities

Interview participants were asked how local public health and health improvement activities, interventions, or partnership working, sought to influence understanding, or prevent or mitigate loneliness and social isolation. This elicited a range of responses.

As noted above, activities that seek to shape understanding and generate activity have been channelled via DPH annual reports,[54] [55] developing responses to the national loneliness and isolation consultation,[56] [57] in the development of a local strategy (focused on at risk groups, to prevent, respond and re-connect individuals,

with an implementation plan focused initially on older people, with a range of actions attached to this),[58] but also for example via research and engagement activity to scope out the factors, barriers and enablers at grass roots level that support and promote 'kindness' in communities.[59]

Influence for one interview participant stemmed from ensuring public health representation on various groups, and community engagement,[60] for another, influence could be channelled through internal CPD to generate consistent messages in work with wider partners, the embedding of staff across localities and the local authority, building good relationships with them but also by being smart about linking the issue into engagement e.g. to family poverty, and making connections to lack of resources, and the increased risk of loneliness and isolation as a consequence. In work with wider partners, e.g. police, fire service, housing and planning, this means for this participant teasing out how to address loneliness and isolation upstream, before time and resources are required to address this downstream (e.g. police resources used post suicide attempt). This was deemed a particularly useful and important hook into the problem of loneliness and isolation.[61]

Another participant felt able to influence wider partners to engage with the issue and get it on their agendas, having a small team precluded much activity beyond this.[62] For another, they were now more able to influence by becoming more locality based, more accessible, by building relationships with others and by engaging with work around assets and community building.[63]

In terms of activities and interventions more broadly, responses provide evidence of activity that is directly aimed at addressing loneliness and isolation and also of activity where loneliness and isolation might be identified, and perhaps addressed, although not the primary aim of that activity.

Examples of activity that might be specifically aimed at preventing or reducing loneliness or isolation include supporting the development of an EU funded community navigator project (mPower) in one board and in work to encourage better identification of the problem in primary and secondary care.[64]

The provision of a local well-being service, in primary care locations including GP practices, health centres and the community, for clients referred from GPs, providing support for mental well-being and lifestyle changes, was identified by one participant as a tool by which loneliness and isolation might be addressed. 'Healthy living networks' in three locations of the same board, aimed at reducing poverty and inequality, but also focusing on providing opportunities to link into various activities such as tea dances, reminiscence work, cooking classes, drop-in lunches and a men's shed were also identified.[65]

‘Health points’ in another board, were identified as potentially useful given their role in providing information, advice and in referring onwards, and also public health team activity around the provision of more novel solutions such as ‘vintage tea parties’ (run by the NHS, the TSI and HSCP) aimed at older people to develop connections and links into wider activities, and in facilitating conversation, pop-up and recovery cafes for various groups including those in sheltered housing, as well as activity to support work to reduce loneliness and isolation in schools.[66]

Emphasis on the isolating nature of rural life and work, particularly farming, and following a needs assessment and engagement with the community, the health and well-being team in one largely rural board has provided support for the development of a small project, now a constituted and independent group providing activities for retired farmers, with seed money having also been provided to kick start a ‘men’s shed’, now running independently.[67]

Several examples of training or ‘resources’ were provided by participants including a workshop developed for the *Business Gateway* for self-employed workers, to address problems reported around mental well-being among this group, picking up on the theme of isolation.[68] In another board area awareness raising sessions were provided on the health impacts of loneliness and isolation, inviting those working with the most vulnerable, such as care staff and mental health workers in one local area to increase understanding including around how to identify the problem, raise with line managers and family and to signpost.

Staff awareness training sessions were trialled in another area, to increase staff understanding around how to signpost. One conclusion drawn from this however was that raising the issue was deemed appropriate only if staff were able to provide potential solutions.[69] In terms of a ‘resource’, a participant identified the development of a ‘6 ways to be well’ themed resource and signposting guide, focused partly on the themes of ‘belonging’ and ‘kindness’ used to support various forms of professional activity, group work and for use by the general public.[70]

In terms of activity that might be described as being less directly focused on loneliness and isolation, several participants did indicate that they felt that loneliness and isolation were featuring in some way across much of the work they do, even if not specifically badged in that way.[71] [72] Moreover as one participant pointed out, they felt that rather than seeking to generate new activity to support this agenda, more could be gained by engaging with existing services (with plans to do this), to consider the nature of service provision for specific groups, to think about addressing gaps and strengthening provision.[73]

Examples provided of wider, less direct work, include supporting the Scottish Mental Health Arts Festival, a focus on the themes of ‘connected’, and ‘Be Kind’ in a

diversity week programme of events,[74] and local delivery of the National Mental Health Week.[75] Further examples include supporting the delivery of cooking skills sessions, or CBT themed classes, run by the public health team, for people from deprived groups who might be isolated, to build resilience and communication skills, or working with the local Fire Service to think about how they may identify wider issues, when making home visits,[76] and also in past work to address lack of opportunity for disadvantaged children to participate in extra-curricular activities in a rural area.[77]

7. Measurement and tools

Participants were asked if locally, loneliness and social isolation has been measured, and if who might be most at risk defined and captured and if they were aware of any local tools or methods to identify those at greater risk of being lonely or socially isolated.

Given the lack of officially and consistently nationally, and locally, generated data that might highlight just how lonely or isolated children and adults in Scotland are, the prevalence of loneliness and isolation has not been clear. However by using proxies generated by surveys, as Teuton has shown, specifically around social networks (the number and frequency of social contact in families, workplaces and neighbourhood) and social support (quality of relationships in providing emotional or practical support) then it has been possible to shed some light on the nature of the problem.[78]

The data gap however is now being addressed to some extent via the inclusion of a loneliness specific question in the Scottish Health Survey, from 2019, and the Scottish Household Survey, from 2018. The questions to be asked in these surveys is as follows:

How much of the time during the last week have you felt lonely?

- None or almost none of the time;
- Some of the time;
- Most of the time;
- All or almost all of the time; or
- Don’t know.[79]

The findings of the 2018 Scottish Household Survey (SHS) which also includes several questions about social isolation, as well as loneliness, are now published, providing national and local authority level data.[80] Responses to a question asked by

the SHS about how often people have felt lonely within the last week (all ages) are reproduced below on Table 1 for Scotland and each local authority area (although samples in local authority areas are small).

SHS findings for 2018 indicate that at a national level, 21% of adults were lonely some, most, almost all or all of the time in the last week. 28% of those living in the most deprived areas experienced feelings of loneliness compared with those in the least deprived (15%). People living with a long-term physical or mental health condition were more than twice as likely to experience feelings of loneliness, and those living in remote small towns had a higher prevalence of loneliness compared with those living in accessible rural areas. Feelings of loneliness were highest in single-occupier households.[81]

Table 1: How often people have felt lonely within the last week (all ages)

Local Authority	% of those respondents who were lonely either: • Some of the time • Most, almost all, or all of the time
Scotland	21%
Aberdeen city	25%
Aberdeen	21%
Angus	16%
Argyll and Bute	12%
Clackmannanshire	34%
Dumfries and Galloway	21%
Dundee City	37%
East Ayrshire	18%
East Dunbartonshire	9%
East Lothian	20%
East Renfrewshire	14%
Edinburgh City	18%
Falkirk	45%
Fife	29%
Glasgow City	22%
Highland	21%
Inverclyde	14%
Midlothian	17%
Moray	20%
Na h-Eileanan Siar	17%
North Ayrshire	16%
North Lanarkshire	15%
Orkney Islands	19%
Perth and Kinross	16%
Renfrewshire	19%
Scottish Borders	15%
Shetland Islands	11%

South Ayrshire	20%
South Lanarkshire	18%
Stirling	15%
West Dunbartonshire	19%
West Lothian	43%

Source: SHS, Vocal Authority reports: https://www2.gov.scot/Topics/Statistics/16002/LAtables2018

In responses to the SHS social isolation related questions, most adults in Scotland (73%) reported meeting socially with friends, family, relatives, neighbours or work colleagues at least once a week. Middle aged groups (35-59) were less likely to do so than other age groups, as were those living with long-term physical or mental health conditions than those without. No differences were identified for urban versus rural areas or by area deprivation levels. Women met socially more regularly than men.[82] (Where there are differences in the prevalence of loneliness and social isolation for some groups, this might mean of course that while people do have social relationships, they might not exist in the form that they may wish to have, in order to prevent feelings of loneliness.)

