Safer Stronger Communities Select Committee		
Report Title	Adult social isolation, community connections and social prescribing	
Key Decision	No	Item No. 4
Ward	All	
Contributors	Executive Director of Community Services and Director of Public Health	
Class	Part 1	Date: 22 May 2019

1. Purpose of the Report

1.1 To update the Committee on borough initiatives to tackle social isolation in adults, including the work of Community Connections and wider social prescribing initiatives.

2. Recommendations

2.1 The Safer Stronger Communities Select Committee is:

- Asked to note and comment on the content of this report.

3. Policy Context

3.1 In October 2018, the Government launched, 'A connected society: a strategy for tackling loneliness', which 'is government's first major contribution to the national conversation on loneliness and the importance of social connections' (1).

3.2 The national strategy outlines how collaboration across local authorities, the voluntary and community sector, employers, friends, family and communities can work towards increasing social connectedness. It also calls on local authorities 'to consider how tackling loneliness can be embedded in their strategic planning and decision making on the wellbeing of their communities' (1).

3.3 A growing body of evidence has demonstrated the value of person-centred and community-centred approaches, alongside greater local understanding of NHS England's self-care aspiration. This underpins why coordinated action on self-care and social prescribing is important. The evidence indicates that involving people in community life is positive for individual health and wellbeing outcomes, stimulates creativity and innovation and is good for the wider community.

3.4 The General practice forward view (2016) emphasised the role of voluntary sector organisations, through social prescribing specifically – in efforts to reduce pressure on GP

1. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/750909/6.4882_DCMS_Loneliness_Strategy_web_Update.pdf

services. In addition, social prescribing contributes to a range of broader Government objectives, for example in relation to employment, volunteering and learning.

3.5 Social prescribing Schemes, like SAIL and Community Connections support Lewisham's Sustainable Community Strategy priority of: Healthy, active and enjoyable, where people can actively participate in maintaining and improving their health and wellbeing and Safer; where people feel safe and live free from crime, antisocial behaviour and abuse.

3.5 Lewisham Health and Care Partners are committed to supporting people to maintain and improve their physical and mental wellbeing, to live independently and to have access to high quality care when needed. Transforming the care that people receive in the community (Community Based Care) so that more people can be cared for out of hospital, is critical to achieving this. Social prescribing schemes play a key role in preventing the need for health and care and help connect people to services and activities to promote wellbeing. The aim is for community based care to be:

- **Proactive and Preventative** – By creating an environment which promotes health and wellbeing, making it easy for people to find the information and advice they need on the support, activities, opportunities available to maintain their own health and wellbeing and to manage their health and care more effectively.
- **Accessible** – By improving delivery and timely access when needed to planned and urgent health and care services in the right setting in the community, which meet the needs of our diverse population and address inequalities. This includes raising awareness of the range of health and care services available and increasing children's access to community health services and early intervention support.
- **Co-ordinated** – So that people receive personalised health and care services which are coordinated around them, delivered closer to home, and which integrate physical and mental health and care services, helping them to live independently for as long as possible.

4. Loneliness and social isolation in Lewisham

4.1 A Joint Strategic Needs Assessment (JSNA) has been previously conducted in Lewisham to explore borough needs around loneliness and social isolation. The findings of this assessment are summarised here.

4.2 Social isolation and loneliness are different concepts though closely related and often used interchangeably. Social isolation is an objective state, whereby a person is cut off from society and does not have anyone to turn to for social support. Loneliness is a subjective state, it is an emotion and involves how an individual evaluates their level and quality of social contact.

4.3 The influence of social relationships on risk of death is comparable with well-established risk factors for mortality such as smoking and alcohol and exceeds the influence of physical activity and obesity.

4.4 Social isolation is a key precursor to loneliness and there are a number of risk factors for social isolation and loneliness that sometimes overlap. The main risk factors are:

- Transitory such as moving house
- Situational such as being a carer
- Geography such as isolated areas with poor transport

- Personal characteristics such as being over 75 years old
- Health and disability such as physical or cognitive impairments

4.5 Between 6–13 %of older people feel lonely often or always. In Lewisham this would mean that overall between 1,685 and 3,651 people aged 65 or above feel lonely often or always (using 2018 population figures).

