HEALTH AND WELLBEING
INNOVATION COMMISSION INQUIRY:

Social Connections and Loneliness

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Introduction

AS A VARIETY OF factors lead to increasing longevity and an ageing population, the demand for robust health and care services continues to grow. Innovation in the areas of health and wellbeing will be crucial to ensure that such services remain sustainable, address needs efficiently, and contribute to positive experiences in later life.

In order to foster developments in this respect, ILC-UK established the Health and Wellbeing Innovation Commission with the support of the Audley Group and EY. The Commission brings together current evidence in this area, generating thought leadership through a critical exploration of the opportunities and barriers with respect to diffusing new ideas and innovations across four themes relevant for later life and across the life course: retirement communities and care homes, the built environment, physical and mental health, and social connections.

The fourth and final inquiry examined social connections and loneliness. Social connections are a fundamental aspect of people's lives, impacting on expressions of identity as well as individual health and wellbeing. Policy interest in this area has also grown in recent years, particularly with respect to addressing the issues of social isolation and loneliness. It is therefore timely that we reflect on the available evidence around how innovation can help foster, harness, and improve social connections to the benefit for all people in an ageing society.

Expert contributions during the fourth inquiry session of the commission, combined with our own research of available literature and examples in this field, have informed this report to explore the current state of affairs around innovations in social connections and loneliness and their role to influence health and wellbeing in later life.

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Setting the Scene: Defining Social Connections

THE TOPIC OF SOCIAL connections is quite broad, covering a number of interrelated concepts and ideas. As a previous evidence review around inequalities in later life notes, outcomes associated with social connections can broadly be categorised into four themes: social contacts, networks, and support; social isolation and loneliness; social participation and engagement; and social inclusion/exclusion, integration, and cohesion.[1]

- **Social contacts, networks, and support** – broadly speaking, social connectedness – refer to the relationships people have with others, such as the frequency and nature of contact with family or friends. Social connectedness can also refer to people coming together to achieve a goal and is fostered when the relationships are positive for the individual.[2]

- **Social isolation and loneliness** refer to the potentially negative experiences related to (a lack of) social connections. We discuss these further below.

- **Social participation and engagement** relate to people's activities in society. The English Longitudinal Study of Ageing (ELSA), which collects data from a representative sample of people over the age of 50 in England, proposes four elements of social participation:[3]

  - Civic participation, e.g. membership of a political party, trade union, church, etc.

  - Leisure activities, e.g. taking part in arts, education, and/or social or sports clubs.

  - Cultural engagement, e.g. going to the cinema, art gallery, etc.

  - Social networks, e.g. being in contact with and/or having friends, family, children.[4]

- **Social inclusion/exclusion, integration, and cohesion** explore how people's access to social activities and experiences manifest and are shaped by external factors, including the societal barriers that limit individuals' opportunities with respect to the other themes of social connections as well as other facets of modern life.

Notwithstanding the overlap in these themes around social connections, of critical significance for policy makers and service providers are the experiences around social isolation and loneliness. **Social isolation** has been defined by Public Health England as "being deprived of social relationships" which provide meaning to an individual.[5] Social isolation is measured by the strength of a person's social connections, and therefore the lack of these connections denotes social isolation.[6] Measures of social isolation therefore reflect an objective assessment of an individual's connections to others.

In contrast, **loneliness** describes the subjective experience related to social connections. It relates to perceptions and feelings and can manifest despite the presence of social connections. It represents an absence of quality relationships in contrast to what an individual's aspirations for such relationships actually are.[7] Moreover, it can be temporary, reoccurring, or chronic.[8]

1 Scharf et al. (2017)
2 The Social report (2015)
3 Davidson & Rossall (2015)
4 The presence and nature of social networks influence an individual's capacity to engage in social participation, while the distinct theme of social contacts emphasises how these networks are created and exist.
5 Public Health England (2015)
6 Berg & Cassells (1992)
7 Public Health England (2015)
8 Davidson & Rossall (2015)

Context: Social Connections in an Ageing Society

SOCIAL CONNECTIONS PLAY an important everyday role in people's lives. They are a vital part of what makes a person satisfied with their lives and represent a "core psychological need".[9] Social connections are now recognised to be an important aspect of health and wellbeing, discussed further below.

