Norfolk JSNA Social Isolation and Loneliness

Contents

Executive summary

Loneliness and social isolation can impact anyone at any age. This needs assessment focuses on the issue for older adults aged 50 and over as Norfolk has an older population and is projected to increase at a greater rate than the rest of England.

Loneliness and social isolation can often overlap, but they are not the same. Both can have a negative impact on health outcomes, resulting in preventable early ill health, mortality or more reliance on use of health and social care services.

This document outlines available local and national evidence of who in Norfolk feels lonely and why, the risk factors, protective factors, and those things that might contribute to feeling less lonely. There are examples of what good interventions and policies look like as well as considering what will work locally.

In England in 2022/23, 25% of people surveyed felt lonely at least some of the time, with 7% saying they feel lonely often or always (1). Survey responses for the three years prior to 2022/23 show that Norfolk was similar to England in the proportion of adults experiencing loneliness, however in 2022/23 the proportion was significantly lower than the England average (1).

Data for loneliness is collected at a national level through two population surveys, neither of these provide sufficient data to assess loneliness at a Norfolk level for population subgroups such as age. However, national data suggests that there is a strong inequality gradient between loneliness and deprivation, with around 1 in 3 people in the most deprived areas experiencing loneliness, compared to around 1 in 5 in the least deprived areas. Young people and the 85+ age group have the highest levels of loneliness, and people of white ethnicity are least likely to feel lonely.

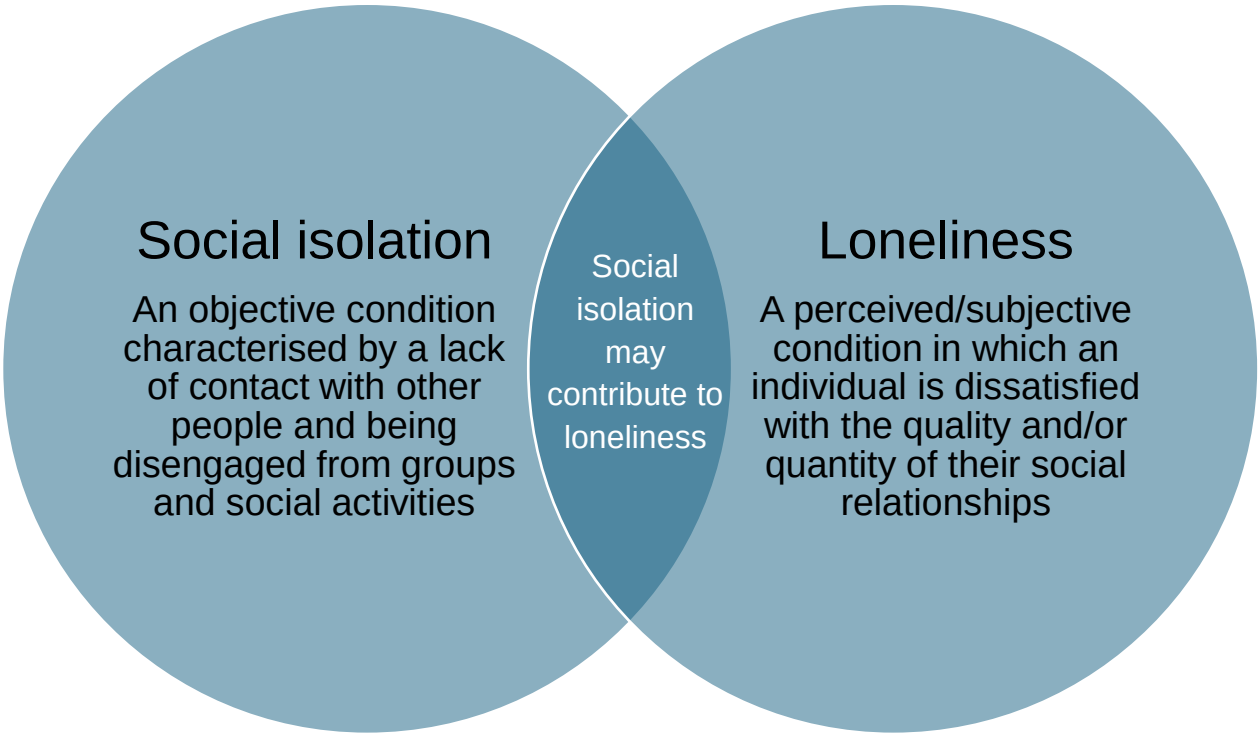
There is not enough information to provide a detailed understanding of social isolation and loneliness at a district level within Norfolk. However, there is sufficient insight to conclude that, with the older population growing, loneliness and social isolation remains a preventable issue.

What is the issue and why is it important for Norfolk?

Loneliness is ‘a subjective, unwelcome feeling of lack or loss of companionship. It happens when there is a mismatch between the quantity and quality of the social relationships that we have, and those that we want’ (2,3). Loneliness is an emotional experience: a perceived deficiency in the amount and/or quality of someone’s existing relationships (4).

Loneliness and social isolation can often overlap, but they are not the same. While loneliness is an emotional experience, social isolation is a lack of social contact. Loneliness is a subjective feeling, whereas isolation is an objective state.

Figure 1: Venn Diagram showing the difference between social isolation and loneliness, based on definitions of the conditions from Taylor (5). Social isolation may contribute to loneliness for some people, while others can feel lonely without being social isolated.



Loneliness seems to fluctuate over the life course, with different causes at different ages (6). Experiences of loneliness can differ in their intensity. This can change from moment to moment, over different durations of time, and in different contexts (7).

There are different types of loneliness. The following three are the most commonly identified in evidence and literature on loneliness (4):

- Emotional loneliness – 'the absence of meaningful relationships'
- Social loneliness – a 'perceived deficit in the quality of social connections'
- Existential loneliness – a 'feeling of fundamental separateness from others and the wider world'

Other types of loneliness can include:

- Transient loneliness – a feeling that comes and goes
- Situational loneliness – only occurring at certain times like Sundays, bank holidays or Christmas
- Chronic loneliness – feeling lonely all or most of the time.

Loneliness and social isolation can impact anyone at any age. In England in 2022/23, 25% of people surveyed felt lonely at least some of the time, with 7% saying they feel lonely often or always (1). Survey responses for the three years prior to 2022/23 show that Norfolk was

similar to England in the proportion of adults experiencing loneliness, however in 2022/23 the proportion was significantly lower than the England average (1).

Norfolk has approximately 125,500 individuals living alone, nationally older adults (65+) are more likely to live alone (8,9). Norfolk has an older population compared to England – about 1 in 4 of the population is aged 65 and over and about 1 in 30 is aged 85 and over. The population of Norfolk is ageing rapidly, and this trend is expected to continue with projections suggesting that by 2040 Norfolk will see an increase of 55% in people aged 75 and over (10). This needs assessment focuses on older people aged 50+ due to the population characteristics of Norfolk, whilst acknowledging that there is evidence of high prevalence of loneliness in younger people nationally.

This needs assessment presents an opportunity to review the current and future needs of Norfolk's population and to consider good practice in the design of services to meet needs.

Limitations to evidence

While this needs assessment focusses on older adults, there are limitations in the data available specifically relating to older adults over 50 years of age. Therefore, some of the data used in this needs assessment will refer to all adults. Where this is the case, this will be clearly stated.

There is also limited data available in regard to loneliness prevalence at a local level. In addition, there is no objective measurement of social contacts available for Norfolk.

While loneliness is associated with different types of health outcomes, there are limitations in the evidence available around cause and effect. These include: the ill-defined nature of social isolation and loneliness; the various scales used to measure the conditions; and the complexities of the causal pathways.

Impact on health

Loneliness and social isolation can have a significant impact on older people's health and wellbeing and is associated with worse physical and mental health outcomes.

Three main pathways through which social relationships may affect health have been suggested. These are (11):

- Behavioural – health-risk behaviours that are associated with loneliness, such as smoking and physical inactivity.
- Psychological – loneliness is associated with lower self-esteem, and limited use of active coping methods.
- Physiological – impacts to health-related physiology like immune function and blood pressure.

Loneliness and social isolation can impact our behaviour, adversely influencing daily activities and functions (12). For example, loneliness is associated with an increase in difficulties with activities of daily living, and a greater risk of being inactive and smoking (13). Research also suggests a harmful association between loneliness or social isolation and behaviours relating to food and eating (14). There is also evidence that social support can influence medication adherence (15). Therefore, loneliness and social isolation may affect

health indirectly through their effects on health-related behaviours, as well as through psychological and physiological processes (12).

Most people experience loneliness at some point in their life, however problems can arise if these feelings are sustained. Often feeling lonely or experiencing chronic loneliness has been linked to adverse health impacts. The association between loneliness and isolation on mortality is comparable to the impact with other public health priorities like obesity or smoking (16). Loneliness may increase the likelihood of premature mortality by 26% (17). A systematic review of studies found that there appears to be a relationship between loneliness and acute stress responses seeming to be predictive of exaggerated responses to acute stress, particularly for blood pressure and inflammation (18).

Loneliness has been associated with increased risk of high blood pressure in older adults (19). It has also been associated with reduced immunity against infections (20). A longitudinal cohort study found that loneliness is a risk factor for type 2 diabetes (21), while another longitudinal study found that individuals who felt most lonely had a twofold higher risk of developing type 2 diabetes relative to those who did not feel lonely (22). A cohort study found that older people who experience high levels of loneliness are at increased risk of becoming physically frail (23). Loneliness can also impact the immune system and metabolic regulation (24) and is associated with poorer sleep quality (25).

Social isolation and loneliness could be linked with systemic inflammation (26), and are associated with an increased risk of developing coronary heart disease and stroke (11). It has been suggested that there is a relationship between social connectiveness and chronic pain, with lower social connectiveness being associated with higher chronic pain ratings, mediated by anxiety (27).