Interview participants were asked, prior to the publication of the 2018 SHS, about local attempts to measure loneliness and social isolation. Not all could identify any current attempts to measure, or to define those most at risk.[83] [84] [85] [86] However non-survey based activity, such as engagement with communities in rural areas, or activity to identify issues associated with becoming isolated, such as fuel poverty,[87] or simply having a sense that professional groups, particularly those working in small, rural settlements had a good understanding of the individuals living within that area,[88] were deemed useful in their own right in understanding the nature and extent of the problem.

Responses indicate that there have been a handful of examples to quantify the nature of the problem and define those most at risk, by public health or health improvement teams, local authorities or an HSCP. These include:

- Gathering ad hoc data through the third sector, such as befriending organisations, to provide an insight into how many people might be experiencing loneliness and isolation, even if not particularly representative of the wider population; [89]
- identifying data from primary care, using proxies for loneliness and isolation such as disability, when working on needs assessments, to get a sense of the scale of the problem; [90]
- using a local component of the Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) to ask questions about loneliness and isolation to then link that to data about e.g. substance misuse; [91]

- using a random sample of 3,000 people, aged 65 and over in one largely rural board to measure loneliness to inform a DPH report. 15 questions were asked, including demographic variables, a set of six validated loneliness questions, three 'sense of coherence' questions, and a general health question; [92]
- use of locality data and mapping in one area to identify priority groups (elderly people, people with dementia); [93]
- a loneliness survey using the Campaign to End Loneliness measurement tool by an HSCP to provide a snapshot of loneliness in one local area in 2016; [94]
- a local authority household survey (2018) that included questions about loneliness and isolation, posted out to 6,000 randomly selected recipients, with results indicating that 33% of respondents had a significant issue with loneliness or isolation, although this couldn't be broken down any further beyond postcode.[95] The questions used by this survey for 2015 and 2018 were as follows:

2018	2015
Do you ever feel lonely or isolated?	Do you feel lonely or isolated as a result of living in a rural area?
• Hardly ever or never • Yes, some of the time • Yes, often • Yes, at certain times of the year • Prefer not to say	• Yes • No • Don't know • Prefer not to say

Further activity reported includes a public health led NHS Health and Well-being Survey, a local population survey undertaken every 3 years (since 1999), which has asked a question about isolation since 2008, thus providing data to describe the trend, with a further question about loneliness introduced in 2017. The survey provides a break down by area, age and gender, allows for comparisons across areas within the board and identifies how loneliness intersects with health, social capital, financial well-being and social health.[96] The questions asked for the 2017 survey were as follows:

How often have you felt lonely in the past two weeks?	Do you ever feel isolated from family and friends?
• All of the time • Often • Rarely • Never	• Yes • No • Prefer not to say

In another board area, the public health team have recently made use of a citizen's panel survey to identify views on loneliness in one local authority area.[97] There are plans in another board area to use the UCLA *Three Item Loneliness Scale*, which the health improvement team are trying to promote, in questions for a local citizen's survey panel using a sample of 1,000 people to measure a baseline prevalence of loneliness as well as use of the SHS loneliness question and plans to use the UCLA tool including in a deprived area, via tenants and residents associations, although there were thought to be a number of practical barriers attached to doing so.[98]

In terms of local tools or methods to identify those who might be experiencing loneliness and isolation, clearly there are locally developed questions, as identified above, and responses provide evidence of the use of a variety of internationally recognised tools, or parts of those, to measure loneliness or isolation, although few participants had any direct experience of using these. Where responses were provided, these indicate some use of the following tools and scales by participants and wider partners, or promotion of these by local public health or health improvement teams:

- The UCLA Loneliness Scale (*Three Item Loneliness Scale* from the *Revised UCLA Scale*) is promoted by one health and well-being team and is thought to be used by some local GPs, although use might be low, mental health workers, community link workers / social prescribers and in several EU funded local health and well-being hubs. A barrier however is around ensuring that technology is able to capture data that can then be used to generate reports[99]
- The *De Jong Gierveld Short Scales for Emotional and Social loneliness*, *Duke Social Support Index, social interaction subscale*,[100] and the *Warwick-Edinburgh Mental Well-being Scale*, used by a community navigator project, pre and post intervention, promoted and supported by the public health based interview participant. Data is being gathered for the local IJB to determine if and how a community links worker service will be provided when the EU funded community navigator project ends[101]
- The IoRN (*Indicator of Relative Need*[102]) tool adapted by the public health team for social care use and including questions around loneliness and isolation. How well this is embedded in practice is unclear, the interview participant thought that there might be a certain nervousness around its use and in asking questions about loneliness and isolation more generally, perhaps because people don't have sufficient, or any, training to do so[103]
- Use of a *Risk Stratification Tool* for an EU funded project where there was an interest in identifying older people at risk of hospitalisation for a range of reasons including lack of social support at home. This included a trawl of primary care data to identify some markers potentially linked to social isolation, and for many of those patients identified, social isolation upon visiting these individuals, to introduce the project, was thought to be a

significant aspect of their lives[104]

- Use of De Jong Gierveld *Short Scales for Emotional and Social loneliness* and use of a *Sense of Coherence* scale (Antonovsky) used to identify loneliness in a sample of older people in one board area[105]
- Use of a 'holistic needs assessment' in acute clinical care settings for some patients using the same methodology applied to MacMillan's *Improving the Cancer Journey*[106]
- The use of a tool linked to MacMillan's *Improving the Cancer Journey*, with link worker follow up[107]
- Use of questions based on Manfred max-Neef and his theory of human needs[108]

Other responses identify for example local third sector work with St Andrews University to develop a tool which can be used to measure how isolated individuals are,[109] third sector use of *Warwick-Edinburgh* on activity seeking to reconnect people back into the community[110] and by an EU funded social prescribing service, run by the third sector.[111]

8. Population groups

Loneliness and isolation can impact on individuals across a broad spectrum of the population, at multiple points in life, and not exclusively older people, where research interest and activity has tended to be located although clearly a range of factors increase the risk of loneliness and isolation for this group such as retirement, reduced incomes, health conditions, reduced mobility and becoming a full-time carer.[112]

Therefore participants were asked if local activity to address loneliness and isolation includes a consideration of the needs of ethnic minorities, LGBT, carers, young parents, adolescents, those with poorer health, disabled people and lower socio-economic groups, as well as older people. They were also asked to comment on if locally, loneliness and isolation among children and young people was being considered.

The picture in Scotland about who might experience loneliness and isolation indicates that while anyone can be affected, some groups are at greater risk. SHS findings, as noted above, point to greater social isolation among the middle aged and those with long-term health conditions. For loneliness, those living in deprived areas, living with long-term health conditions, those living in remote small towns and in single-occupier households might be most impacted. By age, loneliness appears to be higher among older (74+) and younger groups (16-24 and 25-34).[113]

Poorer health and disabilities, including intellectual disability, can limit social contact increasing feelings of isolation and loneliness, and for those who care for them.[114] [115] [116] The relationship between mental health and isolation and loneliness is likely to be bi-directional, i.e. mental health problems increase the risk of loneliness, and loneliness contributes to mental health problems.[117] Those, who as a consequence of the stigmatising effect of having a low income or living in poor social and physical environment, are more likely to be impeded in their ability to build and maintain friendships and socialise.[118] It's not only economic factors such as a lack of sufficient income to afford to participate in social networks but perceived and actual discrimination based on ethnicity, race, nationality, health status, sexual preferences and age can achieve the same.[119]

In terms of the question asked, we need to recognise the difficulty for participants of identifying how loneliness and isolation might be being considered locally across all of the groups identified. The responses tend to indicate local awareness of those wider groups and the risk of loneliness and isolation, with further complexity identified for example in the centrality of the problem of rurality, and rurality and inequality, and loneliness and isolation, in a number of areas of Scotland.[1] [120] [121] Several interview participants thought that existing interventions and programmes including those working with some of the groups identified above[122] [123] [124] [125] or activity by certain professional groups such as health visitors[126] would link to preventing or reducing loneliness and isolation, even if not specifically aimed at that.

