Submission No 132

INQUIRY INTO PREVALENCE, CAUSES AND IMPACTS OF LONELINESS IN NEW SOUTH WALES

Organisation: Sydney Community Collaborative

Date Received: 11 November 2024

Hon Dr Sarah Kaine, MLC
Chair
Standing Committee on Social Issues
NSW Legislative Council
6 Macquarie Street
Sydney, NSW, 2000

11 November 2024

Re: Submission to NSW Legislative Council Inquiry into the Prevalence, Causes and Impacts of loneliness in NSW

Dear Chair,

On behalf of the Sydney Community Collaborative, we are pleased to submit the attached document to the NSW Legislative Council Inquiry.

The Sydney Community Collaborative comprises five Sydney local community organisations:

- Inner Sydney Voice (ISV)
- Canterbury City Community Centre (4Cs)
- Ethnic Community Services Cooperative (ECSC)
- Newtown Neighbourhood Centre (NNC)
- The Junction Community Centre (JNC)

During 2024, the Collaborative has commissioned and guided research led by esteemed academic researchers Professor Michael Fine and Dr. Bob Davidson. The research provides evidence-based recommendations for effective interventions to combat loneliness and social isolation.

Members of the Collaborative, Professor Michael Fine and Dr. Bob Davidson, are available to provide further evidence. We would prefer to do so at a later stage, once our full research report is released.

We urge the Committee to consider these recommendations to enhance the social well-being of older adults across NSW. By supporting community-centred approaches, we can create a more connected and inclusive society, reducing the strain on aged care and health services.

For further information, please contact:

Inner Sydney Voice
Joseph Ferrer

Thank you for your time and consideration.

Sincerely,

Joseph Ferrer
On behalf of the Sydney Community Collaborative

Submission to the

NSW Legislative Council

Inquiry into the

Prevalence, Causes and Impacts of Loneliness in NSW

by

Sydney Community Collaborative

Inner Sydney Voice (ISV)
Canterbury City Community Centre (4Cs),
Ethnic Community Services Cooperative (ECSC),
Newtown Neighbourhood Centre (NNC),
The Junction Community Centre (JNC)

November 2024

Joseph Ferrer
Inner Sydney Voice

The Submission

This submission is based on the findings of a study commissioned by the Sydney Community Collaborative, a group of five local community-based organisations (LCOs) in inner south and inner west Sydney. The study originated from concerns by the LCOs about the increasing requests being made to them to support socially isolated and lonely older people and the lack of adequate programs and resources to enable them to fully assist.

The report from the study will be completed soon and a copy will be provided to the Committee. It contains an account of the theory and empirical evidence concerning the key concepts, prevalence, impacts, causes, and financial cost of social isolation and loneliness; an account of the major interventions to improve social connections that have been adopted or suggested; a strategy and proposals for action to support older people who are socially isolated and lonely; and a local case study of the area in which the five LCOs operate.

Attachment A contains an overview of the key messages and an overview that describes the content of the *draft* report.

Four Major Issues

This submission is primarily focused on what can be done at a *local level* to reduce the growth and adverse impacts of social isolation and loneliness among *older people*. There are four major points we wish to make to the Committee.

a) The imperative for action by government
b) The importance of older people as a group at risk of loneliness
c) The importance of local action
d) The potential for government to save significant money by investing in action to reduce social isolation and loneliness.

a) The imperative for action by government

There is substantial evidence of the large and growing prevalence of social isolation and loneliness worldwide, and the adverse impacts this is having on both individuals, especially on their physical and mental health, and the wider society.

The damaging effect this is having on individuals and the wider society means there is a powerful imperative for government to take action to reduce social isolation and loneliness and to help people to build better connections in their communities and neighbourhoods. Action is necessary for individuals to improve their current well-being and life, and to defer or prevent the need for more complex aged care and health care; for society, to enhance social cohesion; and for government, to reduce the logistic and financial demands upon them.

Two broad approaches are necessary - to ensure a more inclusive society in general, and to provide additional support to people who are socially isolated or lonely or at risk of becoming so. The main focus of this submission is on ways of providing additional support, but Attachment D and our first recommendation sets out broad approaches to promote a more inclusive society.

A wide range of types of intervention to reduce social isolation and loneliness have been adopted or proposed, and the report sets out a number of schemas that have been developed to classify forms of intervention together with an extensive list of possible specific interventions.