The relationship between loneliness and mental health is bidirectional and cyclical. Poor mental health can lead to loneliness, for example, due to withdrawal or reduced capacity for interaction. Loneliness can also negatively impact mental health, for example through having more time alone to ruminate on worries and negative thoughts, losing confidence in the ability to socialise, feeling overwhelmed in social settings, and not talking about how you feel (28). Experiencing severe and long-term loneliness can have a ‘damaging impact on our mental health’ (29). Loneliness puts people at a higher risk of poorer mental health, including depression (30).

Evidence from a systematic review and meta-analysis shows loneliness is a significant predictor of both suicidal ideation and behaviour, with depression potentially the link between loneliness and suicidal ideation/behaviour. However, some age groups and ethnic minorities are under-represented in the literature identified. Studies were more likely to report a significant relationship if participants were aged 16–20 or over 55 years at baseline (31).

Loneliness and isolation are associated with poorer cognitive function (32), and increased risk of cognitive impairment (33), in older adults. Loneliness puts individuals at greater risk of cognitive decline and dementia (34).

Costs of loneliness and social isolation

Due to the impact on wellbeing, health and productivity, at an individual level the monetised impact of severe loneliness has been estimated as £9,900 per person per year (35). The

evidence available also suggests that frequent loneliness and its wider impacts are costly for society. People who are lonely are more likely to rely on the use of health and social care services. Research shows that loneliness is associated with more general practice contacts, emergency treatments and hospital admissions (36). There has also been an association found between loneliness and higher mental healthcare expenditure (37).

The role of loneliness in influencing use of healthcare could be direct or indirect, for example, through its impact on health-related behaviours which in turn lead to use of health services (12). Social isolation may also indirectly influence use of healthcare, for example social isolation and a lack of social support could result in poor health, and increased health needs for older people living alone. Older people living alone are 50% more likely to access emergency care services, and 40% more likely to have more than 12 GP appointments over a year (38). Further research is needed to explain the mechanism driving increased utilisation of health care services for older people living alone, and to explore the role of social isolation and loneliness in this.

In the workplace, higher loneliness among employees is associated with poorer performance on tasks and in a team (39), while social interaction at work has been linked to increased productivity (40). A study by the Co-op and New Economics Foundation in 2017 attempted to calculate the cost of this, estimating that loneliness could be costing UK employers £2.5 billion every year (41). These costs are primarily due to increased staff turnover (64%, £1.62 billion), as well as lower wellbeing and productivity (26%, £665 million), the impact of caring responsibilities (9%, £220 million) and ill health and associated sickness absence (1%, £20 million) (41).

National and local strategies

Since 2018 the issue of loneliness and social isolation has risen on the national agenda. In response to the Jo Cox Commission on Loneliness (42) the government published a national strategy for tackling loneliness. ‘A connected society: A strategy for tackling loneliness – laying the foundations for change’ (2), published in October 2018, set out three objectives:

1. Improve the evidence base on what causes loneliness, what works to tackle it and how it can be measured.
2. Embed loneliness and the importance of social relationships across government policies.
3. Tackle stigma around loneliness and encourage reaching out for help.

Key features of the strategy included: encouraging programmes such as ‘social prescribing’; using the housing and planning system to foster better communities; the role of community infrastructure in tackling isolation and preventing loneliness; addressing digital inclusion; making the transport network more inclusive and accessible; increasing volunteering opportunities; targeted support for certain groups; and running campaigns which aim to reduce the stigma related to loneliness.

The national strategy highlights that tackling loneliness and supporting people’s social connections is a collective effort, and that government, communities and the individual all need to take action. It calls on local authorities to look at how tackling loneliness can be embedded into their strategic planning and decision-making on the wellbeing of their communities.

Norfolk County Council's (NCC) Strategy for 2021-25: Better Together, for Norfolk (43), recognises under its priority for 'healthy, fulfilling and independent lives' that certain groups can be at greater risk of isolation. The strategy commits to improving 'the personal wellbeing of people of all ages living in Norfolk, in particular those who are lonely or isolated'.

Norfolk has many assets to support community and individual level connection, including a broad voluntary, community and social enterprise (VCSE) sector and district council offer such as leisure services and community connectors. There is also support for those who are currently socially isolated or lonely funded via a variety of mechanisms. NCC invest in social isolation and loneliness services across the county, information, advice and guidance services, community development and VCSE development.

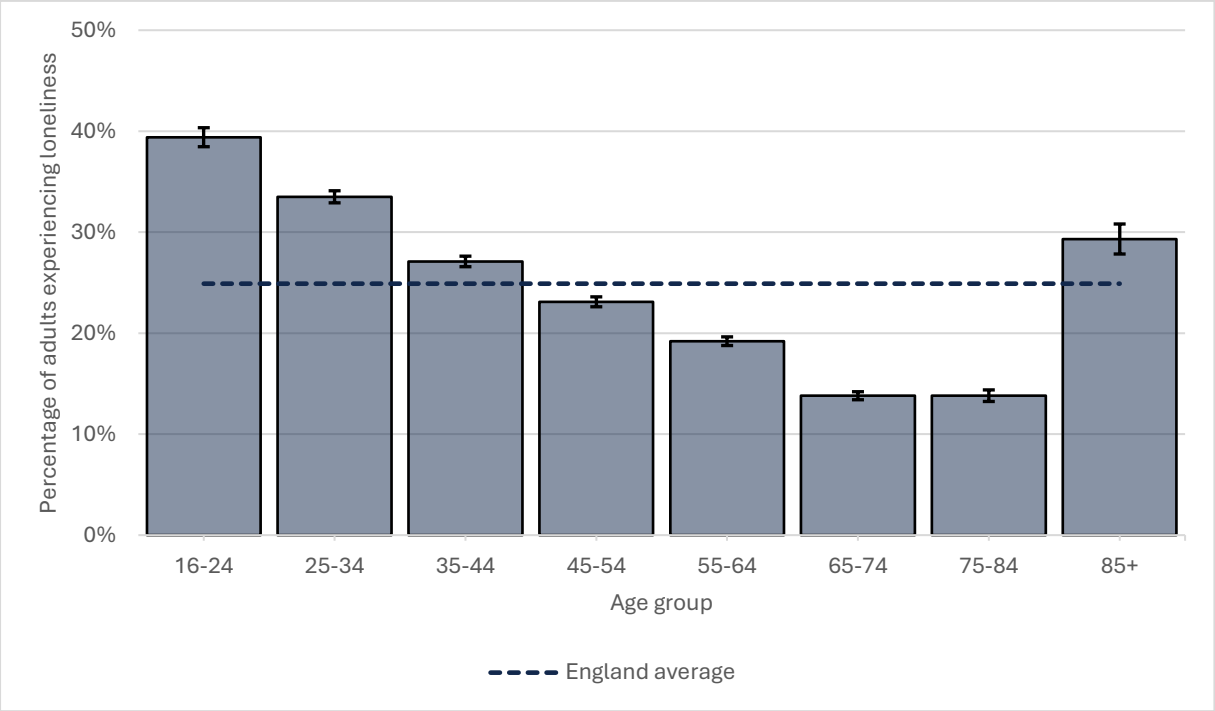
National Evidence

The Active Lives Survey for adults aged 16+ (44) is the primary source of data used to assess the need of the local population in relation to loneliness. There are other data sources for the measurement of loneliness nationally, such as the Community Life Survey. This needs assessment primarily uses the results collected from the Active Lives Survey due to the larger number of households invited to participate in this survey and the collection of data at district level. The methods used for data collection for the Active Lives Survey is also deemed to be more accessible for people who are digitally excluded. The methodology for this needs assessment is detailed in Appendix 1.

In England in 2022/2023, 25% of people surveyed felt lonely at least some of the time, with 7% saying they feel lonely often or always (1).

Data on loneliness for different groups is only available at a national level. This data suggests that loneliness decreases with age, with the youngest age group having the highest proportion feeling loneliness, with the exception of the 85+ age group. This finding from the 2022/2023 Active Lives Survey is broadly supported by the findings on relationships between loneliness and age reported from the national Community Lives Survey for 2021/2022 (45).

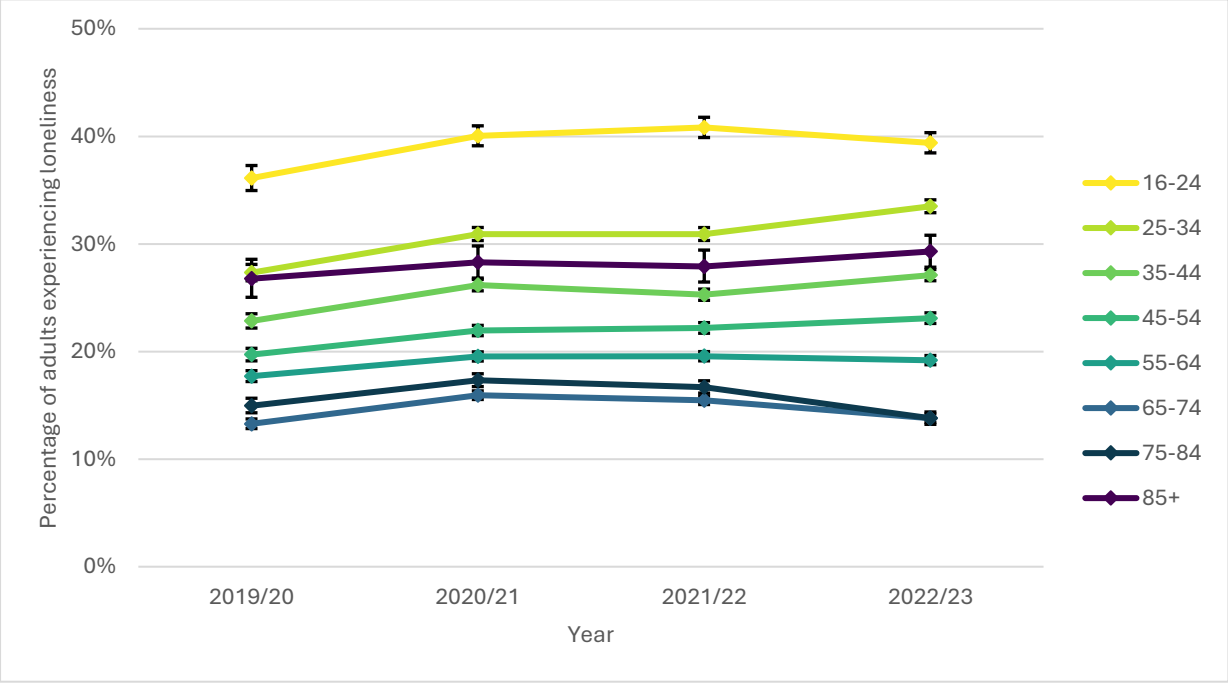
Figure 2: Percentage of adults (16+) in England who feel lonely often or always or some of the time for 2022/23 by age group.