Others identified the existing focus on inequalities, equality and diversity[127] [128] or use of impact assessments for example[129] [130] presumably as a means identifying if those groups have access to services or opportunities, or if activity or policy in one form or another would be detrimental. The responses do however highlight a perception of there having been a greater focus on older people, over any other group.[131] [132] [133] [134] [135] [136] [137] [138]

This might be for reasons to do with pragmatism and to fit with local priorities (although local plans are also focused on a wider range of groups but with an initial

[1] Several contrasting pictures emerge of nature of rural or remote rural life in this work, the isolating nature of rural life but also as several participants identify a strong sense of community (it might be difficult to break into this if you are a newcomer), with high levels of participation and connectedness (which might make life more difficult if you are not part of this). Interviews 8 / 13

focus on older people),[139] or for reasons associated with the demography of the area, but with attention also extending to adolescents and younger people,[140] or to fit with health and social care integration and pressure on services for older people and to generate greater local traction by applying a narrow focus, as in a loneliness and isolation themed DPH annual report, which is what is perceived to have happened.[141]

Children and Young People

The available data, gathered by HBSC Scotland for 2010, indicates that significant numbers of children experience some degree of loneliness. For peer and friendship relationships, HBSC data indicates that a significant minority of children have poor peer support and this appears to be more of a problem among older children, although only a small minority have limited friendship networks.[142]

Responses around if locally, loneliness and isolation among children and young people was being considered, most participants identify awareness, and some form of activity, even if it is not necessarily badged as loneliness and isolation related work, such as addressing adverse childhood experience, to then prevent loneliness and isolation further down the line,[143] or if not explicitly mentioned across strategies and plans (CAHMS, children's service plans, young carers strategy) priorities could nevertheless read across to preventing loneliness and isolation, such as by seeking to improve social connectedness by tackling bullying, or by providing pupil and parenting support.[144]

One participant thought that a local review of services for children and young people with emotional health and well-being problems, was taking loneliness and isolation into account, with training rolled out across schools and youth work settings, with a new third sector provided service commissioned to support the mental health of children and young people (10 to18) in schools.[145] School based mental health and well-being services or activity are identified by several other participants as one means by which loneliness or isolation might be identified[146] [147] with public health support in one area for activity in schools around an annual health and well-being project on reducing loneliness.[148]

Another participant identified local promotion of the 'One Good Adult' approach which emphasises the importance of having one good adult in the life of a child or young person to protect mental well-being,[149] with further local activity around *Scottish Mental Health First Aid* for children and young people.[150]

Other responses identify local partnership work around corporate parenting and looked after children,[151] or plans to work around this specific group, and young carers,[152] the development of a local framework, led by the local authority education

service to support child emotional well-being, with a focus on the importance of social connectedness,[153] and several mention the availability of local befriending activity, presumably delivered by the third sector, aimed specifically at children and young people.[154] [155] [156] [157] [158]

9. Mapping of activity

The identification or mapping of all local activity that might impact on loneliness and isolation would be a herculean task, prone to out-datedness and irrelevance, and the range of activity that might be described as addressing this in some way might be difficult to define. However, given an awareness of tools such as ALISS, it was deemed worthwhile to ask participants if locally they were aware of any activity to identify or map the range of services and interventions aimed at supporting those experiencing loneliness and isolation.

Responses highlight various pockets of activity within board areas and most can point to some service 'mapping' of some kind, whether involving themselves, the third sector or local authority, not specifically aimed at capturing services focused on loneliness and isolation, although presumably the rationale for the provision of most services will not be loneliness or isolation anyway.

In terms of mapping, much of it online and accessible to the general public, several participants mention use of ALISS (https://www.aliss.org/)[159] or activity to develop ALISS content by working with partners to do so.[160] [161] In one board, there has been a commitment to significantly increase the number of records on ALISS about local groups and organisations, working with wider partners to raise awareness of the resource, and while it is deemed to be a useful tool, there was a lack of certainty around how far ALISS is being used by practitioners to signpost people to activity.[162] There are varying perceptions of its usefulness. It is viewed by several participants as in theory, a good idea, but as with print directories was prone to being out of date,[163] [164] [165] with resource required to ensure currency[166] and potential issues with information quality,[167] its layout and data inputting.[168]

Further public health or health improvement / promotion activity has included mapping some services and third sector providers delivering services that address loneliness and isolation, directly or indirectly, for a DPH annual report,[169] the development of a signposting resource, with focus on belonging and kindness,[170] mapping out green health activities emphasising opportunities to connect and volunteer,[171] and work with community learning and development colleagues to map various activities in a number of communities, and identification of mental health related services at board level, but deemed an onerous task, best pursued at a more local level.[172] One participant thought that rather than map activity a more useful

approach, and one that would be attempted in the near future, was to better understand the plethora of activity already going on by engaging with those providers to get their views, as part of wider activity around identifying assets.[173]

There are also references to mapping of a range of activities and organisations by HSCPs,[174] [175] or local authority mapping of mental health services,[176] of bereavement related services,[177] or services in general[178] [179] [180] and by the third sector, such as Red Cross activity to map events across a number of towns,[181] the development of a directory by a local Third Sector Interface, and mapping of various services by a third sector provider working directly with the lonely and isolated.[182]

We don't know how far these sources might be used by those who are lonely or isolated, or by those professional groups working to address this, or how far various information sources developed and delivered by multiple providers might be complex and confusing for users. The perception of such resources by one participant was that they relied on the lonely and isolated to identify activities, and in their view, if they were able to do that then loneliness and isolation may not be a problem.[183] As several participants pointed out, link workers or social prescribers, where in place, would also be likely to source information about community activity[184] [185] [186] and this local knowledge, in the opinion of one of those participants, would be more useful than any form of board wide mapping.[187]

10. Assets and community development

Participants were asked if local asset mapping, asset based community development, or community development in general, was forming any part of local activity to prevent and reduce loneliness and social isolation. The focus of this question therefore is on identifying if asset based approaches to community development, supporting communities to act together to improve local circumstances, that focus on the positive capacity including strengths, skills, knowledge and connections of individuals and communities, rather than their needs, deficits and problems[188] are forming any part of activity.

One definition of the asset based community development approach states that it seeks to create change by identifying assets (community associations, local services, informal groups and networks, and the skills, knowledge and commitment of residents) and by focusing on strengthening relationships within communities and on community initiated activities.[189] It might follow through therefore, as McNally points out, that activities such as social prescribing can really only take place and be truly successful where community development activity is in place and communities are supported to design, develop and maintain initiatives that offer opportunities for social interaction.[190]

The responses to this question are mixed. Participants certainly allude to community development but further exploration would be required to dig deeper to, for example, identify practical examples of how isolation and loneliness might be informing and shaping community development and asset mapping on the ground.
Participants identify for example what they perceive to be very useful activity that could address loneliness and isolation, such as via community development workers based within a public health team, seeking to make connections and develop opportunities[191] and via local authority provision of regeneration officers with, broadly, a community development role to build capacity in the community[192] and also for example via local authority provision of a community capacity building team, set up to engage with local communities by supporting adults though the provision of activities and to encourage communities to create and run their own activities. Local learning community partnerships, with a range of partners, are thought to be taking part in useful community engagement in one board area[193] and elsewhere, there was thought to be a very buoyant community learning offer.[194]

One participant thought that asset mapping and asset based community development was taking place and even if not badged as such was thought to be focused in some way on reducing loneliness and isolation, and this was taking place via the local community planning structure, particularly at locality level, with work forming part of local plans and activities for each locality.[195] In another area community development activities were thought to be apparent in local community plans, including around loneliness and isolation, identified as areas for community action in some plans.[196]

An HSCP local loneliness and isolation strategy in an area of one board has aspirations to identify assets in localities via use of mapping, relationship building and by mobilising community members and so there has been activity to identify existing work around this.[197]

Several others thought that local events, involving a range of partners and services, have at least or will provide opportunities to think about assets,[198] [199] [200] or have plans to engage in asset mapping[201] or are seeking to engage with for example the third sector to identify what the gaps in provision may be and how their activity might be strengthened around this agenda.[202]

The perception that there are insufficient resources however to support community development emerges in several interviews.[203] [204] [205] For example, one participant identified a lack / loss of community development workers and while asset mapping was fine, community development for the participant is the bit of activity that is about having skills on the ground to galvanise support from the ground up.[206] The lack of community development workers in another area was identified despite the ‘big

expectations around it' as well as the limited capacity for other professional groups, such as public health nurses and health visitors, to focus on supporting community development and so, in their view, there weren't enough 'players on the ground' because it [community development] is hugely resource intensive.[207]
Similarly, a further participant thought that while community learning and development staff had been looking at asset based community development for some time and were perceived to have done good work, they had been under-resourced to build any kind of momentum but it was anticipated that future joint working with the health improvement team might provide more opportunities to build better links.[208]

11. Primary Care

Participants were asked if there are local examples of primary care activity to identify loneliness and social isolation. Few participants were able to provide a response, and this might be because GPs and other primary care staff are engaged in this type of work relatively infrequently or because participants might not, in their roles, be connected into activities in primary care to shed any light on what might be taking place.