However, while there is growing evidence about the nature, incidence, causes, and impacts of social isolation and loneliness, together with many options for intervention, it is widely agreed (including by the World Health Organisation (WHO)) that there is only limited evidence about what interventions work well.

b) The importance of older people as a group at risk of loneliness

Older people (defined here as 65yo+) are one of the major population groups at risk of social isolation and loneliness.

There has clearly been a major increase in the extent of social isolation and loneliness among younger people over the last 15 years, but older people remain a major group at risk, as has historically been the case as a result of factors such as retirement and the deaths of family and friends which make it more likely that older people live alone Moreover, older people have been affected directly by each of five major forces that have increased isolation and loneliness in recent years, namely social and demographic change, technological change, political change, economic change, and the COVID pandemic. In Australia, changes to at-home and community-based aged care services over the last decade have reduced the capacity of these services to enhance social connections.

The action required to reduce social isolation and loneliness among older people in Australia needs to take place on two main fronts, namely (a) for those people who receive aged care services and (b) those people who do not receive aged care services.

- *For those people receiving aged care services* (30% of 65+): Currently there are problems of access for some people, limits on the types of programs that can be provided, and inadequate funding to meet the demand for what is a very low cost program. In addition, there is concern about the nature and impact of proposed reforms of CHSP and HCPP in the context of the proposals for the new SAHP.[1]
- *For those not receiving aged care services* (70% of 65yo+): Currently there is only a very incomplete patchwork of support for people who are socially isolated and lonely or at risk of becoming so. There needs to be more planned and active local ecosystems of support to identify and support such people.

c) The importance of local action

Our main focus is on action at the local level of the community or neighbourhood, where there is a geographic and physical proximity that enables people to easily come together, face-to-face, to plan, act, connect, and support each other. Higher level measures originating at national and state level are important, but ultimately the value of such measures rests on how well they translate

[1] These programs are the Community Home Support Program (CHSP); the Home Care Packages Program (HCPP), and the Support at Home Program (SAHP) due to begin in July 2025.

down to enable each isolated or lonely person to build the quantity and quality of their relationships with others in the places in which they live, work, and study.

We consider what can be done locally from a number of perspectives. *First* there is a need to understand the key roles that the concepts of community, social capital, and place-based action must play in any effective program. In this context, at the local level, support must be personalised, localised, inclusive, collaborative, small scale, and - to be sustainable - low cost. Imposing external models not attuned to local circumstances and needs will lead to limited commitment and participation.

Second, we must consider *how* local action is best organised. Local place-based action will be most effective and most cost-efficient if it based on harnessing existing local organisations and assets in a community, especially local community-based organisations (LCOs), primary health care services, and local councils, as appropriate in each area. There is a particularly important role for LCOs, given their long-established presence in their communities, in many cases half a century or more; their wide-ranging and deep local networks; their trusted position in their local communities, and their mode of operation which aligns with the need for the support services to be personalised, localised, inclusive, collaborative, small scale, and low cost. They would also help ensure local systems that are not overly driven by medical bodies.

Third, we must consider *what* needs to be done. Attachment C sets out the critical elements that are required for effective local action. That can form a general template for action, the specifics of which will vary in each locality.

There is evidence of successful local initiatives along the lines of what the report proposes. For example, Attachment B describes the Compassionate Frome project in the UK, which has many of the desired elements, although we would argue for a less-medicalised model that is overseen by LCOs rather than health providers. Further, the local case study of inner south and inner west Sydney contained in the report shows good work is being done in the area, but is being hampered by a lack of resources for delivery and systems that could be recouped many times over from the potential savings by keeping people active, connected, and healthier for longer.

d) The potential for government to save significant money by investing in action to reduce social isolation and loneliness

Intervention to reduce social isolation and loneliness not only has substantial health, personal, and social benefits, but can also save governments and older people a significant amount of money, especially by deferring or even obviating the need for individuals to move onto more extensive, complex, and costly health and aged care services.

Enhancing social connections will help to maintain people's health and resilience, which in turn will mean that many older people will be able to defer or reduce their use of primary health services (e.g. GPs and urgent care clinics), more complex health services (e.g. hospitals, specialists, and treatments for chronic ailments) and more complex aged care services (such as higher level home care packages and residential care).