Source: Active Lives Survey 2022/23 (1).

This pattern of prevalence has been relatively stable over time, with very small variations between 2019/20-2022/23.

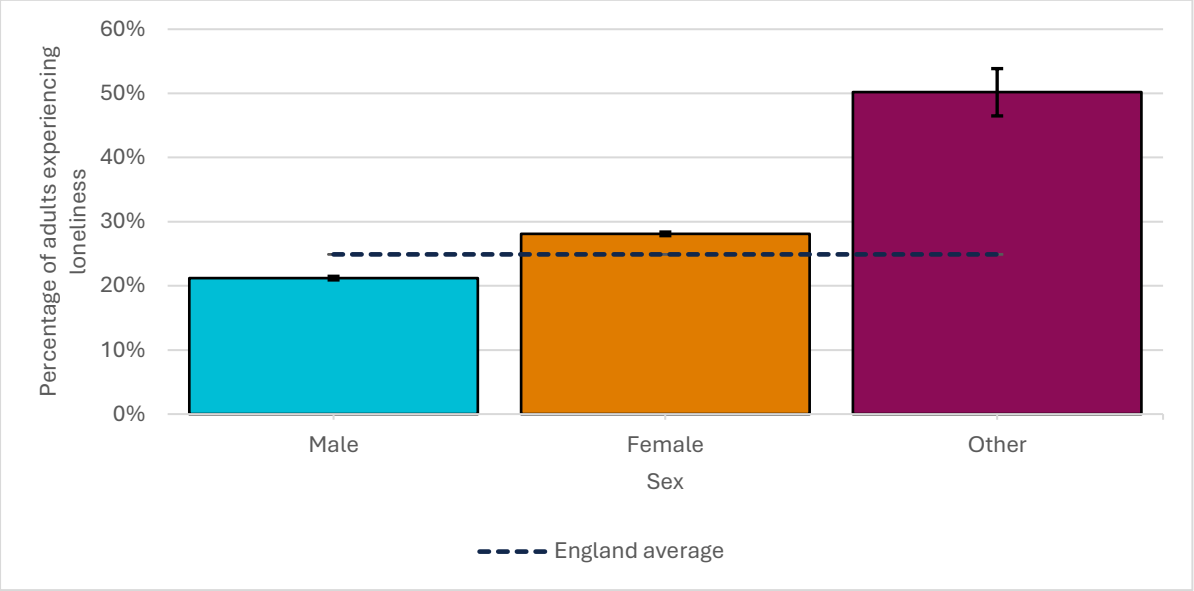
Figure 3: The proportion of adults (16+) feeling lonely often, always or some of the time in England from 2019/20 to 2022/23 by age group.



Source: Active Lives Survey (44).

Generally, the survey finds that, women are more likely to report that they experience loneliness than men. Adults who do not identify as male or female are significantly more likely to experience loneliness.

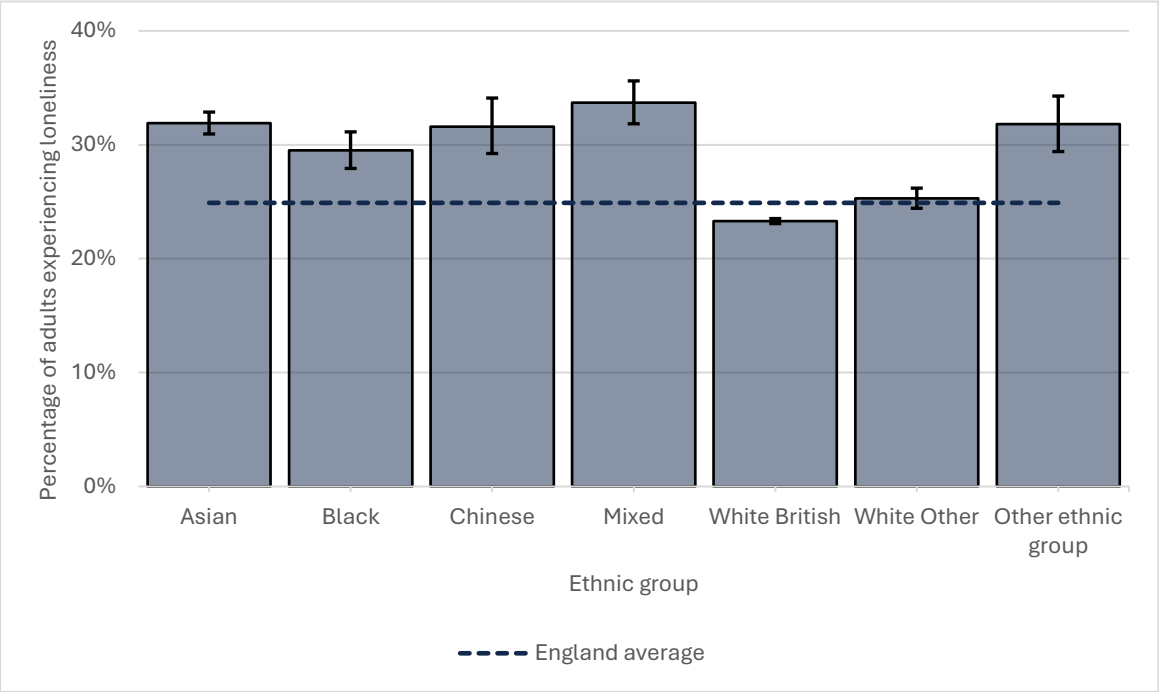
Figure 4: Percentage of adults (16+) in England who feel lonely often or always or some of the time for 2022/23 grouped by sex.



Source: Active Lives Survey 2022/23 (1).

Some ethnic groups such as Asian, Black, Chinese, Mixed, and Other ethnic groups experience significantly higher feelings of loneliness than the England average. People of White ethnicity are least likely to feel lonely. This finding is similar across both the Active Lives Survey 2022/23 and the national Community Life Survey for 2021/22.

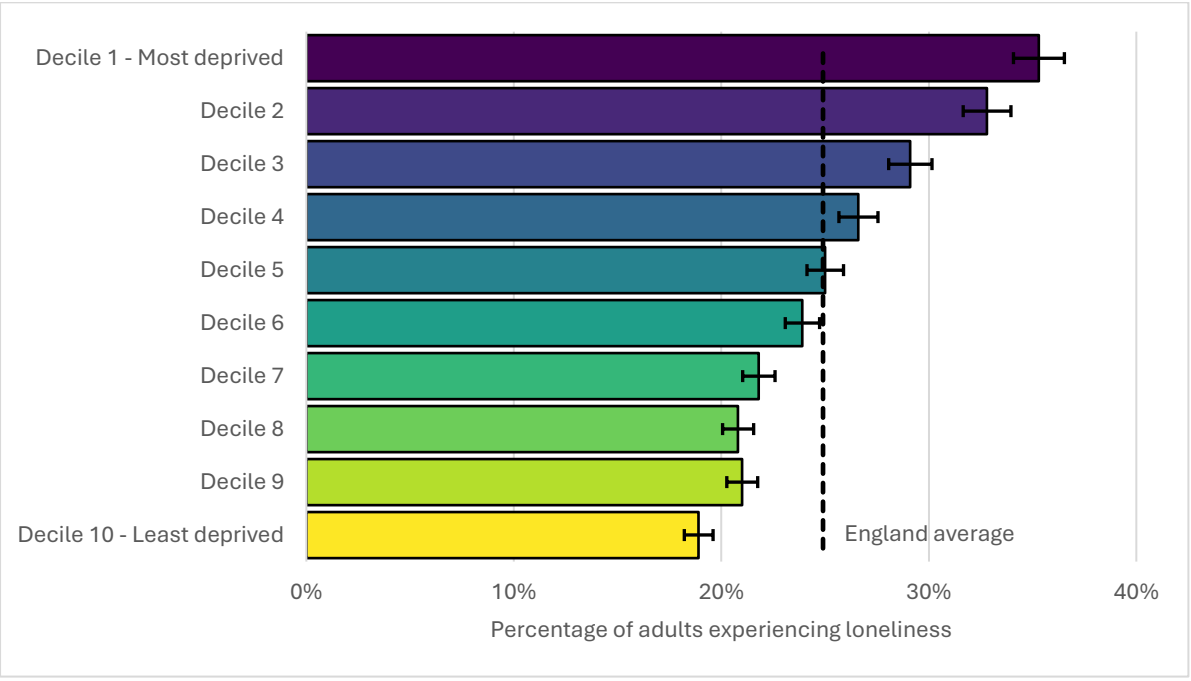
Figure 5: Percentage of adults (16+) in England feeling lonely often, always or some of the time for 2022/23 grouped by ethnicity.



Source: Figures from Active Lives Survey using 2022/23 prevalence (1).

There is a strong inequality gradient between feelings of loneliness and deprivation, with around 1 in 3 people in the most deprived areas experiencing loneliness, compared to around 1 in 5 in the least deprived areas.