Based on the responses however we do know for example in one remote, rural board there have been attempts, led by public health, to identify if data about loneliness or isolation can be collected by primary care. If gathered, extraction of that data (for use by the public health team) is deemed relatively easy given access to all primary care data through the shared IT system. At present, data collection is limited to information about any onward referral to other schemes that might support the lonely or isolated. There has been however resistance from GPs to the gathering of loneliness or isolation data centring on time barriers, how information might be captured and who might do that, e.g. reception staff or other non-clinical staff, and how that could be done sensitively.[209]

One other participant however did mention that the UCLA *Three Item Loneliness Scale* might be used locally by some GPs, among a range of groups, although that use might be low.[210] Another participant mentioned that they had been asked by some GP practices to provide awareness raising training on loneliness, and kindness to administrative staff. In the same area the HSCP loneliness and isolation plan has ambitions to link with GPs, to increase rates of social prescribing and referral, and to use GP practices as spaces that identify local opportunities, with some work also taking place with GPs in one area to encourage referral out to 'community assets' and not solely to other primary care services.[211]

11.1 Secondary Care

Although not a question within the question set, several examples of activity or planned activity were reported by participants around how loneliness and isolation might be identified in secondary care (and it is assumed that volunteers, or possibly other NHS provided services, and the third sector will be active in many hospitals providing engagement, advice, or befriending services, in some form).

For example, in one remote, rural board, changes to hospital admission documentation has prompted the inclusion of several questions, developed by the interview participant, around loneliness and isolation to determine if either were a factor in admission, particularly among older age groups. The questions were accepted on the form but given uneasiness among nursing staff about asking these questions as a routine, and the relevance of these questions to each patient, their inclusion has not yet taken place.[212]

Talks have also taken place in the same board about hospital discharge and e.g. how social prescribing (community navigator) personnel might be attached to the discharge planning process sitting in a multi-disciplinary discharge meeting or by having some link into that. This might be further explored in one small local hospital, where the scale of activity is one which is thought to allow a community navigator to take part in meetings.[213]

Another participant alluded to the provision of a ‘better health hub’ based in one acute hospital, with plans to provide the service in community hospitals, where health improvement staff refer people into opportunities or signpost (but don’t support their attendance by buddying them along to an opportunity). Additionally, the participant has been in discussion with several acute hospital departments, including audiology and sensory impairment, who are keen for staff to be trained given that they are likely identifying loneliness and isolation in those patients but perhaps don’t know how to respond to that.[214]

Other services co-located within hospitals include in one board a ‘health point’, providing information and advice on a drop-in basis, thought to be one means by which loneliness and isolation might be identified.[215] Another alluded to activities around the development of advice services in one large hospital, and possibly a discharge hub, and both could potentially link to issues around loneliness and isolation, and the development of services attached to a health and care village that seeks to provide a community café and therapeutic activity, greenspace and arts related activity, most likely with older people. [216]

The perception for a further participant was that there would be an awareness among hospital staff that some patients are lonely or isolated, but not necessarily the

means for staff to do anything about it (and health care staff might only seek / choose to identify loneliness and isolation where they felt they could do something about it). However opportunities to identify and ameliorate loneliness and isolation were thought to exist given that acute hospitals in the same board provide information and support services (with structured pathways or clinical knowledge pathways,[217] for some non-clinical problems, but possibly not loneliness or isolation, that provide direction around how individuals might be supported, where and by whom.) The same participant also alluded to 'holistic needs assessment' taking place in acute care settings for some patients, such as those with cancer, where there is a high degree of vulnerability and complexity, with the same methodology applied as MacMillan's *Improving the Cancer Journey* (to consider and address the emotional, practical and financial effects of illness[218]) and presumably this tool could identify loneliness and isolation.[219]

12. Social prescribing and community referral

Participants were asked if social prescribing or community referral schemes are available locally in primary care settings and if they are appropriately oriented towards, and resourced, to make a significant contribution to supporting the lonely or socially isolated.

There are various terminologies in use, social prescribing, community link working, navigating or connecting that describe broadly the same role, which in essence is about supporting individuals to cope with non-medical life circumstances. These roles should be integrated into GP practices or clusters to reduce the pressure on GP services, and have strong links to community based services that they can refer patients into.[220] [221] The Scottish Government is committed to providing 250 Community Link Workers, as part of the new GP contract, with 53 Scottish Government funded posts (at 2018) working in areas of socio-economic deprivation in Dundee, Glasgow, North Ayrshire, Inverclyde and Edinburgh. The role of the link workers will be set out by HSCPs based on assessment of local need and collaboration with GPs, patients and the third sector.[222]

Most interview participants could identify something they thought could be described as a form of social prescribing or of link working even if not badged as such (several thought that there had been some headway at least in primary care staff embracing social models of health[223] [224]) and the picture appears to be variable both across and within boards in terms of what might be available. This is unsurprising given the complexity of the sector[225] as shown in Dundee focused research which identified that social prescribing is provided across a range of themes, by the public, third, private and faith sectors, offering varying degrees of support from information

provision and signposting to support to contact or access services,[226] and also in examples of provision provided by the third sector.[227]

We need to acknowledge therefore that it could be difficult for interview participants to construct an overview of the community linking / social prescribing sector across each board area given its likely complexity in some (or most?) areas, and the responses therefore are very unlikely to map all activity that might have some connection into primary care, or to be able to tell us much about if existing linking and prescribing resources are sufficiently oriented or resourced to make a significant contribution to supporting the lonely or isolated.

We know that there is variability in provision of 'community link workers' across Scotland, as noted above, and this emerges in responses, as well as concerns about the level of provision, capacity to accommodate link workers in GP surgeries, and third sector capacity to cope with referrals into the sector from link workers and social prescribers.

Several participants mentioned that 'community link workers' have yet to be provided or the type of model of provision to be applied is yet to be defined.[228] [229] [230] [231] In one board area, a small number of link workers are expected, in more remote areas only (currently being developed by the third sector, given limited capacity in the health improvement team),[232] while in another there appear to be link workers of some form focused on mental health, delivered by the 3rd sector, although there appears to be plans to develop the community link worker role in all areas of this board, with a further phone based service (not dependent on GP referral) and signposting guide, seeking to link people into various opportunities.[233]

In a large rural board, the public health team are designing a programme working within a financial envelope which might extend to 10 to 12 link workers, working across up to 65 GP surgeries, which could mean as the participant pointed out, relatively small periods of time available for link workers at GP surgeries. The lack of space to accommodate link workers, as physical accommodation in surgeries is very stretched, may pose further difficulties. Concomitant with this is a need for local activities for link worker clients to be referred out to, and the participant thought that there may not be sufficient third sector or community provision in some more remote areas.[234]

Further responses highlight a mixed picture around service provision within boards. For example in an area of one board, there are thought to be a reasonable number of community link workers, and certainly this area is identified above as a recipient of the first tranche of community link workers, but the position elsewhere in that board is not clear.[235] In another, community link workers are linked to all GP practices in one city, a green health prescription has been launched in the same city, with social

prescribers thought to be based in some rural areas, with mental health workers in one locale thought to be linking clients into community support.[236]

In another board, HSCP funded link workers are attached to all GP surgeries in one city, employed by a 3rd sector organisation on behalf of the HSCP although a lack of services / opportunities to link people into is mentioned, particularly dementia and befriending services and community activities with transport. Mental health link workers are available in another area and based in GP surgeries (HSCP commissioned, delivered by the third sector) with plans afoot in another area for the HSCP to commission out a signposting service, with plans to recruit link workers with a presence of some form in each GP practice.[237]

For a further participant, the availability of link workers, in a large urban area, where community link worker posts have been created, was thought not to 'stack up' in relation to coverage for all surgeries and how far link workers are available in all areas of deprivation is not clear. A question was also raised about what they perceived as the limited capacity of organisations, including in the third sector, that provide opportunities for those referred to them by link workers, that could potentially lead to a 'push back' from the sector, amid perceptions that it is somehow a 'free resource'.[238]

In another board area, link workers appear to be provided across all local authority areas within that board and include 'community connectors' (HSCP funded, third sector managed, aligned to GP practices), 'community link practitioners' (HSCP funded, primary care based) and community link workers (in all GP practices, delivered by the third sector for the HSCP(?)). Link 'practitioners' were thought by the participant, to have some capacity to do more than simply point to an opportunity, i.e. potentially some buddying along with the individual to attend opportunities, but duration of that support might not be long enough, and that links between the service and clients might lapse too quickly.[239]