The report contains strong evidence of potential savings for both national and state governments from action to reduce social isolation and loneliness. For example, total expenditure on health care for 65yo+ and aged care in Australia in 2022-23 is estimated to be $124B, comprising $96B for their share of health care and $28B for aged care. Simply delaying 1% of people moving to the next level of aged care could save around $200M. In the UK, there is empirical evidence of a 14% reduction in emergency hospital admissions (Abel et al (2018) re Frome), as well as estimates of a potential 17 % reduction in the additional costs of loneliness (Fulton & Jupp).

Recommendations

1) Government at all levels work to *create a more inclusive society* in which policy and practice embraces rather than excludes older people.
   - Attachment D contains a number of possible approaches that governments could follow to help promote a more inclusive society. At a local level, they could resource LCOs to identify policies and practices in their local areas that hinder a more inclusive society.

2) Recognise *older people as one of the major population groups at risk* of social isolation and loneliness.

3) Endorse the need to take action to reduce the social isolation and loneliness of older people on *two main fronts* - for those who are accessing the formal aged care system, and those who are outside the aged care system.

4) Endorse various actions to develop a more planned and active approach to develop *local ecosystems of support* to help older people build and maintain better social connections. Specifically this could involve:
   a) endorsing the template at Attachment C as a set of goals for each community
   b) providing some core funding for LCOs (either new or enhancement funding as appropriate in each case) to enable them to identify and give initial support to socially isolated and lonely older people and those at risk of becoming so
   c) funding for a LCO in each area to act as a local 'steward' to guide and promote development of the overall ecosystem and the capability of local bodies; and
   d) integrating local community services with specialist therapeutic and clinical care services so as to maximise community connection opportunities for people being assisted.

5) Funding for national and/or state action to
   a) develop training for people working with socially isolated and lonely people; and
   b) ensure the availability of specialised support for people who have more complex issues with building social connections.

6) Recommend the NSW Government raise with the Commonwealth:
   a) the importance of ensuring that the forthcoming reform of entry level aged care services must promote better social connections
   b) the need to review Medicare provisions to better support social prescription and therapeutic services for people who are socially isolated and lonely; and
   c) the need for more funding to enable an expansion of Healthy Ageing Hubs.

ATTACHMENTS

A) An Introduction to the Draft Report, A*geing Together*

B) Compassionate Frome Project

C) Creating effective local ecosystems of support for older people - A template

D) A Note on Creating a More Inclusive Society

ATTACHMENT A

An Introduction to the Draft Report, *Ageing Together*

NOTE: This document is a short summary of the draft report. It is NOT the report.

The report sets out the findings from a study commissioned by five local community-based organisations (LCOs) which in total cover seven contiguous Local Government Areas (LGAs) in inner south and inner west Sydney. The five participating organisations in the study are:

- Inner Sydney Voice (ISV)
- Canterbury City Community Centre (4Cs)
- Ethnic Community Services Cooperative (ECSC)
- Newtown Neighbourhood Centre (NNC)
- The Junction Community Centre (JNC).

The study was conducted by Professor Michael Fine and Dr Bob Davidson.

The report has three major purposes:

- first, as a briefing paper for local bodies on research findings about the issues and problems concerning social isolation and loneliness;
- second, as practical guidance to assist local bodies to take effective action to reduce and combat the problem; and
- third, to help develop the case for national and state governments to make policy and funding decisions that support local action in this space.

The methodology for the study primarily comprised:

- an extensive literature review;
- a local study of the area covered by the five LCOs;
- development of a series of analytical and policy frameworks, and
- a series of collaborative research workshops with community service leaders from the five LCOs to consider the research findings and to work through possible responses.

The report contains

- a vision of a world in which most older people have fulfilling social connections (Section 2);
- an overview and discussion of the theory and empirical evidence relating to key concepts, prevalence, impacts and causes of social isolation and loneliness (Sections 3-6);
- an account of the major interventions to improve social connections that have been adopted or suggested (Section 7), with particular focus on local action (Section 8);
- a discussion of the financial costs of social isolation, loneliness, and interventions (Section 9);
- a strategy and proposals for action to support older people (Sections 10-12);
- a local case study of the area in which the five LCOs operate (Section 13-15); and
- an extensive list of references to research and other publications relevant to the underlying issues, the problems, and possible interventions.

Attached are (a) a one-page summary of the Key Findings from the report; and (b) a four page section-by-section summary of the report.

KEY FINDINGS from the Draft Report, *Ageing Together*

1. In recent years, the prevalence of social isolation and loneliness has rapidly increased in Australia and elsewhere. While this has had a big impact on younger people, *older people remain a major group at risk*, as has historically been the case. Given the continuing prevalence of the problems and the extensive adverse impacts they have on individuals and the wider society, there is *a strong imperative for action to ensure people are supported to remain connected to other people and to their communities*.