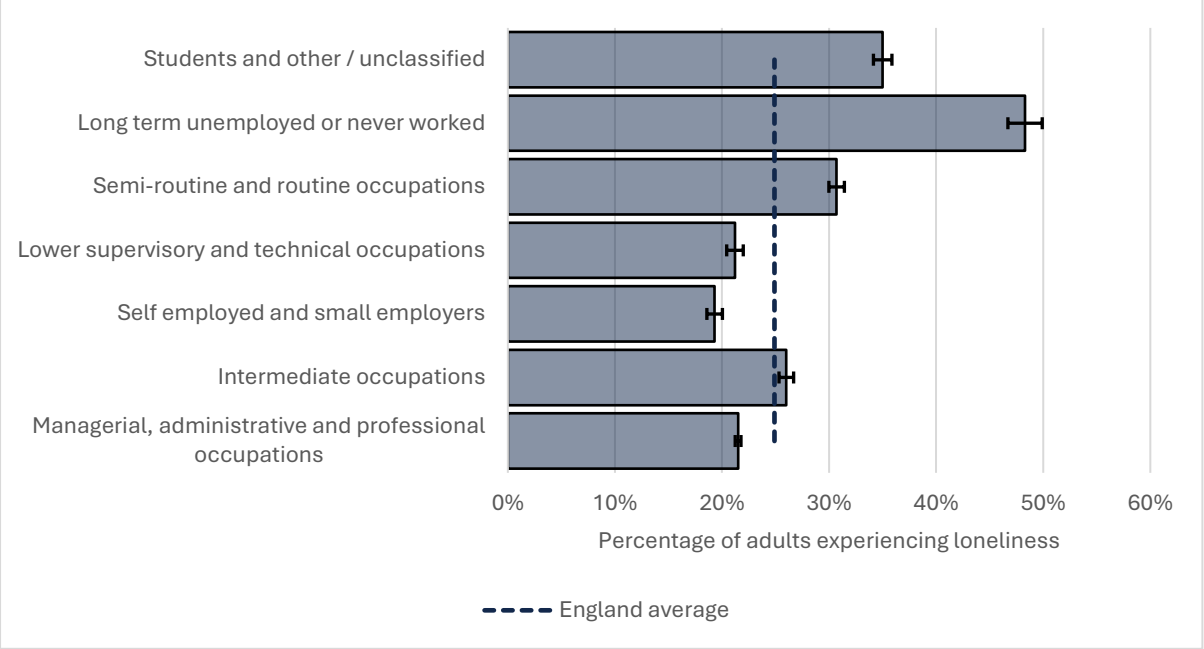
Figure 6: Percentage of adults (16+) in England feeling lonely often, always or some of the time for 2022/23 grouped by deprivation decile.



Source: Figures from Active Lives Survey using 2022/23 prevalence (1).

Those that are long term unemployed or never worked, and students and other/ unclassified occupations are significantly more likely to have feelings of loneliness, 1 in 2 and 1 in 3 adults respectively. Those in lower supervisory and technical occupations, self-employed and small employers, and managerial, administrative and professional occupations are significantly lower than the England average for experiencing loneliness.

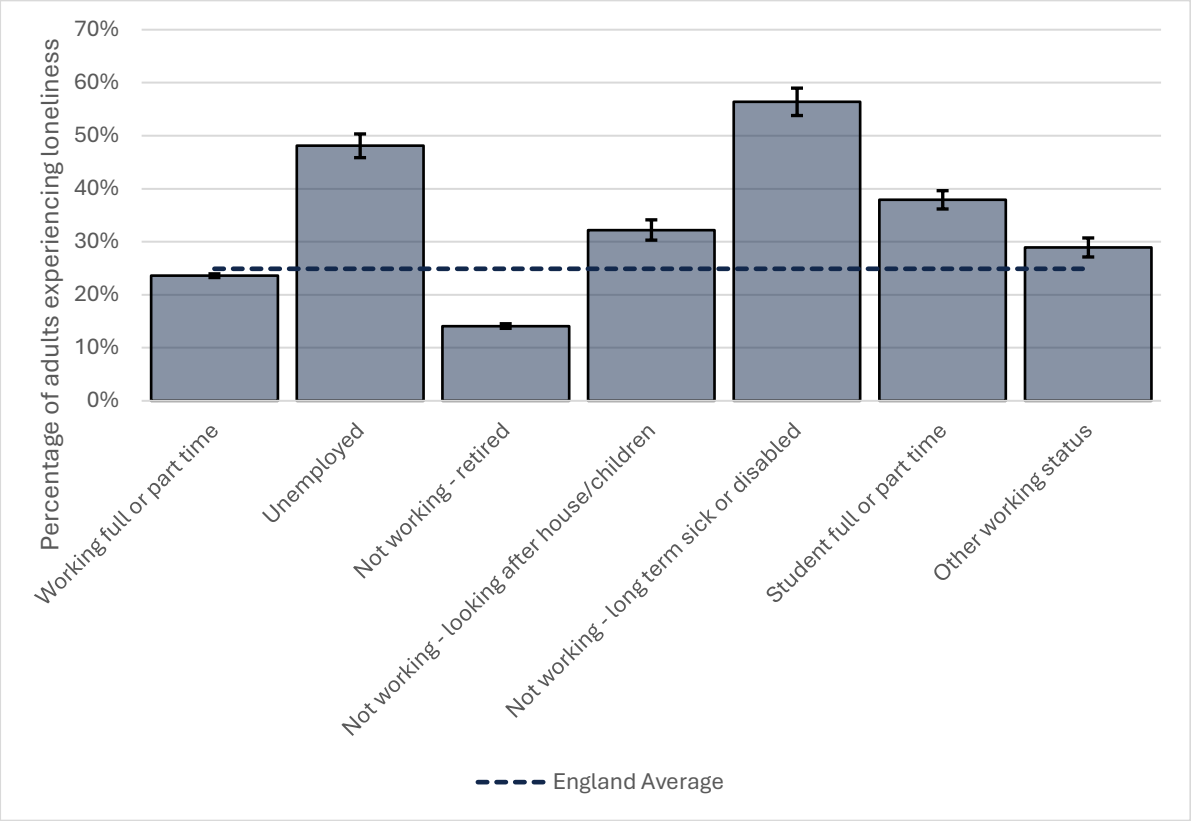
Figure 7: Percentage of adults (16-74 years) in England feeling lonely often, always or some of the time for 2022/23 grouped by social status, as defined by [The National Statistics Socio-economic classification (NS-SEC) - Office for National Statistics (ons.gov.uk)](#).



Source: Figures from Active Lives Survey using 2022/23 prevalence (1).

There are particular working status' that are more likely to report experiencing loneliness. These include those not working due to long term sickness or disability. Those who are students or not working as looking after children are also significantly more likely to experience loneliness than the England average.

Figure 8: Percentage of adults (16+) in England who feel lonely often or always or some of the time by working status for 2022/23, as defined by [The National Statistics Socio-economic classification (NS-SEC) - Office for National Statistics (ons.gov.uk)](#).



Source: Figures from Active Lives Survey using 2022/23 prevalence (1).

Priority Groups

Key groups that have been found to be at risk of loneliness in the UK are:

- Young people and people aged 85+ from the older age groups, as shown in Figure 3
- Those with poor mental wellbeing*
- People with a disability or long-standing health problem*
- People living alone*
- Gay, lesbian, or bisexual people and people who chose 'other' when asked about their sexual orientation
- People living in more deprived areas
- People who were out of work
- Those who have recently moved to their current address
- Women, who were more likely to report feelings of loneliness than men
- People facing bereavement*
- People caring for a partner*

- People who are digitally excluded*
- People with reduced mobility and loss of access to affordable, reliable, and/or suitable modes of transport*.

*Key risk factor associated with loneliness in older age.

As we get older, risk factors that might lead to loneliness can begin to increase and converge – once we have one risk factor, we may start having more (46). This can make the experience of loneliness hard to change, particularly in older age.

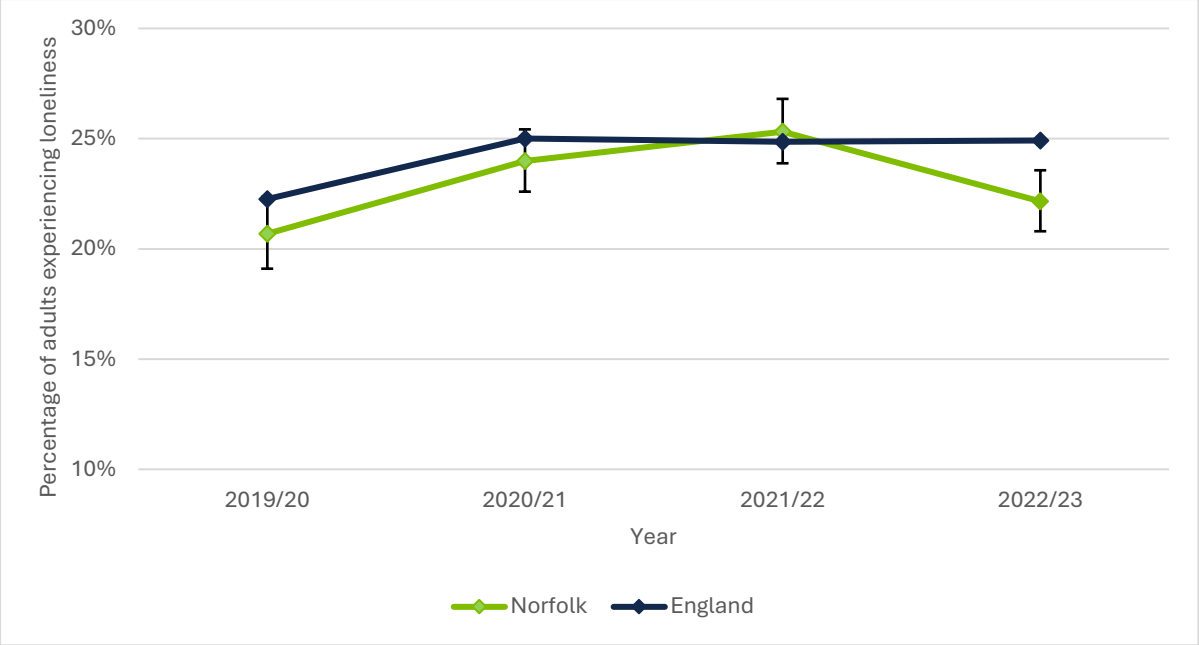
According to Age UK, people aged 50 and over are (47):

- 5.5 times more likely to be often lonely if they don't have someone to open up to when they need to talk
- 5.2 times more likely to be often lonely if they are widowed
- 3.7 times more likely to be often lonely if they are in poor health
- 3 times more likely to be often lonely if they don't feel they belong in their neighbourhood
- 3 times more likely to be often lonely if they feel they are never able to do the things they want
- 2.6 times more likely to be often lonely if they have family circumstances that prevent them from doing the things they want to do
- 2.3 times more likely to be often lonely if they have money issues that prevent them doing the things they want to do
- 1.6 times more likely to be often lonely if they live alone

Norfolk

The Active Lives Survey showed the England average loneliness score increased in 2020/21 and since then stayed at 25% of the adult population. Norfolk saw a rise in loneliness in that time in line with England. Survey responses for the three years prior to 2022/23 show that Norfolk was similar to England in the proportion of adults experiencing loneliness. However, in 2022/23 the proportion was significantly lower at 22.2% compared to the England average (1). Much of this may be attributable to the events of 2020 as outlined below.

