East Anglia Quality Surveillance Group Meeting

Date: January 2018
Title: Report of Norfolk Safeguarding Adults Board

KEY POINTS/ISSUES OF CONCERN

1) Loneliness and safeguarding

Background
Loneliness is a subjective, unwelcome feeling of lack or loss of companionship, which happens when there is a mismatch between the quantity and quality of social relationships that we have and those that we want. It is often associated with social isolation, but people can and do feel lonely even when in a relationship or when surrounded by others (Combating loneliness one conversation at a time: A Call to Action, Jo Cox Commission on Loneliness, pg8 2017).

The Jo Cox Commission on Loneliness was formed by the MP Jo Cox before she was killed in her constituency in 2016. On Friday 15 December 2017 the commission published a year-long study into this issue. Rachel Reeves, Labour MP who co-chaired the commission, is quoted as saying that William Beveridge, one of the key architects of Britain’s welfare state, would have added loneliness as society’s sixth “giant evil” if he were alive today, see The Guardian 10 December 2017. This report says the government should create a national strategy to combat loneliness and appoint a minister to lead action on the issue.

Loneliness and social isolation
Loneliness is often discussed in conjunction with social isolation, and the terms are often used interchangeably in everyday language. However, researchers have pointed out that the two concepts need to be differentiated. Whereas social isolation arises in situations where a person does not have enough people to interact with (an objective state), loneliness is the subjective experience of distress about not having enough social relationships or not enough contact with people. Although the two concepts can be related, a person can be socially isolated but not feel lonely, whereas an individual with a seemingly large social network can still experience loneliness.

A number of recent research reports have investigated the topic of loneliness and its impact on individuals, communities and wider society. A study commissioned by the Red Cross in partnership with the Co-op, notes:

- Loneliness does not just affect older people. Many other groups in society, from young mums to those with health or mobility issues, experience feelings of loneliness and social isolation
• Life transitions can be key triggers for feeling lonely, from retirement to divorce or separation. Health and social care providers often have contact with people at points of transition and so are well placed to spot concerns for people who use their services

• Without the right support at the right time, loneliness can transition from a temporary situation to a chronic issue and can contribute to poor health and pressure on public services. (Kantar 2016)

In particular this study comments:

‘Our social connections are fundamental to our daily experience, to the ways that we make meaning in our lives and to quality of life and life satisfaction. At best, being socially connected – and having roles to play with the friends, colleagues, family members, neighbours, and even casual acquaintances in our lives – provides a sense of purpose, comradery, belonging and identity. Conversely, lacking meaningful and satisfying social connections has surprisingly powerful negative consequences across the mental and physical health spectrum’ (Kantar 2016 pg12)

There are now a number of national campaigns on loneliness, drawing attention to the size of the problem and calling for action on this issue.

Prevalence
The Kantar (2016) report commissioned by the British Red Cross and Co-op evidences that loneliness is a common issue in the UK. The Jo Cox Commission report (2017) highlights the following:

• over 9 million people in the UK across all adult ages – more than the population of London – are either always or often lonely

• 38% of people with dementia said that they had lost friends after their diagnosis. (Alzheimer Society)

• Over 9 million adults are often or always lonely (British Red Cross and Co-op)

• Three out of four GPs say they see between 1 and 5 people a day who have come in mainly because they are lonely, and one in ten sees between six and ten such patients daily (Campaign to End Loneliness)

Loneliness as a health issue
There is a growing body of evidence detailing the impact of loneliness on a person’s health. When we are lonely, we are less resistant to external stressors, it is harder for the body to repair itself (Hawley, Cacioppo 2010), cognitive functioning declines (Steptoe et al
2013), and the risk of dementia (Holwerda et al 2012) and depression increases (Hawley, Cacioppo 2010). Further studies have found:

- Loneliness increases the likelihood of mortality by 26% (Holt-Lunstad, 2015)
- Lacking social connections is as damaging to health as smoking 15 cigarettes a day (Holt-Lunstad, 2015).
- The effect of loneliness and isolation on mortality is comparable to the impact of well-known risk factors such as obesity, and has a similar influence as cigarette smoking (Holt-Lunstad, 2010)
- Also see Campaign to End Loneliness: Threat to Health

Leigh-Hunt et al’s (2017) systematic review of English language studies covering social isolation and loneliness (but not solely social support) from 1950 to 2016 notes that:

- there is consistent evidence linking social isolation and loneliness to worse cardiovascular and mental health outcomes.