Between 2008 to 2033, it is estimated that there will be a 44% increase in the number of people aged 65-74, a 38% increase in those aged 75-84, and a notable 145% increase in those aged 85+.[10] An ageing society will therefore require new interventions and solutions to ensure that social connections are maintained across the life course and that the risk of loneliness is minimised.

One YouGov poll in 2010 found that older people were more likely to report high levels of life satisfaction than those of working age, though this declined for those aged 80 and above.[11] Similarly, in another survey, older people on average were more satisfied with their relationships with family and friends with a rating of 8.6 out of 10, compared to those of working age who rated their relationships 8.2 out of 10.[12]

However, despite findings of higher satisfaction with life or relationships in later life, it is imperative to remember that social connections may change as people age. Important changes that are more likely among older people (such as declines in health or loss of a partner) may mean they stop doing some of the activities they were once doing, which help shape and maintain their connections to others.[13] Transitions into retirement can also take people away from the core of their social networks (i.e. work colleagues), especially among men.

Wider factors such as geography and where people live can further shape how socially connected they are. For example, living closer to children may explain lower levels of loneliness among older people.[14] Transport, particularly rural transport, is equally important for mobility and in turn maintaining social connections. Yet supported bus services within rural areas have been cut by 25% since 2010, which has impacted the availability of transport services.[15] Supported bus services are subsidised by local authorities where commercial bus companies do not offer the service.[16] Such barriers that impact social connections, as well as the differing needs of people as they age, must be considered when looking for solutions to address issues around isolation and loneliness.

While a lack of social connections defines social isolation, it may also manifest into loneliness. For example, those who live on their own experience higher rates of loneliness than those who live with a spouse, and the likelihood of living alone increases with age.[17] 17% of older people report less than weekly contact with family members, friends, and neighbours, while 49% of those aged over 65 say that they use the TV or their pets "as their main form of company".[18] At the same time, health is another important factor related to social connections, as those in poor health are "2.5 times more likely to report feeling lonely than those reporting good health".[19]

9 Greater Good Science Centre (n.d)
10 Davidson & Rossall (2015)
11 Thomas (2015)
12 Thomas (2015)
13 ComRes (2016)
14 WRVS (2012)
15 Hart (2016)
16 Campaign for Better Transport (2015)
17 Griffiths (2017); Thomas (2015)
18 Davidson & Rossall (2015)
19 Thomas (2015)

The Importance of Fostering Social Connections in Later Life

THERE IS NOW GREATER recognition that social connections play a significant role in influencing a variety of outcomes in later life. In particular, a great deal of evidence has emerged to highlight how social isolation and loneliness can have negative impacts on individuals' health and wellbeing, as well as how this relates to public services and policy.

Health and wellbeing

Fostering social connections can be a key protective factor against social isolation and loneliness, and both have been associated with poorer outcomes in health and mortality.[20] For example, a meta-analysis found they were associated with a 50% excess risk of coronary heart disease, similar to the impact of work-related stress.[21] In addition, research has shown that those who report feeling lonely are nearly 7 times more likely to report low feelings of life satisfaction and over three times more likely to report feeling unhappy.[22] The relationship between loneliness and health is so acute it has been compared to smoking 15 cigarettes a day.[23] Furthermore, people experiencing social isolation and loneliness are 3.4 times more likely to suffer from depression, and there is a 14% likelihood of developing coronary heart disease.[24] It is therefore important that social connections are maintained if we want to continue making progress in life expectancy and healthy life expectancy in particular.