Figure 9: The proportion of adults aged 16+ feeling lonely often, always or some of the time in Norfolk and England from 2019/20 to 2022/23 (44) using 2023 mid-year population estimates (48).



Research suggests that risk factors for loneliness during the COVID-19 lockdowns were largely similar to risk factors prior to the pandemic (49). While everyone experienced some degree of separation and many experienced a significant gap between the social connections that they had expected and those they had, some faced particular challenges which may have contributed to the rise in people reporting feelings of loneliness during these years. This included those experiencing (50):

- Extreme forms of isolation – including for those in the 'shielding' group, those who were clinically vulnerable, those who lived alone, and those who experienced barriers to connecting remotely due to the digital divide, or disabilities including sensory impairment and mobility issues.
- Those used to high levels of contact prior to lockdown, or with high expectations of social connection.
- Strains in relationships, especially as lockdown went on, including those with caring responsibilities, many of whom had to manage with less outside support, and who were unable to access formal and informal respite.

Data from the Active Lives Surveys show that the percentage of adults in Norfolk who reported experiencing loneliness in 2022/23 returned to a similar rate as 2019/20.

Loneliness inequalities in Norfolk

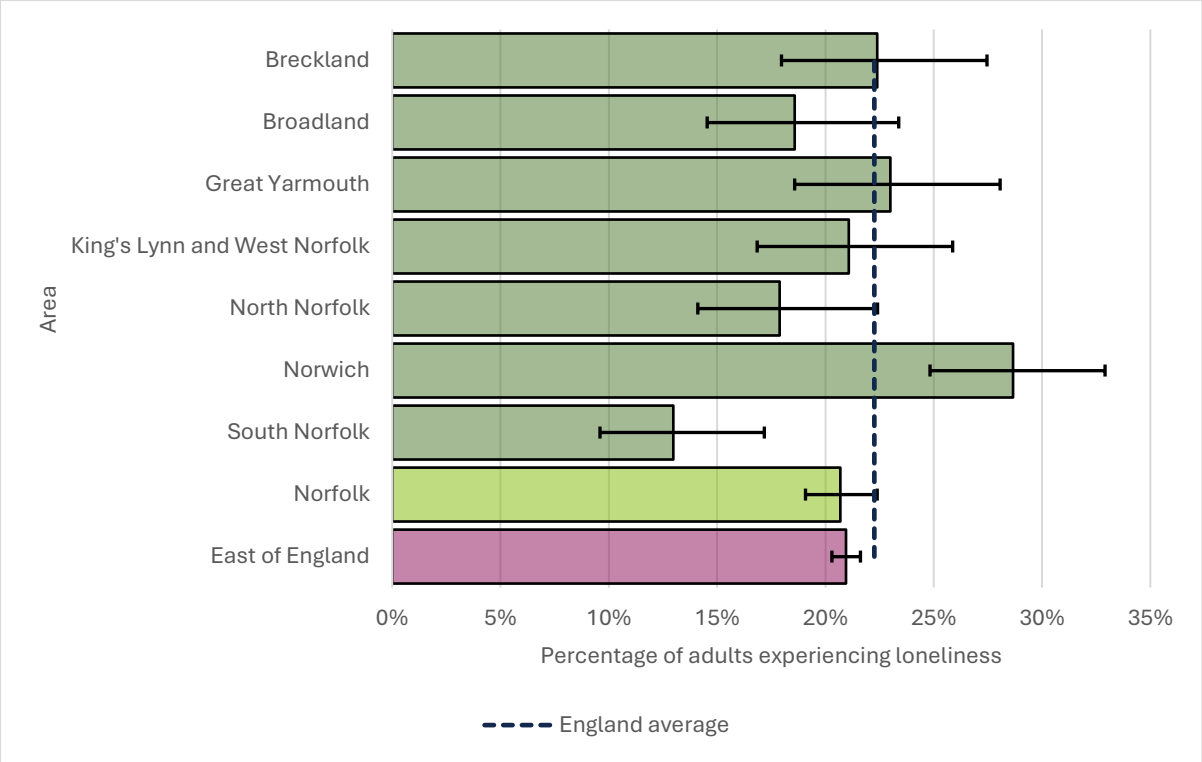
In Norfolk the proportion of adults feeling lonely is greatest in Norwich across all ethnicity groups except White British, which is greatest in North Norfolk. Full details of the proportion of adults experiencing loneliness in each district by ethnicity is included in Appendix 4.

Place

It is only possible to review specific data at **district** level for 2019/20. No other data is currently available.

Norwich has the largest proportion of adults feeling lonely and residents experience significantly higher levels of loneliness than the England average. Higher prevalence of loneliness in the younger ages may explain this *in part*, due to its younger population. Deprivation may also be a contributory factor.

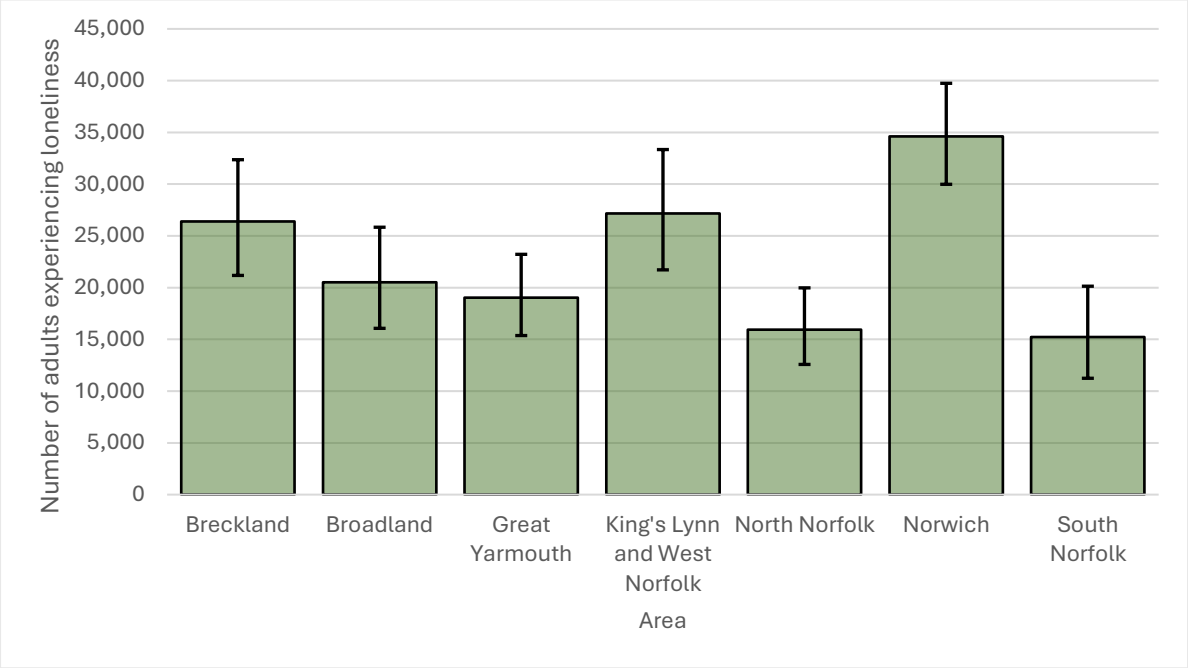
Figure 10: Percentage of adults who feel lonely often or always or some of the time by district in Norfolk.



Source: OHID Fingertips – Active Lives Survey 2019/20 (51).

Applying prevalence to district populations highlights the total number of adults experiencing loneliness. Norwich has the largest number of adults feeling lonely.

Figure 11: Number of adults aged 16+ in Norfolk districts feeling lonely often always or some of the time in 2019/20.