2. As with any social problems, social isolation and loneliness are complex. The report contains a number of *analytical and policy frameworks* to assist in understanding the nature, causes, and impacts of the problems and the possible responses to them.

3. Action at national and state level is important, but that will only be effective if there are *systems and resources at the local community and neighbourhood level* to support individual older people to increase and improve their social connections in the place in which they live.

4. Given the diversity of older people and the situations in which they live, action to support individuals has to be *personalised, localised, inclusive, collaborative, small scale*, and - if it is to be sustainable - *low cos*t.

5. For older people, *entry level aged care services* (via CHSP) can have an important role in this space. but over the last decade CHSP has been changed in ways that have reduced its capacity to improve social connections. The report outlines a better way forward for entry level care.

6. Currently over 70% of older people (65yo+) do not actually use any formal aged care services. A significant number of these people do not need or want formal services but are socially isolated or lonely. However, there is currently little in place to identify or help them to build or rebuild supportive social connections.

7. In this context, it is important to deliberately build and strengthen *local ecosystems of support* within all communities through a more active and planned approach to identify and support older people who are socially isolated and lonely. The report presents a 'template' for these local ecosystems which includes a set of key elements (structures and processes) that ideally need to be in place in each community, but which can be adapted to suit local circumstances and needs. It involves both developing mechanisms to deliver support to socially isolated and lonely individuals, coupled with a local body tasked and resourced as a 'steward' to foster greater capability of local systems and providers.

8. Importantly, the proposed local ecosystems are based on *harnessing existing local assets*, especially local community-based organisations (LCOs), primary health care providers, and local councils. LCOs are particularly valuable in this context given their long presence in their communities, their wide-ranging and deep local networks, and their mode of operation providing personalised, localised, inclusive, collaborative, small scale, and low cost services.

9. Investment in effective intervention can produce *significant financial savings for government*, especially by reducing the need for more complex aged care and health care for older people.

10. A *rigorously evaluated local project* based on the principles in the report can add to the currently limited knowledge about what interventions actually work well.

SUMMARY of the Draft Report, *Ageing Together* [2]

1 *Origin of the Report:* This report has arisen from concerns by community service leaders about the need for a better response to the large and growing problem of social isolation and loneliness among older people, especially in relation to what can be done at a local community and neighbourhood level.

Purposes of the Report: The report has three major purposes - first, as a briefing paper for local bodies on research findings about this issue; second, as practical guidance to assist local bodies to take effective action to reduce and combat the problem; and third, to help develop the case for national and state governments to make policy and funding decisions that support local action in this space.

2 *A Vision*: The report first sets out a positive vision of what daily life would be like for older people in a world where they all had good personal and social connections. The vision rests on two foundation principles- a recognition of the human rights and unique circumstances and needs of each individual person, coupled with the understanding that social connections, human relationships, and people working together, are essential to our well-being as individuals. Building better social connections requires both developing a more inclusive society in general, and ensuring extra support for people who are socially isolated or lonely.

PART A: RESEARCH FINDINGS

3 *Key Concepts*: Living alone, social isolation, and loneliness are three related, but distinct, conditions. The way they interact varies with each person. The first two are more objectively defined and often not a problem, whereas loneliness is subjective and always negative, based on a feeling that there is a gap in one's life. The three conditions can both cause and result from poor social connections and increase the risks and effects of social frailty.

4 *Prevalence*: There are significant and increasing numbers of socially isolated and lonely older people in Australia and elsewhere. There has also been a marked increase in the prevalence of social isolation and loneliness among younger age groups in recent decades. Loneliness is now so extensive that it has been described as a modern public health 'epidemic', with recent studies reporting that over a quarter of Australian adults feel 'persistently lonely'.

5 *Impacts:* Social isolation and loneliness have major adverse impacts from personal to societal level. For individuals the main impact is on their physical and mental health (with studies showing effects similar to smoking and obesity); for the wider society from local to national level there is a loss of economic productivity, social capital and social cohesion; and for governments there are major extra demands on services, especially for more complex and costly health and aged care services for older people which entail large financial costs.