Under-use of services

The health effects of social isolation and loneliness are coupled with the under-use of services that could potentially help people address their social connections. There is a stigma attached to loneliness and social isolation, so much so that almost a quarter of people (23%) say that they would be embarrassed to admit that they feel lonely.[25] The ramifications of this stigma are manifested in how many people access support. One survey found that only 8% of those over the age of 55 accessed help, compared to the average of 11% of 18+ adults.[26] Moreover, another survey found that almost 200,000 older people in the UK do not receive any help to get out of their houses.[27]

Costs

The consequences from a lack of social connections represent a cost to society at large, which is why it is paramount that we work to develop innovative solutions to tackle this issue. It is estimated that "disconnected communities" could be costing the economy £32 billion a year, with costs to various parts of public services including £5.2 billion for health services, £205 million in the demand placed on policing, and a net cost of £12 billion as a result of the loss of productivity.[28] In addition, those over the age of 70 who live alone are 60% more likely to visit Accident and Emergency (A&E) services than those who live with a partner.[29] Evidence also suggests that A&E admissions go down when loneliness is reduced, and the length of hospital stays also comes down.[30]

There are also costs to UK employers, with research showing that the health risks associated with loneliness could be costing employers £20 million in sickness absence.[31] Furthermore, it is estimated that caring responsibilities among employees for those with health conditions associated with loneliness costs employers

20 Public Health England (2015)
21 Steptoe & Kivimaki (2012)
22 Thomas (2015)
23 Davidson & Rossall (2015)
24 Davidson & Rossall (2015)
25 Griffin (2010)
26 Griffin (2010)
27 Davidson & Rossall (2015)
28 The Eden Project (n.d)
29 Griffiths (2017)
30 The Eden Project (n.d); Griffiths (2017)
31 Jeffrey et al. (2017)

around £220 million.[32] In combination with costs to productivity and staff turnover, the total cost of loneliness to UK employers is estimated at £2.5 billion per year, of which £2.1 billion is attributed to employers in the private sector.[33]

All of the above demonstrate that there are huge cost savings that could be made if we improve social connections and prevent social isolation and loneliness. Innovations in this area could offer further savings to the public and private sector, as well as helping those that are in desperate need of such services.

32 Jeffrey et al. (2017)
33 Jeffrey et al. (2017)

The Policy Context around Social Connections and Loneliness

THERE HAS BEEN GROWING policy interest in the area of social connections and loneliness, led by the voluntary sector. The work of Age UK, Independent Age, and the Campaign to End Loneliness (amongst others) has been important in bringing these issues to the forefront of policy making. Examples of policy that has emerged with some degree of emphasis on social connections and loneliness include:

- Adult Social Care Outcomes Framework 2013/2014: This Framework is used by the government to measure outcomes within the adult social care system. The 2013/14 framework recognised the need to better understand experiences related to loneliness and social isolation.[34] A measure was developed based on self-reported levels of social contact that carers and those who use the social care system have. While there was a review to establish an effective, direct measure of loneliness to include in the Framework, this work "has now concluded having been unable to identify a suitable measure" as noted in the 2018/19 update.[35]

- Public Health Outcomes Framework 2016 to 2019: This sets out a vision for Public Health, with desired outcomes and how to reach them. The Framework aims to support local government and considers social isolation and loneliness in a similar manner to that included in the Adult Social Care Outcomes Framework, with a focus on carers and those that use the social care service. It states an interest in pursuing further supportive measures, such as making funding available for those who are working in the field to address the issue.[36]

- Jo Cox Commission on Loneliness: This cross-party commission was set up to take the agenda on loneliness forward, initially with the aim of running for a year working with charities, businesses, and government in order to bring the issue of loneliness to the forefront of public understanding and stimulate policy response. This commission was taken forward by Seema Kennedy MP and Rachel Reeves MP after Jo's murder in 2016, with a report published at the end of 2017.