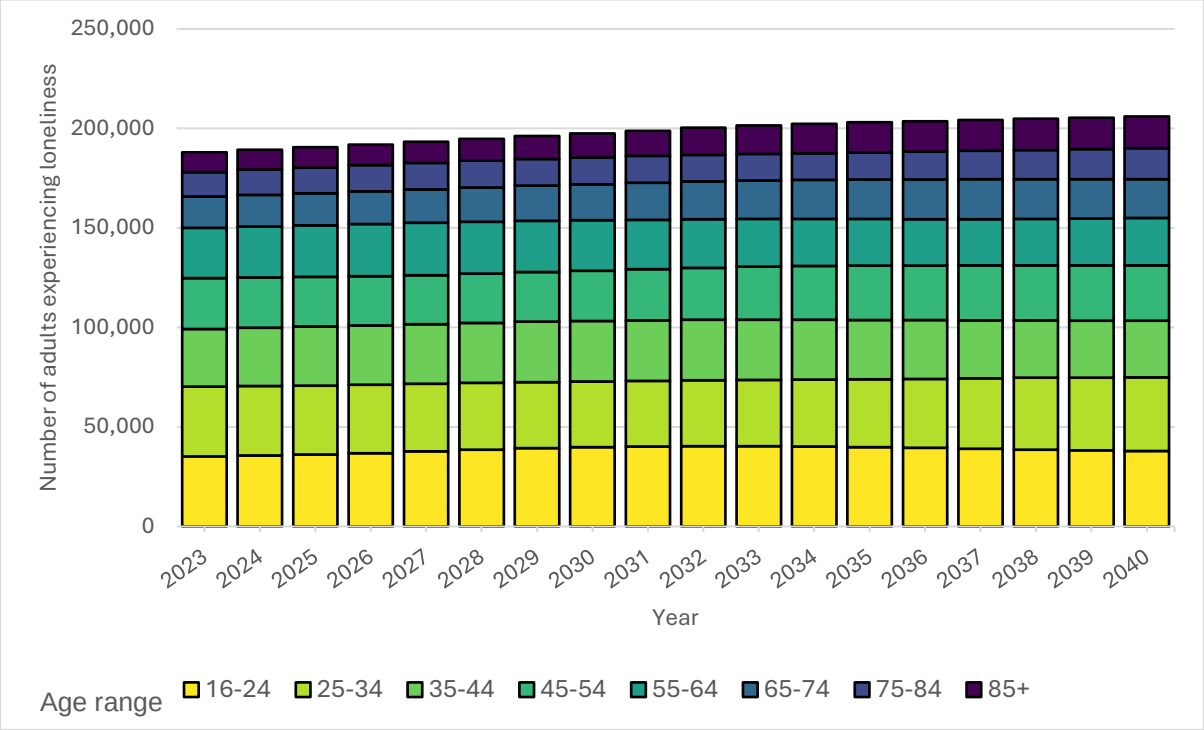


Source: Figures from OHID Fingertips using 2019/20 Active Lives Survey district prevalence (51).

Trends over time

Looking at national data can help predict what might happen in Norfolk. We may be able to make projections about the number of adults in Norfolk likely to be feeling lonely often, always or some of the time over the coming decades. Assuming prevalence of loneliness remains constant at the most recent estimates, the total number of lonely adults (16+) increases from 188,000 in 2023 to 206,000 in 2040.

Figure 12: Projected number of adults aged 16+ in Norfolk feeling lonely often always or some of the time.

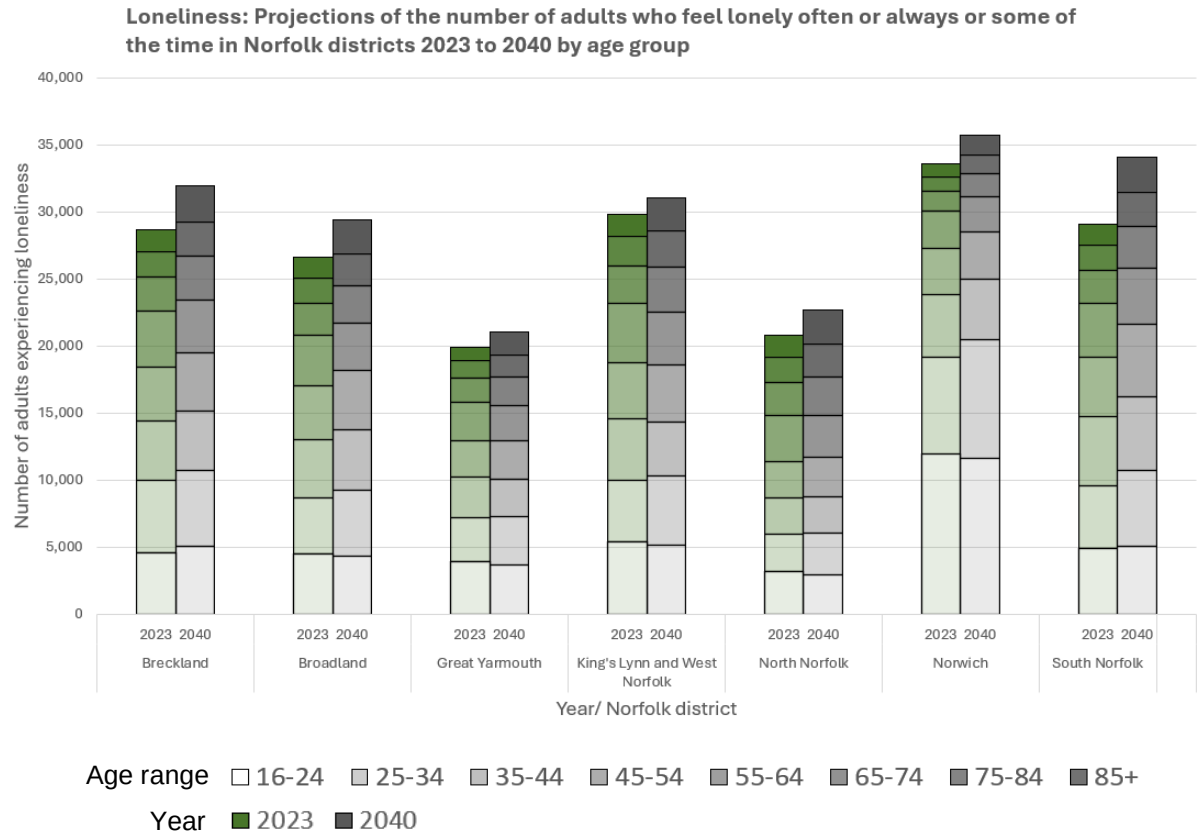


Source: Figures from Active Lives Survey using 2022/23 prevalence and 2018 sub-national population projections (52).

A breakdown of the projections according to age can be found in Appendix 5.

Projections for the districts show that South Norfolk has the potential for the largest increase in the number of adults experiencing loneliness from 2023 to 2040. Norwich will remain the district with the largest number of adults feeling lonely in 2040.

Figure 13: Projected number of adults (16+) in Norfolk districts feeling lonely often always or some of the time 2023 to 2040.



Source: Figures from Active Lives Survey using 2022/23 national age prevalence and 2018 sub-national population projections (52).

It is estimated that all districts will have an increase in older adults feeling lonely. Breckland and South Norfolk have the largest increase of older adults feeling lonely – both above 40% by 2040.

Figure 14: Projected number of older adults aged 65+ in Norfolk districts feeling lonely often always or some of the time 2023 to 2040 using 2022/23 national age prevalence and 2018 sub-national population projections (52); change from 2023 in brackets.

Districts	2023	2025	2030	2035	2040
Breckland	6,000	6,300 (+4.1%)	7,100 (+17.8%)	8,000 (+32.7%)	8,500 (+40.6%)
Broadland	5,800	6,000 (+3.2%)	6,600 (+14.5%)	7,400 (+27.3%)	7,700 (+32.9%)
Great Yarmouth	4,100	4,200 (+3.4%)	4,700 (+15.3%)	5,200 (+27.8%)	5,500 (+33.8%)
King's Lynn and West Norfolk	6,600	6,800 (+3.1%)	7,500 (+13.4%)	8,200 (+24.4%)	8,500 (+29.1%)
North Norfolk	6,000	6,100 (+3.2%)	6,800 (+14%)	7,500 (+26.3%)	7,900 (+32.1%)
Norwich	3,600	3,700 (+2.6%)	4,000 (+11.9%)	4,400 (+23.6%)	4,600 (+29.8%)
South Norfolk	5,900	6,100 (+4.5%)	6,900 (+18.3%)	7,800 (+33%)	8,300 (+41.1%)

Good Practice

Interventions for older adults

The NICE quality standard [QS137] on 'Mental wellbeing and independence for older people' (53) covers interventions to maintain and improve the mental wellbeing and independence of people aged 65 or older, and how to identify those at risk of a decline. The standard includes the following three quality statements:

1. Older people who are at risk of a decline in their independence and mental wellbeing are identified by service providers.
2. Older people most at risk of a decline in their independence and mental wellbeing are offered tailored, community-based physical activity programmes.
3. Older people most at risk of a decline in their independence and mental wellbeing are offered a range of activities to build or maintain social participation.

The accompanying implementation resource, NICE guideline [NG32] on 'Older people: independence and mental wellbeing' (54), recommends group or one-to-one activities for older people that aim to prevent loneliness and social isolation to build or maintain social participation.

Group activities could include (54):

- Singing programmes, in particular those involving a professionally-led community choir.
- Arts, crafts and other creative activities.
- Intergenerational activities. For example, helping with reading in schools or young people providing older people with support to use new technologies.
- Multicomponent activities. For example, lunch with the opportunity to socialise and learn a new craft or skill in a community venue.

One-to-one activities could include (54):

- Programmes to help people develop and maintain friendships. For example, peer volunteer home visiting programmes, programmes to learn about how to make and sustain friendships, or befriending programmes based in places of worship.
- Befriending opportunities that involve brief visits, telephone calls or the use of other media.
- Information on national or local services offering support and advice by telephone and other media.

The NICE guidance also recommends that older people should be made aware of the value and benefits of volunteering, which provides the opportunity to socialise, have an enjoyable experience and help others to benefit from their experience, knowledge and skills (54).