4.6 Other groups also suffer social isolation and loneliness but it is more difficult to estimate numbers.

4.7 Effective interventions to prevent loneliness include:

- Group interventions with an educational focus.
- Targeted support activities e.g. at groups with shared characteristics such as young people who are lonely or those who live in a certain area
- Befriending
- Community Navigators who provide emotional, practical and social support and act as an interface between the individual, the community and public services
- Health Promotion- improving fitness such as attending local walking groups or healthy eating classes- which improve mental wellbeing and promote social connectedness.

5. Social prescribing

5.1 Social prescribing is one potential mechanism through which social isolation in adults can be addressed.

5.2 A scoping paper previously considered by Healthier Communities Select Committee provided a definition of social prescribing that came from the Annual Social Prescribing Network Conference held in London on 20 January 2016:

5.3 Short definition:

Enabling healthcare professionals to refer patients to a link worker, to co-design a non-clinical social prescription to improve their health and wellbeing.

5.4 Fuller definition:

A means of enabling GPs and other frontline healthcare professionals to refer patients to a link worker - to provide them with a face to face conversation during which they can learn about the possibilities and design their own personalised solutions, i.e. 'co-produce' their 'social prescription'- so that people with social, emotional or practical needs are empowered to find solutions which will improve their health and wellbeing, often using services provided by the voluntary and community sector.

5.4 *Social* prescribing schemes can include a variety of activities which might be delivered by the community and voluntary sector; examples include arts projects, sporting activity, gardening, cookery, crafts, peer support and other social groups.

5.5 Lewisham has a rich and vibrant voluntary and community sector and this is reflected in local social prescribing activity. This includes activity that might be considered 'formal' or systematic social prescribing schemes. These tend to have a formalised mechanism for making referrals and a link worker or coordinator who will follow up on the referral. Examples

include Community Connections, SAIL Connections and some of the interventions commissioned by Public Health such as exercise on referral, Weightwatchers / Slimming World, the “Be Inspired” programme delivered by Greenwich Co-operative Development Agency (GCDA) which includes Lewisham Healthy Walks. The Healthy Walks programme offers a variety of routes across the borough for all abilities led by trained volunteer walk leaders.

5.6 There are many other examples of ‘Informal’ social prescribing activities delivered by voluntary and community sector organisations, these tend not to be linked into a formal referral system or have a designated link worker or co-ordinator.

5.7 London Voluntary Services Council (now known as the Charity Hub for London) have mapped social prescribing initiatives in London and have highlighted the work of Sydenham Gardens and the Prince’s Trust. In addition, a range of activities are delivered by community organisations that health and care partners can refer into. Additional examples are:

5.8 Natures Gym who provided 2685 volunteer hours to support conservation activities in Lewisham parks. Trinity Laban’s ‘Retired not Tired’ programme provides opportunities for over 60s to take part in creative activity, interact socially and develop new skills. Meet Me at the Albany is a programme of activities for isolated older people produced by Entelechy Arts and the Albany.

6. Community Connections

6.1 Community Connections is a scheme for adults to help improve health and wellbeing by using local community services and activities. This scheme is an important local contributor to reducing social isolation among adults in Lewisham.

6.2 Community Connections operates via:

- Community Development Workers, who support the local community and voluntary sector through work with groups, organisations, individuals, networks and partnerships (including the Neighbourhood Community Development Partnerships).
- Community Facilitators, who work with vulnerable adults experiencing low mood or social isolation to improve their wellbeing and feeling of being connected to their communities.

6.3 In 2017-2018, Community Connections Development Workers supported 39 groups through development plans and made 517 development visits to those and other groups around the borough. Meanwhile, Community Facilitators supported 804 vulnerable adults through person-centred planning and work. The team supported an additional 201 vulnerable adults through advice provided to the London Borough of Lewisham Social Care team. 72% of those supported reported an improvement in their overall wellbeing after Community Connections’.