- Minister for Loneliness: In response to the recommendations made by the Jo Cox Commission, Tracey Crouch was appointed to the new role of Minister for Loneliness. The ministerial position will work to tackle loneliness through the creation of a dedicated fund for innovative solutions and the development of an England-wide strategy for loneliness.[37]

- Campaign to End Loneliness Framework: The Campaign to End Loneliness developed a loneliness framework, designed to cover the range of interventions to support older people in this area.[38] It includes four main categories. The first, foundation services, involves having specific services that reach and understand the needs of those who are experiencing loneliness. The second, direct interventions, covers a variety of services that improve the number and quality of social connections/ relationships that older people have. The third category addresses gateway services, those that help sustain social connections such as transport and technology services. The last category involves structural enablers, which consist of having the right structures in place in local environments to reduce the level of loneliness for those who live with it or are vulnerable to it.

- Industrial Strategy Fund: £300 million has been set aside for the Industrial Challenge Fund. The fund has four key priorities: artificial intelligence, clean growth, mobility, and an ageing society. Within this strategy, £98 million will go towards a healthy ageing programme which will help older people "live longer, tackle loneliness, and increase independence".[39]

34 Department of Health (2012)
35 Department of Health and Social Care (2018)
36 Department of Health (2016)
37 Gov.UK (2018b); **https://www.jocoxloneliness.org/**
38 **https://campaigntoendloneliness.org/guidance/theoretical-framework/**
39 Gov.UK (2018a)

Innovations to Foster Individual Connections

THE NEED TO HELP people maintain and foster their social connections is ever more important with the reality that people's lives change. Indeed, transitions points that occur across the life course – a number of which are more likely to occur later in life, e.g. retirement – can substantially alter people's access to social connections.

Two distinct but interrelated aspects are reflected in successful innovations to address social connections: peer support and group initiatives. Peer support links people with others like them, enabling interactions to draw on shared experiences and similar perspectives. Such support can be provided on a one-to-one basis or offered in a group context. Moreover, group approaches to foster social connections can also bring different groups together, expanding on the peer approach to encourage the sharing of diverse perspectives and stories.

The Value of Co-production

Many programmes explicitly seek to encourage improved health and wellbeing alongside improved social connections. Prevention and self-management are key principles associated with this. As noted in our inquiry by Jolie Goodman, co-production is a powerful tool for helping initiatives underpin a preventative approach to health and wellbeing. She highlighted work done by the Mental Health Foundation that includes peer support courses for vulnerable prisoners, of particular note as prisons are a notable provider of social care for older men in the UK. The foundation has also incorporated co-production into another project, Standing Together:

- Standing Together was a partnership project between the Mental Health Foundation and Housing & Care 21, a specialist provider of retirement housing, later joined by Notting Hill Housing. Running over 2015-2017 with funding from the Big Lottery Fund, the project established peer-support and activity-based groups among residents in retirement community settings, with the goal to improve emotional health and social connections. An evaluation of the work found evidence to suggest that participants did experience benefits in their wellbeing and sense of belonging, among other improvements.[40] It has also been recognised that the use of skilled facilitators was key to the project's success.

Innovations that incorporate co-production can generate broadly applicable lessons that are useful for further programmes. However, the nature of the co-production approach requires this element to be replicated in any new setting, involving the people that such a programme targets. From one perspective, this is a limiting factor on the scalability of programmes that incorporate co-production, although the co-production component does not have to be difficult or resource-intensive. Moreover, the underlying ethos – and success – of such endeavours requires that they be built based on feedback and engagement with users, so repeating this step of project development is ultimately beneficial for all involved.

These ideas were echoed in our inquiry by Dr Suzanne Moffatt, who highlighted research on another intervention to reduce loneliness and social isolation through food-related activities. In particular, the evaluation of the Age UK County Durham "Come Eat Together" project found that co-production or co-creation approaches confer benefits in particular ways:[41]

- Harnessing natural enthusiasm for a project can result in outcomes unlikely to be achieved through central development.
- Drawing on the assets of a group who may be marginalised increases project sustainability.
- Services that genuinely meet the needs of users may challenge the assumptions of professionals.

Overall, co-production reflects the point made multiple times in our inquiry that good innovations around social connections adopt a bottom-up approach rather than emerging from larger strategies.