In a slightly different arrangement, in one board, link workers are provided from the health improvement team, based across the board (remote, rural), including in primary care, seeking to link individuals into their communities or with other services. The interview participant felt that there were opportunities to build relationships with those using the service and knowing other services well enough to avoid linking people into 'faceless' services was useful, as well as having the ability to follow up, although they also mentioned that the service was less able to identify those who weren't actively seeking out support from services (existing users might already be more connected and motivated) and that the service might therefore be simply 'reactive, firefighting'.[240]

In another (rural) board area, community link workers have not yet emerged, but an

EU (INTERREG) funded project, mPower, also delivered in two other NHS board areas, has direct public health team involvement and is providing three community navigators with a presence in primary care, sitting in practices on occasions, with aspirations to do more of this as well as to take referrals from the third sector. The project is running to 2021, with evidence being generated about impact (via use of various scales to do so) to inform how / if the local IJB will provide community link workers. Referrals to mPower take place via the SCI gateway system and upon referral, the navigator will go to meet the individual to assess need, draw up an action plan then re-visit to assess progress, bearing in mind that there may not be a great deal of local capacity to support all referrals, such as referral out to befriending opportunities, by the navigator. The service, offered to all adults but targeting older people, is at an early stage but uptake has been limited, despite loneliness and isolation perceived as being a significant problem in the area, and this may be because individuals are reticent to present themselves as such,[2] and that social prescribing differs from befriending is perhaps not understood in the community and among professional groups. The project is therefore seeking to find a route to tap into unmet need, address stigma and discourage referral by professionals to befriending as the default solution. There are also aspirations to assess use of or to provide technology to support lonely or isolated people (as used by a programme previously in the board aimed at elderly people, with intergenerational activity featured as part of this, to link children with older people via technology).[241]

The situation differs again in another area, a primarily rural board, where there are multiple providers of social prescribing / link working opportunities, provided and funded in different ways, and available in different areas, but with a need for 'more boots' on the ground, particularly when EU funding is lost for two local projects and for more monitoring of referrals and evidence about need (and more opportunities for 'natural connections' within the community and not just via link workers or equivalent).[242] In one area a Community Link Worker service is operating taking referrals from e.g. GPs, Social Work, Mental Health Team, Occupational Therapy, cottage hospitals and the third sector. In another, the EU funded (mPower) NHS led project is working with over-65s with long term conditions, with social prescribing and digital health interventions, with three to four sessions provided with flexibility in this, run by a project manager and two navigators, and funded to 2022.[243] Further social prescribing opportunities are dotted across several other areas, provided by NHS

[2] As several participants pointed out, loneliness and isolation aren't particularly ideal terms (Interviews 7 / 9) and for one, past activity with a local volunteer centre and focused specifically on engaging with the lonely and isolated hadn't been particularly successful and it was felt that this was because of the stigmatising nature of the problem. Consequently, more positive language is now being used around the issue, such as building communities, connecting people and creating kinder communities. (Interview 7).

health improvement, allowing for referrals from e.g. GPs, social work and nursing staff. In addition to this, in several locations are an EU (INTERREG) funded project that aims to promote healthier lifestyles, with connecting into the community featuring in the service offer. Covering parts of the board area is SPRING, a social prescribing project (also available in one other board), which is a partnership of the Healthy Living Centre Alliance and Scottish Communities for Health and Well-being, funded by the National Lottery, based in the third sector, and provided by volunteers. The overarching aim is to support and guide individuals into community activities, following GP or healthcare professional referral.[244]

SPRING, in a second board, where the provision of community link workers is yet to be worked out, is delivered by the third sector, linking into GP practices and a local well-being service, an integrated NHS health and social care service to help individuals make changes to their health or well-being and based in primary care (the service is making referrals and signposting but not actively helping people attend, as some link workers and social prescribers would, deemed a bit of a gap in service provision). Link workers are also attached to a mental health and learning disability area co-ordination team. GPs can chose which service to refer into and there is thought to be some negotiation required around how for example the well-being service and SPRING might complement one another, and to avoid duplicating effort and processes for clients and also some apprehension about how sufficiently resourced SPRING will be given some reliance on the use of volunteers and the size of the geographical area it might cover.[245]

In terms of other opportunities not all badged as social prescribing or link working, but that might lead to loneliness or isolation being identified, several of which would have connections with primary care, participants mentioned:

- Making Every Opportunity Count (MEOC) training, led by public health staff, which uses a self-completion form that asks about how individuals are feeling as an ice-breaker to explore wider issues to then provide information and signpost if required;[246]
- exercise or green exercise referral schemes;[247] [248]
- local area co-ordinators (relatively few in number) and HSCP and voluntary sector funded in one board, attached to specific localities and for whom connecting people into the community might be one aspect of their work;[249]
- Red Cross provided ‘Connecting Communities’, offered in four locations in Scotland, to link volunteers to those who might wish to be better linked into opportunities;[250] and
- The House of Care model used by GPs to support people with long term conditions.[251]

13. Social services and social care

Participants were asked if locally, there are examples of social services and social care activity to identify loneliness or isolation, or of linking out to other service providers to source support for patients or clients. Not all were able to comment[252] [253] [254] [255] e.g. because of a lack of direct contact with the sector within the context of workplace activity.[256]

The responses tend to raise more questions, and this is unsurprising given the breadth and scale of the sector, how, where and who it is delivered by, and point to the need for engagement with individuals in the social services and social care sector to find out more about how loneliness and isolation is or might be identified and if training is provided, and by whom. This is outwith the scope of this work.

In terms of direct opportunities to address loneliness and isolation, one example was provided of working with the local social care sector to encourage referral into the local community navigator service project (mPower), and use of specific questions around loneliness and isolation, but with nervousness around this, possibly because people don't have sufficient training around the problem.[257]

Less directly, the provision of a number of social care hubs based in the community in another board staffed by e.g. social work, a local community capacity building team (to support individual's independence and community involvement), occupational health and health improvement staff, supported by third sector partners, without the need for GP referral, was identified as one means by which loneliness and isolation might be identified in those accessing the service, with signposting of clients such as out to third sector groups working with the hub.[258]
Other opportunities to identify loneliness or isolation were thought to present themselves within the context of adult social care assessments that consider wider family and social support for the individual being assessed, but how that would be recorded and acted upon is less clear.[259]

For social care staff providing care in client homes, if loneliness or isolation are identified, recorded and passed on to those who may provide support was thought likely to depend on the individual member of staff providing care, if they are able to recognise loneliness and have an awareness of what they may do[260] (and staff were thought by local care managers in one area to be good at this[261]).

The practicalities for some social care staff however of identifying and addressing loneliness might be problematic given limited resources, tight time scales and the pressure on staff to complete tasks very quickly, likely precluding much engagement with clients, and where channelling any observations about loneliness or isolation may be impossible.[262] [263] Multi-disciplinary meetings about clients however, including

where link workers are attending, might be one route whereby loneliness or isolation may be more usefully addressed.[264]

Even where identified, the sticking point however might be around client referral onto something or someone to provide support (having ready access to an online tool that highlights opportunities in the community could be useful[265]) and training to support social care staff to do this.[266] Furthermore, the issue was raised about concerns around sharing and passing on information to others by care staff about a client, especially to the third sector but also the NHS, where loneliness and isolation are identified by care staff, as well as the need for training in knowing what was available to refer people on to.[267]

The extent to which social care, or social services staff, might be trained, and who by, in identifying or addressing loneliness or isolation is not clear. One participant, as noted above, indicated that awareness raising sessions, with care staff in attendance had been provided (if this is a regular offer is not clear).[268] A local implementation plan focused on loneliness and isolation is however seeking to improve the knowledge and skills of key services including home care, social work and housing services in identifying and responding to the lonely and isolated.[269]

In another board area, the third sector was thought likely to provide training, but how routinely and what that might include was unclear.[270] Another pointed to internally generated training around for example therapeutic one to one intervention work, offered out to the third sector, with plans for further workforce development.[271] The view of one participant was that learning and development plans for social care staff had not been established, at least locally on a number of key themes.[272]

Several participants were keen to point out however that the key to addressing loneliness and isolation wasn't simply via health and social care encounters. One board is developing activity around compassionate communities, i.e. what communities can do to help themselves (such as meals on wheels) and to deliver it and provide opportunities for social engagement, and to consider how such services can make connections into health and social care, when loneliness and isolation are identified.[273] For another, one route might be around promoting, and re-building, the notion and practice of neighbourliness.[274]

14. Change or closure to local services

The wider context within the last decade has been one of public sector austerity and cuts to services. The precise nature of this is difficult to identify but we know that Local Government funding in Scotland, as in the rest of the UK, is not particularly advantageous with a 6.9% real terms reduction in Scottish Government revenue

funding since 2013/14.[275] Spending cuts are estimated to have been greater in more deprived Local Authority areas than in more affluent areas, with increases in Local Authority fees and charges in an attempt to offset budgetary pressures, and thus more likely to impact on those with lower incomes, who are already more dependent on public services.[276]

Reduced funding, including from the public sector, and increasing competition for a diminishing pool of resources, has also been a feature of the experience of the third sector in Scotland.[277] (We need also to recognise the loss of income for many families and individuals in Scotland as a consequence of welfare reform, with an estimated £3.7bn reduction in welfare spending in Scotland between 2010 – 2020/21[278] and more broadly, rising income inequality, rising poverty rates and stagnant median incomes[279]). How far the broader economic environment in recent years might exacerbate the problem of loneliness or isolation would be extremely difficult to gauge but we have to assume that it would shape the picture in some way.