6 *Causes:* People are socially isolated and/or lonely for many diverse and complex reasons. Each person's situation is an outcome of their personal characteristics and history, their group identities, and their current circumstances, especially their stage of life and the geographical

[2] The number of each paragraph below is the number of the corresponding Section in the Report.

place in which they live. The report outlines both the major risk factors for any individual, and the developments that have led to the major increase in the number of socially isolated and lonely people, older and younger, in recent decades (notably social and demographic change, technological change, political change, economic change, and impacts of COVID).

Older people have historically been more affected by social isolation and loneliness as a result of factors such as retirement from work and the relocation or deaths of family and friends. As well, they have been particularly affected by each of the development in recent decades.

7 *Interventions:* A wide range of types of interventions to reduce social isolation and loneliness have been suggested and adopted in Australia and elsewhere, with varying degrees of success. These interventions include action taken from international, national, and state level through to action in the local community and by individual people. However, there is limited evidence about what actually works well.

The report sets out some of the major conceptual approaches that are used to classify the types of interventions at different levels, as well as practical on-the-ground measures that can be adopted. This includes action at all levels both to create a more inclusive society in general and to offer additional support for people who are isolated or lonely.

8 *Local Interventions:* Ultimately the value of higher-level action rests on how well it is translated to what happens at a local community and neighbourhood level to support and enable each isolated or lonely person to build the quantity and quality of their relationships with others in the places in which they live, work, and study. Hence, this report is primarily concerned with what can be done at the local level to ensure a flexible, responsive, and diverse ecosystem of support for all older people in all places.

The report examines the considers the concepts of community, social capital and place-based approaches; the relative strengths and limitations of different types of organisations that operate at local level to ensure the necessary support, especially LCOs, and the types of supports that are necessary. Importantly, for additional support to be of real and lasting value, the measures adopted locally need to be *personalised, localised, inclusive, collaborative, small scale and low* cost. There is a key role for local community-based organisations (LCOs) in this process as they are well-suited and long-experienced in providing these types of services, as well as having a long-established presence in their communities, and wide-ranging and deep local networks.

9 *Financial Implications:* Social isolation and loneliness generate major financial costs for government, especially in relation to leading to an earlier and greater use of more extensive, complex and costly aged care and health services by older people than would otherwise be necessary. One Australian study of just some of the health costs estimated the additional cost of loneliness was $2.7 billion per year (Duncan et al, 2018). Overseas studies (AARP, 2018; Fulton & Jupp, 2015) report similar results. There is strong evidence to indicate that these costs can be substantially reduced by low cost early intervention support aimed at building better social connections for older people.

PART B: PROPOSALS FOR ACTION

10 *Strategy:* More can be done in Australia to support older people who are socially isolated or lonely, or at risk of becoming so. This requires action on two main fronts - for people within the formal aged care system (see 11 below) and for the large majority who are outside that system (see 12 below). In both cases, a key goal must be to ensure that all older people are able to gain easy initial access to basic services and support that can help them develop and maintain meaningful personal and social connections. Minor one-off funding grants, or self-help and internet-based support, can be useful, but are insufficient to address entrenched patterns of social withdrawal by some older people.

11 *Within the aged care system*: Australia has a relatively effective but undervalued system of primary (entry-level) aged care services that operate via the Commonwealth Home Support Program (CHSP), which is the main source of funds for services that most directly help older people to make and retain social connections (especially though social support and community transport). CHSP and its predecessor HACC (Home and Community Care program) have been the bedrock of the Australian aged care system for the last forty years.[3] CHSP is by far the most used and the lowest cost of the three major aged care programs in Australia[4], and makes an important contribution to reducing the demand for those other aged care programs that provide more complex and expensive care and support.

However, in recent years, the value of CHSP and what makes it work well appear to have been poorly understood by decision-makers who have sought to turn it into a far more individualised (not personalised) fee-for-service scheme. Some enhancements to CHSP are needed, but more fundamentally there is a need to re-consider some of the Support At Home Program (SAHP) 'reform' proposals that will change the very design features of CHSP that have made it work well. There is a need to formally acknowledge the role and importance of primary (entry level) aged care services, to better understand the dynamics that make such a system work well, and to structure and fund it accordingly.

12 *Outside the Aged Care System:* Some 70 percent of people 65+yo do not receive any services from the formal aged care system. However, a significant number of older people do not need formal care services or do not want to become involved with them (e.g. because they see them as unnecessarily bureaucratic processes), but they are often substantially socially isolated or lonely or at risk of becoming so. A major contribution of this report is to identify the key elements of an effective and efficient *local ecosystem of support* that can identify and support older people who have limited social connections. Currently there are many initiatives to promote healthy ageing, but there is only a very incomplete patchwork of measures that directly address social isolation and loneliness for older people who do not need or want to be in the aged care system.