40 https://www.mentalhealth.org.uk/publications/evaluation-standing-together-project
41 Wildman et al. (2018)

Intergenerational Activities

Some initiatives to promote social connections in later life have adopted an intergenerational approach, linking younger and older people. One example is the Cares Family, currently operating through four locally run branches in Liverpool, Manchester, North London, and South London.

- The Cares Family began in 2011 with its first branch in North London. Each branch of the Cares Family works to reduce loneliness and social isolation for both older people as well as young professionals. They create local community networks to facilitate social engagement, the sharing of stories, and new experiences and friendships. Programmes have included Social Clubs, a one-to-one Love Your Neighbour friendship programme, and Outreach and Community Fundraising.

The founder of the Cares Family, Alex Smith, noted in our inquiry that intergenerational approaches should be designed to function both ways, i.e. conferring benefits to both younger and older participants rather than seeking to only address the issue of isolation or loneliness for older people. This has also been observed in other contexts where different generations have come together, e.g. where nurseries have been placed in care homes. Such observations strengthen the case for the benefits that come from encouraging greater social interactions across different age groups.

ILC-UK has previously done work with Age UK on projects designed to facilitate intergenerational connections among members of the LGBT community. This work brought together the evidence in this space, evaluated three projects conducted in Camden, Leicester, and Stockport, and developed a toolkit to inspire and inform future endeavours.[42]

Social Prescribing

Another innovation to address the link between social connections and health is social prescribing. As highlighted in our inquiry by Dr Suzanne Moffatt, social prescribing functions by enabling health care professionals to refer patients to a range of non-clinical services, typically provided by community and voluntary sector organisations.[43]

While there has been extensive support for social prescribing, the evidence for its effectiveness or value for money has not been clearly established.[44] However, many efforts to evaluate social prescribing have suffered from methodological issues that restrict the ability to identify its impact in a robust way. In our inquiry, Dr Moffatt presented information on a new initiative, Ways to Wellness, that seeks to address some of the limitations that have affected previous evaluations.

- Ways to Wellness is a social prescribing programme in Newcastle-upon-Tyne, serving 17 general practices in a multi-ethnic inner-city area of high social deprivation. It targets people aged 40-74 with at least one of eight long term conditions: type 1 diabetes, type 2 diabetes, chronic obstructive pulmonary disease, asthma, heart failure, coronary heart disease, epilepsy, and osteoporosis. Patients are referred to the programme and assigned a Link Worker, a trained facilitator who helps patients set their own goals, promotes improved self-care, and provides support and guidance to access community services. Ways to Wellness is currently linked to over 200 voluntary, community, and NHS services. Activities and services include walking groups, physical activity classes, welfare rights advice, promotion of volunteering opportunities, and assistance back to work. Engagement in the programme can last up to two years.

42 http://www.ilcuk.org.uk/index.php/publications/publication_details/celebrating_intergenerational_ diversity_among_lgbt_people
43 https://www.kingsfund.org.uk/publications/social-prescribing
44 Bickerdike et al. (2017)

The evaluation of Ways to Wellness has taken a staged approach, starting with qualitative research involving interviews with 30 service users. This was followed by a feasibility study exploring the collection of quantitative outcome data including a short self-completion questionnaire; this stage suffered from low response rates as seen in other studies of social prescribing. A new research project has now begun to improve on these efforts to evaluate the programme, using mixed methods including primary and secondary data and ethnographic techniques of observation and interview. Natural experimental methods and economic assessments will further seek to address the shortcomings in previous evaluations by including control groups, larger sample sizes, longer-term follow-up, and clinically meaningful outcome measures.

It should be noted that there is anecdotal evidence for the success or effectiveness of social prescribing. The current lack of evidence should not stand as a barrier to investment in such an approach, if for no other reason than evidence can only be collected by implementing programmes and evaluating them.

There is also a need to frame initiatives as part of a broader community-building approach rather than simply services available for people. Part of this relates to the idea that some people do not want to feel like clients but would be more encouraged to join a group and feel part of a community. While a distinct concept, this does relate to other approaches around social connections that focus on how developments and changes in community spaces can facilitate social interactions and reduce social isolation and loneliness. The next section turns to look at these approaches.