In participant responses to a question that sought to identify if loneliness and isolation had been taken into account in any changes to or closures of local services, there was a lack of certainty around this or a sense that it probably hasn't been taken into account[280] [281] [282] [283] [284] [285] (although one thought it might have been included in one service review)[286] despite, as one participant stated, there having been fairly hefty decisions [around service provision] made in local authority areas in the previous year.[287]

This is a broad question, requiring identification of what services or resources have been lost or reduced or changed, in both the public and third sector, and so limited responses might not be particularly surprising. One interview participant identified a lack of ability to influence such decisions, around service closure or change, at present but the incorporation of *health in all policies* in community planning was deemed as having potential to provide access to a range of policy areas.[288]

For several of those based in predominantly rural boards there was a lack of certainty but loneliness and isolation was thought to feature somewhere in service planning discussions, or might be identified in local equality and diversity impact assessments[289] or, for example, in discussions about transport links in particular.[290]

The threat of closure in rural areas as one participant pointed out could act as a rallying cry for communities (with evidence of community take-over of some assets), with loneliness or isolation possibly featuring in this, but how much weight communities might have to face down the loss or change of resources might be limited.[291]

15. Transport, active travel, housing, regeneration, public spaces, green space and local digital technology developments

Participants were asked if loneliness and social isolation, and fostering connections were embedded in local activity and plans around the following:

- Transport and active travel;
- housing and regeneration;
- public spaces and greenspace; and
- local digital technology developments.

The question is asked because of the centrality of transport, housing, public spaces, and digital technology as key factors thought to shape loneliness and isolation.[292]
The responses to this question are mixed, and don't shed a great deal of light on these factors but the question is very broad and would require participant engagement with activity and plans across a wide range of local authority activity in particular, and beyond.
In terms of **transport and active travel** (the focus of responses has been around the former), a number of participant responses acknowledge the lack of or very limited nature of public transport provision across all or part of the geographical areas covered by their board, and in many areas this will be provided solely in the form of bus transport, or by community transport.[293] [294] [295] [296] [297] [298] [299]

The absence of commercially or local authority operated transport might be partly addressed via provision of community transport schemes of one form or another. The importance of community transport is acknowledged by several participants[300] [301] [302] and which might be very strong in some places[303] and may also be a source of opportunities for social activity, as well as transport,[304] but it might be possible to state that it can't easily assuage the lack or limited provision of public transport, and the high costs attached to its use in many places.

The national loneliness strategy sets out broad aims to make improvements to transport such as via the Transport (Scotland) Bill, now passed, and this might provide greater opportunities for example for Local Authorities to determine the nature of public transport, specifically bus services[305] although this clearly would be some way off in the future. At present, the challenge appears to be significant, and the Scottish bus industry comprised of 200 operators of varying size, has been contracting with fewer staff, buses, routes and users (with community take-over filling some gaps) and rising fares,[306] [307] [308] [309] and not solely in rural areas.[310]

Transport is clearly on the agenda, identified as a problem for many local areas particularly, and unsurprisingly, in those areas with significant stretches of rural and remote rural geography.[311] [312] [313] [314] [315] [316] [317] [318] [319] Just how far loneliness and isolation might be informing conversations around transport is unclear but clearly any activity to improve transport options is a positive step in terms of loneliness and isolation.

The responses indicate that participants are raising awareness locally of the issue.[320] [321] [322] [323] It features for example in one DPH annual report, particularly around access to community transport to address loneliness and isolation and has been informing participant activity with the CPP.[324] It is featuring in a HSCP implementation plan around loneliness and isolation to develop local community transport, explore better rural transport links, and a network of accessible and affordable volunteer drivers, to support older groups in particular.[325]

The growing importance of loneliness and isolation for rural populations has been the focus of a conference in one board area, with the participant and colleagues as a consequence of this, developing work around rural transport costs, identified as a big issue locally, to consider the health and well-being impact of some access to free bus transport in some form.[326]

Further responses point to community transport provision and the strengthening of transport links featuring in HSCP plans as a means of addressing loneliness and isolation[327] [328] and links made to transport provision within the context of connecting people (but not specifically loneliness and isolation) in one LOIP.[329]
Further activity identified by participants includes HSCP work around transport and older people accessing GP appointments,[330] NHS work to address the transport challenges of travel to health appointments,[331] [332] local authority led appraisal activity around the provision of transport routes[333] and the development of a community car scheme.[334]

In terms of **public space** and the development of well-designed good quality public space in communities to support opportunities for social interaction locally (the recently introduced Planning (Scotland) Bill might further shape opportunities for this) is not identified by the responses although one participant did state that they were hoping to influence local planning, as set out in a HSCP implementation plan to address loneliness and isolation, when designing housing and community space to ensure that there were proper resting spaces as a means of encouraging those with mobility problems to leave their homes, as well as social spaces in general.[335]

References to **'green' space** specifically are absent in the national loneliness strategy but the platform such spaces offer, presumably where these are of a good quality, for community activities, social interaction and physical and leisure activities

is thought to link into improving social cohesion and reducing isolation.[336] [337] [338] [339] It's worth noting however based on public perception, as captured by Greenspace Scotland, that the quality of local greenspaces in Scotland may be falling, use may be falling and the likelihood of living further away from greenspace is greater for those living in areas of deprivation, with less use of and lower levels of satisfaction reported.[340] Wider questions to be considered might also include around how well parks and greenspaces are faring as a consequence of local authority budget cuts and if staff and skills are being lost as a consequence. The picture is bound to be variable across Scotland.

Participant responses to this question are relatively limited but do highlight the development of green health partnerships (in Dundee, Highland, Lanarkshire, North Ayrshire) funded by Sottish Natural Heritage and Transport Scotland, among others, and managed by local authorities and local health boards, linking across a range of partners to increase physical activity and improve mental health through engagement with the natural environment.[341]

There might be some variation in what each partnership will do, but there is an anticipation that the activity that partnerships generate will support attempts to address loneliness and isolation. Public health plans in one board incorporate green health activities and getting people to use the outdoors for any reason, and the development of green health initiatives to address loneliness and isolation.[342] In another, partnership work is providing opportunities for health care professionals including GPs to refer clients into green based interventions (green health prescriptions) alongside development of a green health opportunities directory.[343] In a third example, there has been mapping out of green health activities to identify these for social connectedness and for volunteering, among a range of benefits.[344]

A further response alludes to the development of a city wide *Open Space Strategy*. A consultative draft of this strategy makes only very brief reference to the role of green space in relation to isolation.[345] Given that local authorities are asked to consider open space in local development plans, Strategic Development Plans (in the four city-regions) and in the development of open space audits and strategies to set out the vision for new and improved open space and to address any deficiencies identified, it would be useful to identify how or if a consideration of isolation, loneliness or social cohesion or other proxies are being incorporated into this activity.