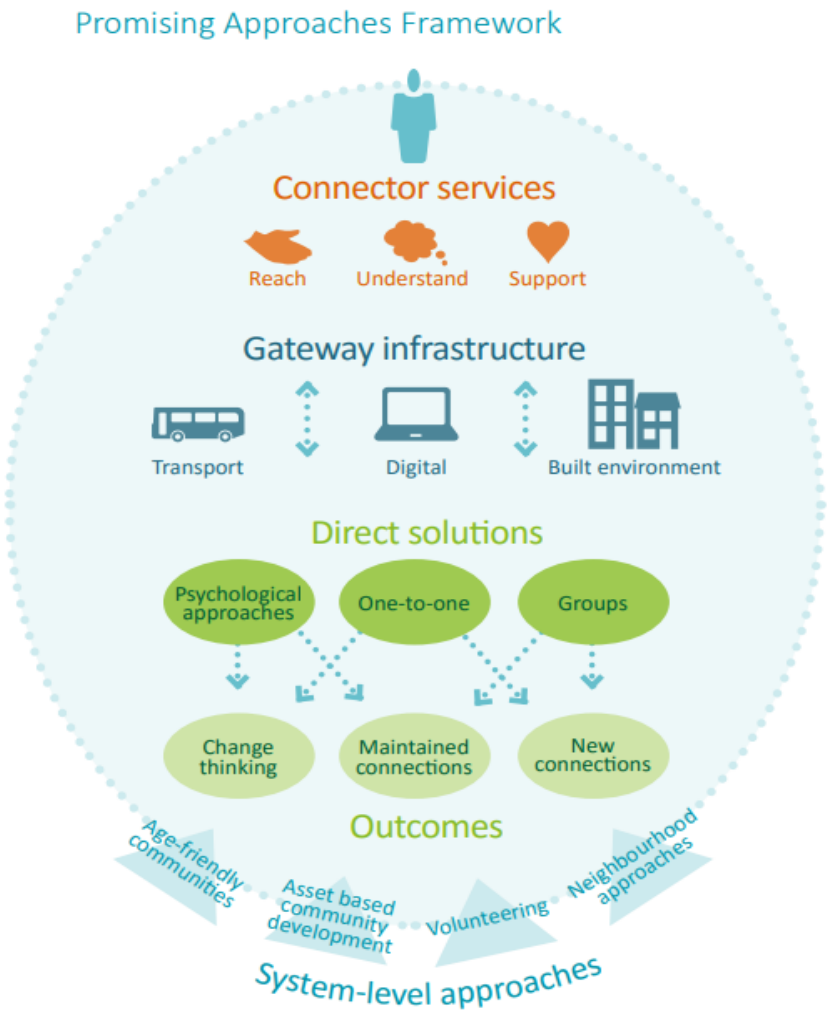
The guidance recommends that staff in contact with older people should be able to identify those most at risk of a decline in their independence and mental wellbeing, for example, older people whose partner has died in the past two years, carers, and those who live alone and have little opportunity to socialise (54).

Opportunities for prevention

In their policy position statement on healthy ageing (55), the Association of Directors of Public Health (ADPH) states that 'loneliness is a significant issue amongst older adults and should be recognised as part of the healthy ageing agenda'. ADPH recommends that addressing loneliness should be considered as a key preventative measure in shifting from acute and long-term care to self-help and support in communities across the health and care system. At a local level they recommend that the voluntary and community sector (VCS) should be supported to scale up evidence-based interventions to tackle loneliness, as the success of social prescribing and other referral schemes relies on the VCS to offer the opportunities and activities to which people can be referred.

The Campaign to End Loneliness have developed a promising approaches framework – a model for commissioners, local authorities, health bodies and third sector organisations interested in reducing loneliness in later life.

Figure 15: Promising approaches framework from the Campaign to End Loneliness (October 2020) (50).



In addition to communities offering a range of ‘direct solutions’ to tackle loneliness, with ‘connector services’ to provide the loneliest individuals with the support they need to access and engage with the direct solutions available in communities, the model also highlights the importance of ‘gateway infrastructure’ and ‘system-level approaches’. These different levels of support are able to more effectively tackle the different types of loneliness experienced. More involved, personalised support is made available for those experiencing chronic loneliness, whilst also having in place a variety of accessible community activity (that people can easily find out about) to suit different interests to tackle transient loneliness. This takes a more preventative approach to enable people to build and sustain their social networks.

Gateway infrastructure, such as transport, digital technology and the built environment, helps people to connect and is vital for an effective community response to loneliness. Where this kind of infrastructure is unavailable, inappropriate or inaccessible, it renders service delivery difficult and makes it hard for people to connect.

System-level approaches, such as neighbourhood approaches, asset-based community development, age-friendly communities and volunteering create the environment in communities which enables loneliness to be addressed. They are not interventions, but rather ways in which local authorities and other institutions can encourage and support communities to develop approaches, groups and activities. These approaches underpin community responses. Wider service provision, activities and events could consider small changes that help people overcome personal, social or environmental barriers to attending services, activities and events, for example by considering how welcoming the environment is, how people might get there, how accessible it is, and how the activity might promote exchange between people.

Cost effectiveness

Understanding the cost of loneliness and the return on investment from interventions is currently limited and is a significant gap in the evidence base. The government has called for more robust evaluations and economic analysis to be embedded into the intervention trials, to understand the relative programme costs, direct impacts on loneliness, and impacts on other areas (56). In 2017 the London School of Economics estimated the potential cost savings associated with addressing the loneliness of an older adult, who is severely lonely, to be in the region of £6,000 across their later life (57).

A summary of local services

Norfolk has a range of services which address social isolation and loneliness. Some of these are targeted interventions for specific groups such as older people, which tend to be commissioned by statutory sector organisations, or delivered by voluntary and community services or both. Others are universal services for the whole population. It is not possible to map all the services which are in place, however it should be noted that Norfolk County Council invests significant resource to address loneliness.

A recent survey undertaken by residents in receipt of locally commissioned services demonstrated there is satisfaction with the services delivered, however they have had limited success in addressing loneliness. This may be due to the short-term nature of interventions that are commissioned, and it may also be that services are geared towards addressing social isolation challenges, rather than the root causes of loneliness or increasing resilience through long term approaches.

Information gaps

There is a lack of information on the different types of loneliness experienced at a local level. The Active Lives Survey data does not distinguish between different types of loneliness, such as emotional or social loneliness. Although measuring loneliness with a single question has been found to correlate highly with loneliness measured using larger scales, this approach may still be regarded as a limitation as it does not provide insight into the type of loneliness experienced (58).

Services in Norfolk which provided evidence for this needs assessment reported that more women than men utilise their services, which indicates a gap in knowledge about if and where men access services to tackle these issues. Although women in the data available at a national level report experiencing loneliness more than men, it has been noted in the literature that men may be more reluctant to acknowledge that they are lonely and ask for help (59).

More robust evaluations and economic analysis is needed at a local level to be embedded into services seeking to tackle social isolation and loneliness, to understand the relative programme costs, direct impacts on social isolation and loneliness and impacts on other areas.

Conclusions

Loneliness and social isolation present a population health challenge for Norfolk, the two terms are often coupled together and whilst they can often overlap, they are not the same. Loneliness is a subjective feeling, whereas isolation is an objective state.

Loneliness is a problem, but it is complex to define and explain, as it may occur in different ways and at different times, in different groups of people with various intensity and impact. Social isolation and loneliness may be both a cause and a consequence of poor physical or mental health and wellbeing. Although it is not clear how the tangled effects of poor health and loneliness interact with each other.

Risk factors for loneliness and/or social isolation vary from individual factors (e.g. bereavement) to broader characteristics of the environments in which we live (e.g. access to transport). That national data suggests that factors such as age, gender, ethnicity and measures of deprivation all contribute to variation in prevalence of loneliness. For older

people there are particular characteristics such as living alone, poor health and digital exclusion that increase the risk of social isolation and/or loneliness.

The evidence base for what works to tackle social isolation and loneliness is mixed, there is variation in approaches that exist addressing different groups of population, as well as variation in measures of success. Whilst it's essential that policy and service interventions are informed by the evidence base it is also important to evaluate the impact of such changes at an individual and population level. At a population level, whole system approaches, such as those described in the promising approaches framework are likely to make the most significant impact.

There are significant assets in Norfolk that support residents to remain connected and protect against social isolation and loneliness. Targeted interventions commissioned by Norfolk County Council may provide effective support for those who are isolated and/or lonely, but local evidence of effective community approaches for long term resilience, is not clear. It is important that short term support for individuals is embedded within a wider system of interventions to address root causes of loneliness.

Glossary

Confidence intervals are indicated by error bars on the charts. They show the range that we are 95% confident the true value for the population falls between. When there is no overlap between the error bars for two or more groups, we can be more confident that the differences between groups represent true differences between these groups in the population.

Deprivation is where people don't have the conditions that are usually considered necessary for a pleasant life, for example sufficient income, employment, education, health, living environments, and low levels of crime and few barriers to housing and services.

Loneliness is 'a subjective, unwelcome feeling of lack or loss of companionship. It happens when there is a mismatch between the quantity and quality of the social relationships that we have, and those that we want' (3).

Prevalence means the proportion of a group or population that has a particular condition or engages in a specific behaviour – for example, the number of people who are lonely at a particular time.

Social isolation is a lack of social contact.

Social prescribing is an approach that connects people to activities, groups, and services in their community to meet the practical, social and emotional needs that affect their health and wellbeing (60).

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Appendices

Appendix 1: Methodology

It is important to note the differences in how loneliness and social isolation are measured, and the limitations in the data available.

Social isolation can be objectively measured by looking at the number and frequency of social contacts someone has. Loneliness is subjective and a personal experience and therefore cannot be measured in this way.

In 2018 the Office for National Statistics (ONS) published guidance on the measurement of loneliness to ensure a consistent approach is taken nationally to improve the evidence base on loneliness (61). This included recommended national indicators of loneliness (62), consisting of four questions to capture different aspects of loneliness, as shown in Appendix 2 of this document.

The Active Lives Survey for adults aged 16+ (44) is the primary source of data used to assess the need of the local population in relation to loneliness. The survey results are adjusted through weighting to accurately represent the population, considering various demographic and geographic factors, to reduce bias. The most responses to the most recent survey in 2022/2023 were received from people aged 55-64 years, with the fewest responses received from people aged 85+.

Due to sampling sizes within the survey the district level loneliness specific prevalences are only available from Fingertips using the 2019/2020 Active Lives Survey.

There are other data sources for the measurement of loneliness nationally, such as the Community Life Survey. This needs assessment primarily uses the results collected from the Active Lives Survey due to the larger number of households invited to participate in this survey and the collection of data at district level. The methods used for data collection for the Active Lives Survey is also deemed to be more accessible for people who are digitally excluded.

Summaries of the methodologies used for the collection of data for the Active Lives Survey for 2022/2023 and the Community Life Survey for 2021/2022 can be found in Appendix 3 of this document.

Studies have shown that there is social desirability bias associated with social isolation and loneliness, which may mean that it is difficult for an older adult to admit they are feeling lonely or are socially isolated (5). It has also been reported that socially isolated older adults may be less likely to participate in research studies (63) and may also be less likely to participate in interventions to improve their social connectedness and decrease the isolation and loneliness (5).