Approaches to Promote Connected Communities

THERE ARE SOME REALITIES of the lived environment that negatively impact social connections among older people. There is long-standing evidence that motor traffic plays a significant role in this by inhibiting social interactions, as noted by Dr Susie Morrow. For example, people who live on heavily trafficked streets have fewer friends and acquaintances than those living on lightly trafficked streets. Such aspects lead to what is termed community severance, i.e. the barrier effect that results when transport features limit rather than facilitate people's social engagement.[45]

Pavements and crossings are also fundamental features that impact people's ability to be active in their communities. This can be particularly salient for older people and others with mobility issues, as they need environments where the risk of falls is not higher due to poor condition and the ability to cross the road safely is ensured. Fundamentally, there needs to be greater effort to view streets as spaces for more than just cars and vehicles; this is reflected by the lack of seating in many places. Parking is also a big problem, especially outside London, as it contributes to streets crowded with parked cars, restricting space on pavements.

Associated with heavy traffic, the issue of air pollution can also negatively impact social connections for people in later life. Poor air quality can be a deterrent for some people to leave their home, reinforced by public health recommendations to stay home when pollution levels are high. Yet this contributes to the hidden problem of isolation and loneliness; by definition, people are not getting out into their communities to demonstrate that this is an issue for them.

The Healthy Streets Approach was one example featured in our inquiry that works to reshape public spaces to address such concerns. The approach places people and their health into the heart of decision-making around streets, using ten indicators:[46]

- **Pedestrians from all walks of life**: London's streets should be welcoming places for everyone to walk, spend time in and engage in community life.
- **People choose to walk, cycle and use public transport**: A successful transport system enable more people to walk and cycle more often.
- **Clean air**: Improving air quality delivers benefits for everyone and reduces unfair health inequalities.
- **People feel safe**: The whole community should feel comfortable and safe on our streets at all times. People should not feel worried about road danger.
- **Not too noisy**: Reducing the noise impacts of traffic will directly benefit health and improve the ambience of our streets.
- **Easy to cross**: Making streets easier to cross is important to encourage more walking and to connect communities.
- **Places to stop and rest**: A lack of resting places can limit mobility for certain groups of people.
- **Shade and shelter**: Providing shade and shelter enables everybody to use our streets, whatever the weather.
- **People feel relaxed**: More people will walk or cycle if our streets are not dominated by motor traffic, and if pavements and cycle paths are not overcrowded, dirty or in disrepair.
- **Things to see and do**: People are more likely to use our streets when their journey is interesting and stimulating, with attractive views, buildings, planting and street art.

45 See e.g. Anciaes et al. (2015)

46 The descriptions of the indicators, as well as further information on Healthy Streets, can be found at: **https://tfl.gov.uk/corporate/about-tfl/how-we-work/planning-for-the-future/healthy-streets**

The London mayor has embraced the Healthy Streets Approach as part of a 25-year Transport Strategy. All projects that involve the streets of London are scored on how well the plans implement the principles of the framework and improve the inclusivity of the street environment. When issues related to the design of spaces could have a detrimental impact in this respect, this approach allows them to be flagged before they are built rather than afterwards when it would be too expensive to change. However, it was noted that this is more feasibly done in London given available resources, e.g. funding to hire a consultant specifically on this. While tools are available that can enable local authorities to adopt the framework, doing so successfully also requires knowledgeable people familiar with the more technical aspects and overall policy environment. There is also a distinct lack of support in place to help further diffusion of innovations of this nature.

While the Healthy Streets framework may seem particularly relevant for urban and suburban residents, there is a question whether such an approach remains applicable for rural settings. However, as Lucy Saunders noted in the inquiry, most rural living still takes place in a town or village, so the same principles apply. The main difference relates to the elements and areas of focus for a particular location. The scale and nature of what would be needed will depend on existing structures. For example, the extent of public transport provision in London makes this a large part of the story, whereas other areas will need to explore how to deliver this approach in the absence of broad public transport coverage.