Access to safe, secure, affordable and accessible **housing**, with communal spaces to foster social interactions, emerges as a key factor in the consultation responses to the national draft strategy in tackling isolation and loneliness[346] but given the problems associated with the contemporary housing market in Scotland, around lack of affordability, relatively low levels of social housing supply and a growing

private rental sector and rising rents, affordable and accessible housing remains out of sight for many individuals and families.[347]

The national loneliness and social isolation strategy indicates a need for a review of planning to consider how local development plans can support vibrant communities with opportunities for greater social interaction and prioritises the piloting of housing solutions for older people, testing intergenerational and other co-living arrangements (of increasing interest not solely for older people[348]) to meet housing need and reduce loneliness and isolation.[349] Research by *Demos* for instance has indicated that older people living in age-specific housing, including retirement and sheltered housing and extra care assisted living developments, tend to report being less lonely than their peers given what appears to be greater opportunities to socialise, feel part of a community and have access to communal space.[350]

The responses to this question are slight but given the complexity of the local housing and planning sector, the range of housing providers, and the lack of any direct connection with the sector by interview participants could also explain this.

Several participants identify the lack of any specific reference to loneliness or isolation in local housing strategies.[351] [352] This work can't identify if or how local housing strategies are or could respond to the loneliness or isolation agenda specifically, although clearly aspirations and activity to address housing affordability and supply, provide attractive shared spaces, improve housing stock, address fuel poverty and ensure connectivity to local resources, assets and transport is central to addressing loneliness and isolation. Moreover local authorities can use their powers to address for example poor quality housing in the private rented sector, stalled and derelict spaces and homes in the private sector, bar poor landlords from their landlord registers and maximise the percentage of affordable housing built by private developers. Some of this activity might positively impact on loneliness and isolation.

Participant responses also highlight the use of the Place Standard tool that might shed some light on various aspects of the local social and physical environment including housing and opportunities for social interaction,[353] [354] the use of community engagement workers by housing associations, providing activities for residents[355] and what was thought to be the loss of community wardens in care homes and in supported accommodation in one area, thus reducing opportunities for interaction.[356]

One participant however did mention working with local housing officers around their potential to identify loneliness and isolation in homes they visit and how they could make a referral out to other services and to make adaptations that allow people to leave their homes. The local loneliness and isolation implementation plan also sets out a number of housing related aspirations. These include the provision of a mix of housing for older and younger people, promotion of sheltered housing, expansion of

sheltered housing community hubs (providing activities for all in the community) and investigation of the potential to develop partnerships between schools and care homes and intergenerational connection making.[357]

In terms of local **digital technology** developments, the national loneliness and isolation strategy identifies a role in addressing loneliness and isolation for digital technology, internet access and digital skills, particularly for those who are older, are disabled, have a chronic health condition or are on low incomes.[358]

One participant response mentioned that locally there were discussions going on around technology enabled care, but if this was suitable in relation to loneliness and isolation was not clear, use of technology such as the service provided by *NHS Near Me* (providing health appointments via video consultations from a patient's home), and interest in the use of intergenerational projects to increase technology use.[359] Another mentioned *NHS Near Me* technology, but thought that while this might be worthwhile, paradoxically it might simply encourage people to remain at home.[360] In one board where N*HS Near Me* technologies are used, it was thought that it might have applicability for loneliness and isolation, but this probably hadn't been scoped out.[361]

Another felt there was little focus on technology as applied to public health (with no reference to this in the local e-health strategy) although there was interest in applying technology to a local community navigator project, with public health involvement, and there had already been use of technology in an intergenerational project aimed at children and elderly people.[362] There are also aspirations, set out in a local loneliness and isolation implementation plan, in one area to provide opportunities for older people to develop technological skills via activity with younger people, and to investigate technology enabled care.[363] One participant, while supportive of the use of technology, had some reservations about its use based on past experience of using technology to provide health coaching, as without a visit to the individual's home, getting a full sense of their problems, the person and the nature of their home was problematic.[364]

16. Community Empowerment Act

Participants were asked if loneliness and isolation are forming part of local activity in response to the Community Empowerment Act (e.g. asset transfer, participatory budgeting, empowering communities fund) or by empowering communities and community groups via some other mechanism.

The act gives community bodies the right to request to buy, lease, manage or use land and buildings belonging to local authorities and public bodies,[365] and community

operated or programmed buildings are deemed to have the potential to bring local communities together, as set out in the public health priorities for Scotland.[366] Participatory budgeting (PB) involves the distribution of small amounts of public money within communities and allows communities to have a say in deciding where larger sums of public money are invested in public services and infrastructure.[367] There are further aspects of the act that are of interest such as around Common Good properties that local authorities can't dispose of or change without consulting with community bodies and also the need for local authorities to take reasonable steps to provide allotments,[368] and it would be interesting to identify how far work to address loneliness and isolation might be featuring in any of this activity.

Not everyone could provide a response but around PB but there was certainly an awareness of PB bids taking place but how far they were bidding expressly with loneliness and isolation in mind was unclear.[369] [370] [371] [372] One participant thought that work they had done with community groups around PB wasn't particularly successful and that PB was favouring the most vocal and best organised.[373]

Perhaps more positively, several participants identified that PB might be fitting with local priorities around loneliness and isolation and for example the locality planning groups had in one area run a PB event, with PB applications required to fit with those priorities[374] and likewise in another area with local focus on isolation and loneliness.[375]

In another board, there was thought to be quite a bit of PB taking place, and some asset transfer within the local authority. The PB examples, mainly from the third sector, were thought to all have the potential to address loneliness and isolation, but not all would be badged that way, and perhaps because tackling loneliness and isolation and being able to prove that you have done so is difficult to measure?[376]

For asset transfer, one participant thought that at CPP level there was at least more of an openness than there had been to talk about how underused assets in communities might be transferred, with some small initiatives developing around this.[377] Another pointed to what they thought had been very little evidence of asset transfer, and a sense of 'invisibility' around activities linked to the Community Empowerment Act.[378]

17. Support from ScotPHN, Health Scotland, wider NHS and local authorities

Participants were asked to identify what forms of support, or evidence ScotPHN or Health Scotland, the wider NHS or local authorities could provide to help them progress activity around loneliness and isolation. In general they were keen to see greater clarity particularly around the evidence, and specifically how evidence might be translated in such a way that it may be effectively applied at a local level. For several participants a national network to support this activity was deemed potentially useful.

Recognising the problems attached to maintaining an awareness of the burgeoning loneliness and isolation evidence base, and the 'very grey findings' of systematic reviews[379] respondents make a number of points in relation to evidence and data and these include a need for:

- access to clear, well translated, lucid evidence that can be applied in local contexts; [380] [381]
- evidence that is transferrable to rural settings, not solely big population centres, and that isn't just focused on SIMD, given that deprivation in rural populations tends to be scattered (and that poverty might be masked in several ways, such as by owning a car); [382]
- evidence that recognises that consistent approaches can be problematic e.g. when working with various structures (such as HSCPs) who might be working in diverse ways; [383]
- actionable knowledge, to avoid simply counting and quantifying the problem, and doing nothing; [384]
- sharing good practice[385] and case studies and guidance around what has been helpful elsewhere; [386]
- briefings about new evidence, done once for Scotland and to avoid a duplication of effort around; [387]
- evidence about what might work elsewhere and innovative approaches; [388] [389] [390] [391]
- evidence to provide a steer, to transfer the learning to partners and to consider existing practice[392] [393]and a place to share that information; [394]
- evidence about the health effects of loneliness and social isolation; [395]
- evidence around the economic impacts of social isolation; [3] [396]

[3] The lack of cost-effectiveness evidence of interventions aimed at reducing and preventing loneliness data is confirmed by McDaid et al (2017) who identify few attempts to assess the economic benefits of addressing loneliness. The interventions that do, apply a mix of different economic methodologies to appraise cost effectiveness, and the evidence is mixed,

- better local and national data and that without this has allowed the subject to 'drift a bit and not feature strongly'; and [397]
- experiential knowledge, (and broader national campaigns to raise awareness) i.e. the sharing of lived experience is under the radar as people don't want to talk about loneliness and isolation to raise awareness.[398]

To support this, several interviewees point to the potential usefulness of a national network to bring people around the issue, with expert contributions, the sharing of good practice and evidence interpretation and what works and what doesn't [399] [400] or just a place to share information and find out what is going on in other areas and that isn't focused on systematic reviews.[401]

In relation to how loneliness and isolation might be measured, participants make several points around:

- The need for clarification about what should be measured in order to demonstrate effectiveness around this agenda; [402] [403]
- the use of helpful proxy measures; [404]
- the need for consistency in the use of language, with a common suite of indicators, and of outcomes, that people are working to and that is consistent across Scotland, that adequately describes the story and that generates a better understanding of what the collective impact of activity is; and [405]
- better measurement and evaluation, so that we can trace which direction loneliness and isolation is headed in [406] and to measure impact.[407]