Appendix 2: Office for National Statistics (ONS) recommended national indicators of loneliness

The recommended questions and response categories are as follows (62):

Measures	Questions	Response categories
The three-item University of California	1. How often do you feel that you lack companionship?	"Hardly ever or never", “Some of the time” or “Often”.

(UCLA) Loneliness scale		
	2. How often do you feel left out?	"Hardly ever or never", “Some of the time” or “Often”.
	3. How often do you feel isolated from others?	"Hardly ever or never", “Some of the time” or “Often”.
The direct measure of loneliness	How often do you feel lonely?	“Often or always”, “Some of the time”, "Occasionally”, “Hardly ever” or "Never".

Appendix 3: Survey methodology summaries

Active Lives Survey 2022/2023 (1)

- The Active Lives Survey for 2022/23 was conducted from November 2022 to November 2023 for adults aged 16+ in England.
- The survey involved sending two questionnaires per household to 562,644 addresses in 12 different waves, with an incentive of £5 offered for completion.
- Households received a postal letter to complete the survey online, followed by four reminders if not completed. The third reminder including a physical paper survey.
- Out of the total surveys sent, 172,968 were completed with 73.1% completed online and 26.8% by paper.
- The sample was taken from the Postcode Address File maintained by Royal Mail
- The survey results were adjusted through weighting to accurately represent the population, considering various demographic and geographic factors, thereby minimising bias, and extreme values. It controls for unequal selection of addresses across local authorities, the selection of adults within a household and seasonality, and matches ONS mid-year population estimates.
- There were 3 routes to completing the survey, online group 1, online group 2, and the paper survey. All groups were asked the ONS Loneliness question.
- The survey had targets for each local authority. The specific targets and completion numbers for Norfolk districts were:

Local Authority	Achieved	Target
Breckland	511	500
Broadland	505	500
Great Yarmouth	497	500
King’s Lynn and West Norfolk	457	500
North Norfolk	479	500
Norwich	510	500
South Norfolk	499	500

- The national age distribution was:

Age group	Online	Paper	Total
16-24	7.3%	2.8%	6.1%
25-34	16.4%	6.9%	12.6%

35-44	18.2%	8.3%	15.6%
45-54	17.4%	11.5%	15.8%
55-64	18.6%	21.1%	19.2%
65-74	15.6%	26.2%	18.4%
75-84	6.6%	19.7%	10.1%
85+	1.1%	5.2%	2.2%

- The national ethnicity distribution was:

Ethnic group	Online	Paper	Total
White – British	81.1%	89.1%	83.3%
White – Other	6.5%	4.1%	5.9%
Asian	6.4%	3.2%	5.5%
Black	2.2%	1.7%	2.1%
Chinese	1.0%	0.6%	0.9%
Mixed	1.8%	0.8%	1.6%
Other	1.0%	0.6%	0.9%

Community Life Survey 2021/2022 (64)

- The Community Lives Survey for 2021/2022 was conducted from October 2021 to September 2022 for adults aged 16+ in England.
- The survey sent 4 questionnaires per household to 25,813 addresses in 8 different waves, with a £10 incentive offered for completion. Two reminder letters were sent if not completed and a third to a targeted subsample (high deprivation/ younger household structure).
- Some households (40% based on response probability strata) received a paper questionnaire with the second reminder. The paper questionnaire was also available on request.
- Out of the total surveys sent, 10,126 were completed with 82.4% completed online and 17.6% by paper.
- The sample was taken from the Postcode Address File maintained by Royal Mail and was based on age, deprivation, and ethnicity. The survey had a target of at least 2,000 ethnic minority respondents.
- Weighting was completed to compensate for variations in sampling probability and to partially compensate for variations in response probability within the population.

Appendix 4: Proportion of adults aged 16+ in Norfolk districts feeling lonely often, always or some of the time by ethnicity.

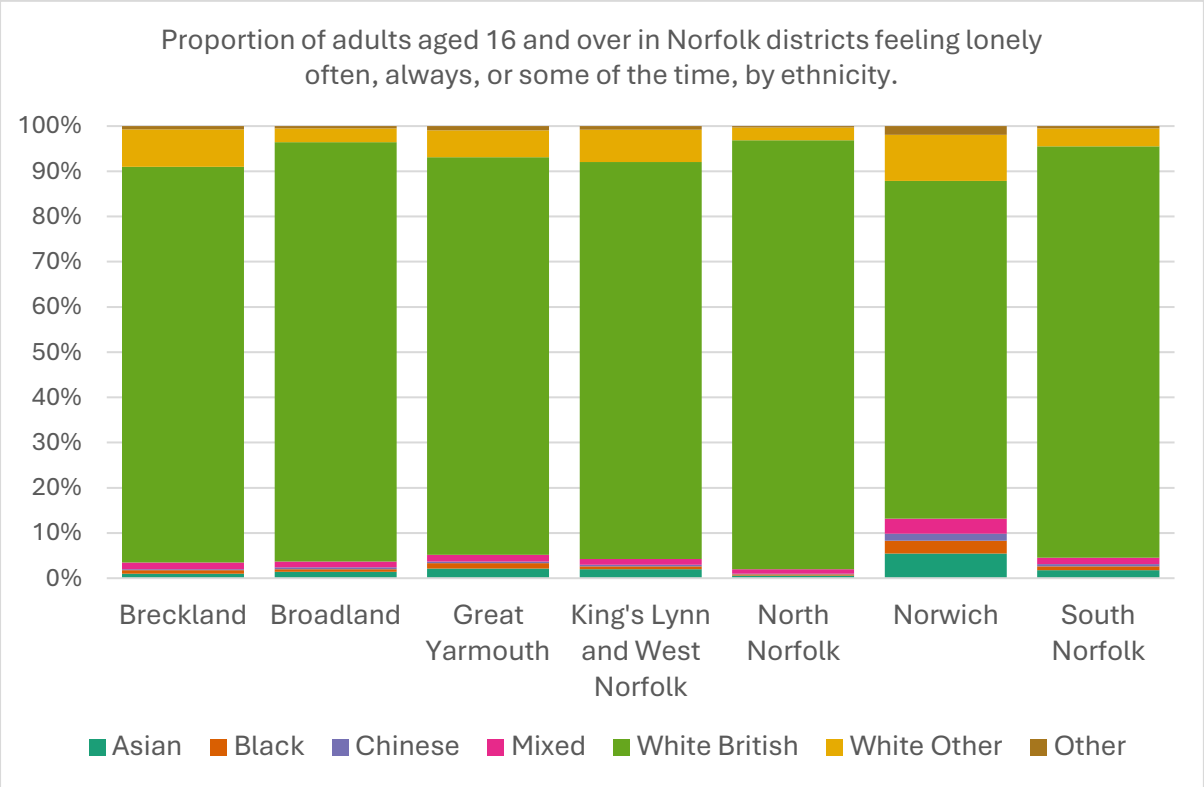
Figure A: Proportion of adults aged 16+ in Norfolk districts feeling lonely often always or some of the time using 2022/23 prevalence rates and 2021 census population estimates

(65), grouped by ethnicity; Orange indicates the district with the largest proportion in each ethnicity group.

Districts	Asian	Black	Chinese	Mixed	White British	White Other	Other
Breckland	1.0%	0.8%	0.3%	1.4%	87.6%	8.2%	0.8%
Broadland	1.4%	0.6%	0.5%	1.3%	92.8%	3.1%	0.5%
Great Yarmouth	2.1%	1.2%	0.3%	1.5%	88.0%	5.9%	1.0%
King's Lynn and West Norfolk	2.0%	0.6%	0.4%	1.3%	87.8%	7.2%	0.8%
North Norfolk	0.6%	0.2%	0.2%	1.0%	94.9%	2.8%	0.3%
Norwich	5.5%	2.8%	1.6%	3.3%	74.7%	10.2%	2.0%
South Norfolk	1.8%	0.9%	0.5%	1.4%	91.0%	4.0%	0.5%
Norfolk	**2.1%**	**1.1%**	**0.5%**	**1.6%**	**87.7%**	**6.1%**	**0.9%**

Source: Active Lives Survey 2022/23.

Figure B: Proportion of adults aged 16+ in Norfolk districts feeling lonely often, always, or some of the time by ethnicity, using 2022/23 prevalence rates and 2021 census population estimates.



Source: Active Lives Survey 2022/23.

Appendix 5: Projected number of adults aged 16+ in Norfolk feeling lonely often always or some of the time.

The number of people considered lonely in the younger age groups stays somewhat constant compared to older adults that see a large increase from 2023 to 2040 due to the ageing population.

Figure C: Projected number of adults aged 16+ in Norfolk feeling lonely often always or some of the time; change from 2023 in brackets.

Age	2023	2025	2030	2035	2040
16-24	35,200	36,200 (+2.8%)	39,800 (+13.1%)	39,800 (+13.2%)	38,000 (+7.9%)
25-34	35,000	34,600 (-1.1%)	33,100 (-5.5%)	34,100 (-2.6%)	36,900 (+5.4%)
35-44	29,000	29,600 (+2.2%)	30,300 (+4.7%)	29,800 (+2.8%)	28,500 (-1.7%)
45-54	25,600	24,900 (-2.4%)	25,200 (-1.3%)	27,300 (+6.6%)	27,800 (+8.9%)
55-64	25,300	26,000 (+2.7%)	25,400 (+0.2%)	23,500 (-7.3%)	23,800 (-5.9%)
65-74	15,800	16,100 (+1.6%)	18,100 (+14.7%)	19,800 (+25.2%)	19,400 (+22.8%)
75-84	12,200	12,900 (+5.7%)	13,500 (+10.6%)	13,600 (+11.4%)	15,600 (+27.5%)
85+	9,900	10,300 (+3.8%)	12,000 (+21.7%)	15,100 (+53.4%)	16,000 (+61.5%)

Source: Active Lives Survey using 2022/23 prevalence and 2018 sub-national population projections.