There are new tools for an area to understand and identify what elements should be addressed in this context. The Street Mobility & Network Accessibility project at UCL, led by Dr Jennifer Mindell, has developed a Street Mobility Project Toolkit, essentially a set of diagnostic tools that local government and local communities can use to assess the degree of community severance in their area. The tools allow routine modelling by planners and enable local communities to engage with professionals on how to improve their lives and local environments.

Living Streets is another actor in this space working to promote safe environments for pedestrians to encourage more active walking in communities. One element of their work is the Community Street Audit, a participatory tool for local communities to diagnose issues in their streets.

- Community Street Audits involve a range of stakeholders across communities, including local residents, businesses, and councillors. They seek to evaluate the quality of streets and spaces from a user's perspective, making assessments on foot. A detailed report is then produced, highlighting recommendations and solutions to foster a safe, attractive, and enjoyable environment for all users. Living Streets also produce briefing materials that can help communities articulate what they need to achieve streets that address barriers to social interactions.

There are also other efforts to encourage cycling and walking, particular in city centres, as a way to foster community connections. Yet while good examples exist, these are found in certain areas or neighbourhoods rather than existing as authority- or borough-wide initiatives. One example cited was in Waltham Forest, where money was spent to introduce small features in the centre of residential streets, providing a low-cost measure that reduced traffic and facilitated more social engagement in these neighbourhoods.

In many areas, the question of financing and resources can be a minor issue if there is willingness to reallocate existing funding arrangements. Some improvements can even be free, such as changing speed limits. Good innovation in this space is generally small scale and can be relatively inexpensive and sometimes even cost-saving. It also gives control to people over some of the determinants of their health and wellbeing in an inclusive way. Good infrastructure feels natural to the user and is context-specific – there is no one-size-fits-all.

Fundamentally, innovations in this area start from the point of what streets need to deliver for them to be good for human beings in terms of health, wellbeing, and society.

This is about addressing a structural barrier to people being able to live in a socially connected way. As such, it represents an innovation in how a system works and how a series of institutions work together, rather than the introduction of technology or diffusion of a singular social programme.

Barriers to and Opportunities for Innovation

THIS REPORT HAS HIGHLIGHTED the context in which social connections are seen as crucial to supporting health and wellbeing, along with examples of innovations addressing both the individual and community perspectives involved. The contributions of expert witnesses in our inquiry also allow us to identify some of the barriers and opportunities that impact the development of such innovations. We discuss these here in two parts, looking at resources and structural factors.

ISSUES AROUND RESOURCES

Barriers

- Within programmes, a lack of sufficient staffing can serve as a barrier. Even when the appropriate training is available and has been provided, it can be difficult for staff to provide all the resources and activities that the programme wants or needs to deliver.

- Some initiatives can only be scaled up in a sequential way according to the demand of both users and providers (especially where volunteers are used). This is particularly true for programmes providing one-to-one or peer support, as individuals need to be matched in an appropriate way.

- Collecting sufficient amounts of robust data to evaluate the effectiveness of interventions like social prescribing can be extremely resource and time intensive.

Opportunities

- Interest in approaches like the Healthy Streets initiative exists; however, the delivery is more challenging. Tools are available for local authorities to adopt some existing frameworks like Healthy Streets, but this also requires people with the relevant expertise to implement them. Nonetheless, there is an opportunity for similar innovations if greater support were available to access the necessary resources.

- Programmes to foster social connections must consider the quality or depth of the connections made as well as the quantity or breadth of them. Applying this focus may increase the effective use of available resources, e.g. through targeting particular subgroups.

- Similarly, transition points in later life can have a significant impact on the development of loneliness. Targeting people who are going through notable transitions, e.g. following the loss of a partner or becoming a carer, can be an important opportunity for future innovations.

- Greater efforts should be made for large collections of data, such as from GPs and secondary use services, to be more readily available and accessible for evaluation and research purposes.

STRUCTURAL FACTORS

Barriers

- A focus on the efficiency of an initiative rather than what is important to help people and impact their lives remains a structural barrier to the development of innovations to promote stronger social connections.