The proposed approach presents a set of principles and elements that need to be present for an effective local ecosystem of support for older people. It draws on the well-established local strengths of each community and neighbourhood, especially by harnessing the LCOs, the

[3] HACC was established in 1985 and (together with some other small programs) was replaced by CHSP in 2015.
[4] The other two are Residential Aged Care (RAC) and the Home Care Packages Program (HCPP).

local primary health care system (e.g. GPs and community nurses) and local councils that are already working in this space. It involves a dual approach that ensures systemic oversight (by a local 'steward' tasked and resourced for the role) coupled with structures and resources to help individual people to better connect with others. It is a transferable and scalable proposal that sets out a range of possible measures, the specifics of which will vary with the nature and needs of each place.

PART C: A LOCAL CASE STUDY

13 *The Area:* The report includes a case study of a specific area in inner south and inner west Sydney that encompasses seven contiguous LGAs. This study reinforced the general findings of the report about the nature incidence, impacts, and causes of social isolation and loneliness among older people and the types of interventions needed, while also pointing to the distinctiveness of each local area (e.g. it has a relatively high proportion of people from culturally and linguistically diverse groups, and a wider range of wealth and income than most communities).

14 *The Services:* The case study focused on five medium-size LCOs in the area in terms of their capacity to combat loneliness among older people. One of these plays a supportive role in building the capability of local organisations and a community-development role across the area (i.e. as an informal 'steward' of the service system). The other four directly provide services to individual people from a range of backgrounds and groups, including older people and support for people who are isolated or lonely. These bodies have shown a strong capacity to make a real difference to people's lives, but there are limitations imposed by current policy and funding settings on what they can do.

PART D: A LOCAL PROPOSAL

15 The report contains a proposal for an initial project in this area to trial and evaluate how the general frameworks proposed for an enhanced CHSP and a local ecosystem of support (as set out in sections 10-12) can work in practice. As well as the project being expected to pay its own way (i.e. by generating savings for government more than its cost) a rigorous independent evaluation will be a valuable contribution to the limited research about what interventions to reduce social isolation and loneliness among older people work well.

ATTACHMENT B

Case Study: The Compassionate Frome Project

(Appendix 7.1 in *Ageing Together* Draft Report)

Frome is a town in Somerset, UK, with a population of 27,000. In 2013, a local GP, Helen Kingston, believed that many of her older patients were coming to see her mainly because they were lonely and socially isolated. Moreover, these patients "seemed defeated by the medicalisation of their lives" (Monbiot 2018).

In response, she began a collaboration with the local National Health Service (NHS) group and local agencies to develop (a) a directory of agencies and community groups that could provide people with activities and (b) a system whereby GPs and other local health staff could refer people to these agencies and groups. This is commonly regarded as the beginning of social prescription (whereby GPs refer people to local social groups and activities rather than prescribing more and more medication). Funds were then made available to employ 'health connectors' to help people plan their care, and to train voluntary 'community connectors' to help patients find the support they needed.

The apparent initial success of the project caught the interest of the national government, including the then Prime Minister, Theresa May. This led, inter alia, to some extra funding for Frome, an extension of the idea to some other places, promotion of the idea nationwide, and the creation of a national Minister for Loneliness in 2015. According to Monbiot (2018), 'Helen Kingston reported that patients who once asked, "What are you going to do about my problem?" now tell her, "This is what I'm thinking of doing next." They are, in other words, no longer a set of symptoms, but people with agency.'

Abel et al (2018) report on a formal evaluation of the Compassionate Frome Program over a 44 month period between April 2013 and December 2017. This involved a comparison between the program and the rest of Somerset, which effectively acted as a control group where no special measures were taken. The aim of the study was described by the authors as 'to evaluate the impact of a complex population health intervention using an enhanced model of primary care and compassionate communities on population health improvement and reduction of (unplanned) emergency admissions to hospital.'

Abel (2018a, 2018b) describes the program that was evaluated as follows

1) The program was based on patient-centred goal setting and care planning, combined with a compassionate community social approach implemented across the population of Frome.
2) It consisted of three main components (a) an internal hub in a GP surgery for identifying and managing people in need of support (b) a community development service embedded in primary care, and (c) the application of Institute of Healthcare Improvement implementation and change methodology.
3) The community development service comprised four key functions (a) a web directory of services (b) the formation of groups where there are gaps (c) one-to-one work with Health

Connectors, involving motivational interviewing, community development, and network enhancement, and (d) training and support for Community Connectors.