Having some consistency around measurement might be particularly important given as one participant points out the breadth and scope of the Scottish strategy, and that indicates that there is a role for many local actors to contribute to addressing loneliness and isolation and who need to measure their impact.[408]

Moreover the need to measure and to report on specific deliverables, centrally driven targets or any outcome measures and to do so with consistency, as several participants point out is currently not a requirement [409] [410] and the lack of any targets around this agenda is viewed as creating a situation where it is down to interested individuals to pursue and badger to raise awareness of loneliness and isolation, deemed time consuming and challenging.[411]

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e.g. befriending initiatives may be highly cost effective or highly ineffective, social activities may be cost saving or not cost ineffective, although modelling by the authors of signposting / navigation services indicate a positive return on investment. Source: http://www.lse.ac.uk/business-and-consultancy/consulting/assets/documents/making-the-economic-case-for-investing-in-actions-to-prevent-and-or-tackle-loneliness-a-systematic-review.pdf

In terms of tools, several participants express a need for standardised tools to identify those who are lonely or socially isolated or at risk (and to measure impact of interventions)[412] [413], or a practical toolbox of the most useful tools.[414]

Several mentioned a need for dedicated staff[415] [416] to develop a greater focus on loneliness and isolation (to map assets and initiatives, to develop new initiatives, to make connections, identify evidence) to achieve more than simply having partners try to build it into existing programmes and services,[417] but another thought that given that loneliness and isolation cuts across a wide range of themes, dedicated staff was not the solution.[418]

Another participant pointed to a need for more community development staff with a remit to work with local communities and across service boundaries to build relationships and connections, to support volunteering and peer provision, with the latter developed and invested in (i.e. not solely the provision of befriending services that might have various conditions attached to their use).[419]

Several comments also emerged around the Scottish strategy on loneliness and isolation. So while the strategy, where mentioned, is viewed positively[420] [421] [422] a useful 'starting point'[423] and useful in reframing thinking and raising awareness of the problem beyond older people[424] several points indicate a need for further direction or prioritisation.

For example it might not be viewed as providing direction at a local level[425] and hadn't been followed up by a directive, resource or an expectation of CPPs or other agencies to incorporate activity into plans which meant that you might be simply framing 'what you are currently doing under the auspices of that strategy'. What is required therefore is strong governance arrangements and a requirement to report on something, with resource attached.[426] Likewise another participant was keen to keep the problem of loneliness or isolation on the agenda, not solely via a stand-alone strategy, but also by ensuring its incorporation into all relevant policies, with for example, health boards and local authorities required to do so.[427]

Participants were also asked to identify what forms of support, or evidence their wider partners (CPPs, HSCPs, NHS, local authorities, other statutory service providers, third sector) require to develop their understanding and activities around loneliness and social isolation.

Understandably there is less clarity about what others might need although several responses relate directly to the third sector, such as around the need for consistent funding[428] but also around a need for:

- Third sector partners to separate out the impacts of their activity to be clear about the contributions they make to preventing, reducing or treating loneliness or isolation;[429]
- understanding of the health and cost impact of isolation;[430]
- employee confidence to discuss isolation and to then be able to do something about it;[431]
- analytical capacity to trace impact, and apply for funds;[432]
- support to generate evidence as proof of worth amid fighting for funding;[433]
- case studies to better tell the story about activities (and so even if not specifically focused on loneliness and isolation, about how this can be addressed via use of another activity, such as cooking skills) beyond raw numbers about who attended; and [434]
- guidance pre- and post-intervention measures, to identify what works and what doesn't.[435]

Other responses identify a need to make loneliness and isolation relatable for wider partners (i.e. if you can identify and address loneliness and isolation, you might reduce demand for your services),[436] to provide evidence of how wider partner activities might impact on loneliness or isolation[437] and to support people with information and knowledge and to help them concentrate their efforts where these might be best placed.[438]

18. Conclusion

In conclusion, this is a short report based on a handful of interviews, that can't adequately capture the totality of activity to identify, prevent or reduce loneliness and social isolation, given the likely breadth of activities that might take place locally and that won't always be badged as loneliness and isolation specific.

Moreover, given the wide ranging nature of the questions, it might be helpful if this work is followed by some attempt to engage with representatives from primary, secondary and social care sectors for example to find out how or if loneliness and isolation is being identified or could be identified in those settings.

Therefore it is difficult to come to anything other than some tentative conclusions. Perhaps what we can say is that there will be variation across public health / health improvement / promotion teams, as well as wider partners, in terms of the extent to which loneliness and isolation are prioritised, but that those staff will be influencing partners around this issue in manifold ways. There are clearly examples of where loneliness and isolation have featured heavily in some form of output, such as a DPH annual report, HSCP plan or via activity to generate and support interventions, but

they will also feature in activity that might impact positively on loneliness or isolation, but won't be badged in that way.

It might also be fair to say that some of this dedicated activity has focused primarily on older people, although this does not mean that there won't be local activity or interventions that identifies or addresses loneliness and isolation in other groups, it just might not be badged as such.

Interviews have identified a small number of examples of work, or proposed work, in primary, secondary and social care, that indicate that there is activity to identify loneliness and isolation is these settings but potentially resistance to this, as examples have indicated. Based on participant responses, it might be particularly useful to identify where there is a need for staff training around this issue in each of these sectors.

We know that social prescribing / community link working is a diverse sector, and based on participant responses there will be variability in the provision of social prescribers / link workers etc. (and presumably some areas will be well served in terms of provision?). Responses indicate however that there are also concerns about link worker provision and the capacity of the 3rd sector to absorb referrals to it from link workers.

There are clearly a range of questions included in this report where answers are relatively slim, and so it would be useful to dig deeper into these to identify if or how discussions would take place around service closure or change, transport, housing, public space, and digital technology use etc. and how a consideration of how loneliness or isolation might or could feature within this, and the mechanisms that might allow public health / health improvement / promotion staff to influence this.

In terms of what might push the agenda forward for participants, responses indicate that while the national isolation and loneliness strategy is useful, they would like translated evidence, evidence about economic impact, a national network to share activity and innovation, better local and national data, a clarification around what should be measured, consistency in language use, a requirement to report on something, with resource attached, and that agencies should be obliged to incorporate loneliness and isolation into their respective plans and strategies.

Appendix 1

Question Set:

1. Locally, have loneliness and social isolation been identified as public health priorities, and not solely by public health and health improvement teams?
1. If so, is this generating activity within the NHS and among wider partners including HSCPs, IJBs, CPPs, local authorities and the third sector?
2. Locally, has loneliness and social isolation been measured, and who might be most at risk defined and captured?
3. Are you aware of any local tools or methods to identify those at greater risk of being lonely or socially isolated? (Would you be willing to share these with the research?)
4. Does local activity include a consideration of the needs of ethnic minorities, LGBT, carers, young parents, adolescents, those with poorer health, disabled people and lower socio-economic groups, as well as older people?
5. How have local public health and health improvement activities, interventions, or partnership working, sought to influence understanding, or prevent or mitigate loneliness and social isolation?
6. Locally, are you aware of any activity to identify or map the range of services and interventions aimed at supporting those experiencing loneliness and social isolation?
7. Locally, are there examples of primary care activity to identify loneliness and social isolation?
8. Are social prescribing / community referral schemes available locally in primary care settings?
9. If so, are they appropriately oriented towards, and resourced, to make a significant contribution to supporting the lonely or socially isolated?
10. Locally, are there examples of social services and social care activity to identify loneliness and social isolation, or of linking out to other service providers to source support for patients / clients?
11. Locally, is loneliness and social isolation among children and young people being considered?
12. Has the need to tackle loneliness and social isolation been taken into account in any changes to or closures of local services?
13. Are loneliness and social isolation, and fostering connections, embedded in local activity and plans around:
    - transport and active travel?
    - housing and regeneration?
    - public spaces and greenspace?
    - local digital technology developments?

14. Is local asset mapping, asset based community development, or community development in general, forming any part of local activity to prevent and reduce loneliness and social isolation?
15. Are loneliness and social isolation forming part of local activity in response to the Community Empowerment Act (e.g. asset transfer, participatory budgeting, empowering communities fund) or by empowering communities and community groups via some other mechanism?
16. What forms of support, or evidence, do public health and health improvement teams require (e.g. from ScotPHN, Health Scotland, wider NHS, local authorities) to progress activity around loneliness and social isolation?
17. What forms of support, or evidence, do you think your wider partners (CPPs, HSCPs, NHS, local authorities, other statutory service providers, third sector) require to develop understanding and activity around loneliness and social isolation?

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