- Ageism among health care professionals is another barrier that impacts how easily innovations can reach people in later life. There is a perception that older people are not interested in accessing talking therapies, although the evidence is strongly against that. There is also still a stigma around mental health issues.

- In many communities, parking is a big problem, especially outside London. This contributes to streets crowded with parked cars, restricting space on pavements and many people's ability to get out and about. This barrier has the most impact on vulnerable people.

- The front door can itself be a physical and/or emotional barrier for some older people. For example, in some retirement housing, some people are unable to physically open certain doors. So while the environment is designed to facilitate social connections, access to activities and communal areas remains restricted.

- There is a further structural challenge around the commissioning of health and care services, in that the aspect of social connections is largely absent from current approaches.

Opportunities

- Although ageism and stigma, especially in health care settings, remain barriers to improving social connections for older people, attitudes are changing. Discussions around these issues are shifting, and recognition is growing. This implies the situation could be much improved in the coming decades.

- The Minister for Loneliness offers a new opportunity for innovation in this area to flourish. In particular, a dedicated minister may bring benefits by stimulating cross-departmental collaborations and focus on the issue of social connections.

- There is an opportunity for innovations to do more to take advantage of the spaces between buildings rather than simply focusing on what is inside them. This links to the broader theme of the built environment, featured in our second inquiry of this commission.

- This also links to the Healthy Streets approach. Moreover, as a framework for policy, it can be a gamechanger in promoting liveable neighbourhoods that foster social connections if it can become more widely applied.

- It was noted that the UK has been a global leader in inserting public health into transport, although there are good examples elsewhere in the world of linking health and the lived environment. However, the UK has less challenges than some other parts of the world that remain incredibly low density, which could enhance the ability for innovations to develop here.

Recommendations

OUR INQUIRY HAS IDENTIFIED a wide range of innovative programmes, services, and approaches that seek to promote and foster social connections. The diversity in such provision implies that each initiative faces its own distinct set of challenges, but there are a number of recommendations that would apply to all efforts to encourage, stimulate, and support such innovation.

- Innovations to support social connections must clearly connect with people. This should start with a person-centred or bottom-up approach, and investment in this respect would help stimulate new innovation.

- It is also important that initiatives are designed so that they will be fun for people. A simple example of this is reflected in the success of intergenerational approaches that incorporate the sharing of stories.

- Part of the process of coming up with innovations is the application of creativity. Flexibility is a key factor in allowing new and imaginative ideas to emerge and flourish. In addition, creative and flexible approaches to foster social connections that have inclusivity at their core will help reach those groups who often remain outside the coverage of mainstream services.

- Government and large organisations can support local and national campaigns to inspire people to take action in their own communities to develop organisations that bring different groups together. This could have a particularly strong impact among those who are positioned to take greater personal responsibility in managing their own social connections. Greater awareness could also stimulate behavioural change that facilitates concerted action to address a lack of good social connections.

- Future efforts around housing should consider avoiding low-density projects. Many of the characteristics of low-density living have isolation built directly into them.

- New technologies have tremendous potential for improving health and wellbeing as well as facilitating social connections and interactions in one's environment. However, new innovations should have more of a focus on people rather than simply introducing new technology. Human contact will always be of fundamental importance and should be taken into consideration.

- While it is a fairly semantic point, there may be reason to rename the Minister for Loneliness the Minister to End Loneliness. This would not only highlight the primary objective of the role but also help delineate how it should be held accountable for tangible action in this area. Fundamentally, such a role needs to have the power to effect change through budgets and influence. Otherwise, it will revert to being only another good advocate.

- There is substantial value in innovative services that target hard-to-reach groups and foster culturally-sensitive or appropriate connections. However, an issue like loneliness affects everyone across the life course, so new services need to be designed to address it in a wide-ranging way. In this respect, there needs to be innovation in systems rather than just specific services, so that models are developed that are holistic, comprehensive, and integrated with areas like primary care, housing, and transport.

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