4) The resources required for the community development service consisted of a Community Development lead and about one Health Connector per 10,000 population, with all staff helping with the four functions of the community development service.
5) There were four main steps involved for each person being assisted (a) identifying those in need of support (b) patient-centred goal setting and care planning (c) enhancement of naturally occurring networks, and (d) linkage to community networks.

The evaluation found that over the 44 months of the study, the program had three main outcomes, namely (a) improved patient outcomes in both health and well being (b) improved working lives for health and social care teams, and (c) a major reduction in emergency hospital admissions. The most striking outcome was the reduction in emergency hospital admissions in Frome by 14 percent (7.9 cases per quarter), while over the same period across the whole county of Somerset they rose by 29 percent (236 cases per quarter). This led to a decrease in healthcare costs across the whole population of Frome.

According to Abel (2018a, 2018b)

- 'This is the first intervention that has successfully reduced emergency admissions across a population, as opposed to a cohort such as frail older people with multiple long term conditions.'
- 'We have found a way of making social relationships and compassionate communities become a routine part of clinical practice in Frome.'
- 'Through the combination of targeted identification of people at risk of unplanned admission, systematic care planning for this group, referral to the social prescribing scheme, and proactive community development, the practice has been able to demonstrate an increasing trend of reduction of emergency admissions to secondary and tertiary care.'

The GP who began the process, Helen Kingston, has commented on the overall process:

> 'Connectedness matters. We need to acknowledge our humanity and that we are inherently social beings. Connecting with each other makes life worth living. At the heart of any care must be recognition of what is most important to the individual. Clinical guidelines will guide management of diseases, but the patient is the expert in their life. Connectedness matters too for our workforce. Working in the NHS today is intense and unrelenting. What sustains us is the sense of making a difference and of working together as a team.
>
> The Compassionate Frome project has focused on improving connectedness for staff and patients. Reintegration of care and collaboration between health, social care, and our community empower staff to take a holistic approach and to do what is right for the individual. This approach can improve both the care we provide and the working lives of those providing it. Our results also indicate that a coordinated person centred approach can be cost effective through a reduction in emergency admissions.' (Kingston 2018).

The above account has drawn on Abel et al (2018), Abel (2018a), Abel (20181b), Kingston (2018), Monbiot (2018), and Mackay (2024).

ATTACHMENT C

Building Effective Local Ecosystems of Support for Older People

1) All support services and support should be based on the following set of key principles

a) Universal, with no one left out
b) Inclusive
c) Ease of access
d) Protective of people using the services
e) Preventative and pre-emptive
f) Personalised
g) Localised
h) Expansive (providing new experiences)
i) Collaborative (between groups and organisations)
j) Value-for-money

2) Action directed at both *systemic improvement and support for individuals*

3) *Action via five main sources* - government (national, state, local), the community, service providers, the general population, and individual people.

4) An understanding and acknowledgement of importance of *community, social capital, and place-based approaches* in enhancing personal, group, and societal well-being.

5) *A set of key elements that are needed in all local communities*, while noting that the actual set of specific actions will vary by location, given that each place is different and some places already have some of these elements. These elements include:

a) local mechanisms to identify isolated/lonely people and refer them to possible sources of support
b) harnessing and integrating the local primary care health system into local ecosystems of support (e.g. through social prescribing)
c) a multitude of groups and activities that can appeal to the diverse range of individual interests of older people
d) networks to bring people into contact with local groups, activities, and possible associates
e) community infrastructure (physical and social) to facilitate connections (e.g. transport)
f) a front-line service provider to directly assist individual people to make connections (e.g. via link people, community events, etc)
g) a neighbourhood hub for the front-line provider to ensure a visible and accessible physical location
h) a local entity (a 'steward') that is tasked and resourced to monitor the system and to enable or advocate improvements to local social capital and the capability of local organisations

6) A key role for local community-based organisations, given their long-established presence in their communities; their wide-ranging and deep local networks; their trusted position in their communities; and their mode of operation which aligns with the need for the support services to be personalised, localised, inclusive, collaborative, small scale, and low cost.