Richman et al (2016) as cited by Fenge (2017) suggest that ‘loneliness disrupts the clarity and structure of the self, which in turn, disrupts people’s mental health’. However, less is known on the role of other conditions and wider socio-economic consequences (Leigh-Hunt et al 2017). These authors conclude that:

> ‘policy makers and health and local government commissioners should consider social isolation and loneliness as important upstream factors impacting on morbidity and mortality due to their effects on cardiovascular and mental health. Prevention strategies should therefore be developed across the public and voluntary sectors, using an asset-based approach.’

**Loneliness as a safeguarding issue**

While loneliness and social isolation are separate issues there is an interplay and interdependence between them. Loneliness is one of main indicators of social well-being, and health and social care practitioners often work with individuals who present as lonely or socially isolated (Fenge 2017 pg53). Increasingly loneliness is a concern for organisations as it can be a ‘tipping point’ for an individual being referred to health and social care. Social isolation is understood as a factor increasing the risk of an adult becoming a victim of adult abuse, as is low self-esteem (Boland et al 2013). Johannesen, LoGiudice (2013) also identify loneliness as a risk factor in adult abuse, while Olivier et al (2015) notes that increased emotional vulnerability due to loneliness may increase susceptibility to scams involvement.

Conversely a protective factor against adult abuse and harm is having numerous, strong relationships with people of varying social status. By taking a proactive approach to tackle loneliness, organisations can also strengthen the protective factors within communities which can help tackle adult abuse and harm.
Suggested actions for Clinical Commissioning Groups

- explore with current providers what steps they are taking to raise staff awareness about loneliness and its impact on individuals
- via Clinical Quality Review Meetings (CQRM), ask providers how they might demonstrate the impact of their work in this issue
- consider innovative ways to incorporate tackling loneliness in the development of social prescribing and joint commissioning work
- in their role as members of safeguarding adults boards, CCGs to raise this issue for discussion at their next SAB meeting - specifically to develop actions for joint working to address loneliness, well-being and adult safeguarding.
- explore options of addressing loneliness as an outcome measure of Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy

Actions for health providers and other partners

- raise the awareness of this topic with staff
- sign up to the national campaigns
- actively participate in local campaigns; for example, see Norfolk’s In Good Company campaign

2) CARE HOMES
Norfolk is currently concluding a Safeguarding Adult Review which is looking at lessons from the death of an elderly female in November 2016. The resident was taken to hospital and was found to be suffering from severe hypothermia and pneumonia, and died on the day of her admission.

The care home (now closed) was an old uninsulated building with high ceilings and large rooms. Its heating and hot water ran on two boilers dating back to the 1960s. There were two boilers, as one would be unable to take the full load of the output required by the home, therefore the boilers were run alternately for short periods, as the home had been made aware that one would not be sufficient. There had been heating failure within the home since June/July (2016).

Due to current inclement weather Clinical Commissioning Groups are asked to seek assurance that the care homes they commission have appropriate contingency plans in place in the event of heating failure.

3) PHARMACIES / BOOTS
NEL Clinical support Unit advised that Boots Pharmacy were planning on reverting to original boxed medication and ceasing supplying in blister packs. It is unclear what is prompting this change in practice, but it may be financially related.

This appears to be a wider issue across the community pharmacy market and the concern is that removal of this safety measure could lead to more medication errors and potentially Safeguarding reviews in Norfolk and Waveney.

Clinical Commissioning Groups are asked to investigate through their commissioning functions.

References


Kantar (2016) Trapped in a bubble: An investigation into triggers for loneliness in the UK


Other useful resources