7. Neighbourhood Community Development Partnerships (NCDPs)

7.1 The four Neighbourhood Community Development Partnerships (NCDPs), are an additional component of Lewisham’s social prescribing offer that works towards reducing adult social isolation.

7.2 The NCDPs were set up in each GP neighbourhood in 2017. The NCDPs, delivered by Community Connections, bring together voluntary and community sector organisations and groups in that area to support community development and connect to statutory health and care providers.

7.2 Community Connections workers are encouraging local community groups to engage with each partnership, organising the partnership meetings, and playing a key role in aligning the work programmes of the different community development workers in each neighbourhood to maximise the use of resources and avoid duplication.

7.3 In 2018 Neighbourhood Community Development Partnerships each produced a neighbourhood community development plan which was informed by the Community Connections gaps analysis and identified key priorities. This plan informs the future work of the local NCDP partnership and local health and care partners. A small grant fund of £25k was made available for each partnership to deliver local solutions to the local priorities identified.

7.4 The NCDPs recognise the vital role that local volunteers play in supporting community cohesion and prioritise volunteer recruitment and training.

7.5 The partnership funding has continued for 2019-20, with 12 of the funded projects having some potential impact on reducing social isolation:

NCDP 1	**NCDP 2**	**NCDP 3**	**NCDP 4**
• VSL and Entelechy Arts. Brighter Futures Together • North Lewisham Community Health Network and Good Neighbours • Co-oPepys and We Women Community Arts Project	• Francis Drake Bowling Club • Asian Elders • St Mauritius Lunch Club • Lewisham Irish Community Centre	• Diamond Club Holidays at Home • Carers Lewisham	• Stanstead lodge Senior Club • Linking Lives

8. Lewisham Safe and Independent Living (SAIL) Connections

8.1 Lewisham SAIL Connections is a service delivered by Age UK Lewisham and Southwark, which acts as a single point of contact between services and organisations in Lewisham to help older people stay safe and independent. It is another important initiative in Lewisham that can contribute towards reducing social isolation and loneliness in adults.

8.2 The SAIL Connections Impact Report (The first twelve months, 2017) shows that since the formal launch in February 2017, SAIL has been embraced by local stakeholders with over 50 different organisations using the checklist (mechanism for referral), 1063 referrals have been

received to date and 926 older people have received support. About 20% of referrals are from GP practices. A significant number of referrals have also been received from the voluntary sector, hospital and the police.
8.3 Each SAIL checklist generates on average 1.4 onward referrals including to the Community Fall Service, Mindcare, Dieticians and the WarmHomes Project.

8.4 The average age of service users is 78 but this extends to 98 years old. The service has also received 61 referrals for people under 60 years of age and who are considered suitable for preventative services listed on the checklist.

8.5 SAIL will continue to promote the service to widen access. For example, they have focussed outreach with housing providers in the most deprived areas of the borough. They have also targeted health and care professionals in order to ensure access to those with limited community access, socially isolated and to people experiencing a range of physical and mental health conditions.

8.6 Approximately 23% of checklists include a referral to a Community Connections Facilitator to combat social isolation and the SAIL team work closely with Community Connections by referring people to community based groups and activities including social activities, lunch clubs, befriending, exercise classes and community learning.

9. Financial Implications

There are no specific financial implications of this report.

10. Legal Implications

There are no specific legal implications of this report.

11. Crime and Disorder Implications

There are no specific crime and disorder implications of this report.

12. Equalities Implications

It is important to consider any inequalities in population groups that may be at increased risk of social isolation and loneliness, where data is sufficient to monitor protected characteristics in those who are socially isolated.

13. Environmental Implications

There are no specific environmental implications of this report.

14. Conclusion

This is a report to provide an update on Lewisham initiatives that aim to tackle social isolation in adults.

If there are any queries on the content of this report please contact

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