ATTACHMENT D

A Note on Creating a More Inclusive Society

(Extract from Section 7 of 'Ageing Together' Draft Report)

Many of the problems of socially isolated and lonely people derive from the fact that there are many aspects of their daily lives in which they are effectively excluded from full participation in society. This can range from broad policies and practices that discriminate on a daily basis against all people within some sub-group, through to problems from impact on individuals of specific policies and practices in matters such as income support, transport, housing, access to health service, and so on.

The World Health Organisation (WHO) stresses the importance of societal level strategies to reduce social isolation and loneliness and recommends a suite of measures that include 'laws and policies to address discrimination and marginalisation (including ageism), socio-economic inequality, digital divides, social cohesion and intergenerational solidarity' (WHO 2021: 10). WHO also emphasises the importance of promoting social norms that foster the enhancement of social connections, but does note that evidence of the effectiveness of some such measures may be limited.

Some steps that governments at all levels could take to promote a more inclusive society in general are to:

a) Endorse the importance of establishing mechanisms and allocating resources to promote and monitor action to develop a more inclusive society.
b) Review legislation, policies, and practices through an inclusive society lens, especially in developing new and society-wide programs and provisions.
c) Identify a potential set of specific actions that can be taken by governments at each level to contribute to a more inclusive society.
d) Set up feedback mechanisms so that the experience of front-line services regarding inclusion and exclusion can be conveyed to central policy and program areas.
e) Encourage business and non-profit organisations to review their policies and practices though an inclusive society lens
f) Resource LCOs to identify government, third sector and private policies in their local areas that hinder a more inclusive society.

This is particularly relevant for (a) the national government (e.g. in regard to income support, Medicare, telecommunications, aged care, disability) (b) state governments (e.g. in regard to transport, health, housing) (c) local government (e.g. in regard to ease of movement around the community), and (d) all three levels in relation to cross-jurisdictional issues (e.g. transport, health, urban development and planning) and the siting of their service centres in local places (e.g. Centrelink and state service centres). In fact, ensuring a genuinely inclusive society where people are embraced rather than excluded needs to be even more wide-ranging, influencing policy and practice in fields from early childhood through to social media policy.

REFERENCES

(Note: These references only relate to publications mentioned in this submission. The draft report contains an extensive list of references relevant to the whole study).

Abel. Julian, Helen Kingston, Andrew Scally, Jenny Hartnoll, Gareth Hannam, Alexandria Thomson-Moore, Allan Kellehear (2018), 'Reducing emergency hospital admissions: a population health complex intervention of an enhanced model of primary care and compassionate communities', *British Journal of General Practice*, November, DOI: https://doi.org/10.3399/bjgp18X699437

Abel, Julian (2018a), 'Compassionate Frome', Letter to *BMJ* 2018;363, 16 October 2018. k4299 doi: 10.1136/bmj.k4299

Abel; Julian (20181b), 'Compassionate Communities Transforming Health and Social Care', Slide presenation, https://abuhb.nhs.wales/files/integrated-well-being-networks/julian-abel-integrated-well-being-networks-presentation-pdf/

American Association of Retired People (AARP) (2018), *Loneliness and Social Connections: A National Survey of Adults 45 and Older,* AARP Research and GfK Custom Research, (Authored by G. Oscar Anderson & Colette E Thayer) Washington, DC https://www.aarp.org/content/dam/aarp/research/surveys_statistics/life-leisure/2018/loneliness-social-connections-2018.doi.10.26419-2Fres.00246.001.pdf

Duncan A, Kiely D, Mavisakalyan A, Peters A, Seymour R, T. C. and and V. L (2021), *'Stronger Together: Loneliness and social connectedness in Australia',* https://bcec.edu.au/publications/stronger-together-loneliness-and-social-connectedness-in-australia/

Fulton, L. and B. Jupp (2015). *Investing to tackle loneliness: a discussion paper*. London, Cabinet Office.

Kingston, Helen (2018), 'Connectedness benefits both patients and staff'. Letter to *BMJ*;363, 16 October 2018, k4305 doi: 10.1136/bmj.k4305

Mackay, Hugh (2024), *The Way We Are*, Allen & Unwin, Sydney.

Monbiot, George (2018), 'The town that's found a potent cure for illness – community; *Guardian*, 21 February, https://www.theguardian.com/commentisfree/2018/feb/21/town-cure-illness-community-frome-somerset-isolation

World Health Organisation (WHO (2021), *Social isolation and loneliness among older people,* Advocacy Brief, WHO, Geneva,