Effects of Bristol Ageing Better Projects for Older People

Evaluation of the impacts of the programme on loneliness, isolation and a range of associated outcomes

Mat Jones, Amy Beardmore and Jo White

Acknowledgements, authorship and contacts
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Further information
Bristol Ageing Better: http://bristolageingbetter.org.uk/

UWE Centre for Public Health and Wellbeing:
https://www1.uwe.ac.uk/hls/research/publichealthandwellbeing.aspx

Abbreviations

BAB	Bristol Ageing Better
CMF	Common Measurement Framework
DjG	De Jong Gierveld: an instrument for measuring loneliness
EQ5D	EuroQol-5D: an instrument for measuring quality of life
EQVAS	EuroQol-visual analogue scale: an instrument for measuring general health
SWEMWBS	Short Warwick-Edinburgh Mental Wellbeing Scale

Executive Summary

Bristol Ageing Better is a city-wide programme running between 2015-2022 aimed at reducing social isolation and loneliness amongst older people. The programme has run a wide range of initiatives to promote community involvement, participation in social activities and local decision-making, and personal support.

Many participants in BAB projects agreed to provide questionnaire based information about their personal circumstances over the course of their involvement. This report brings together the findings from this questionnaire-based data, with a focus on the main outcomes concerned with isolation, loneliness, health, wellbeing and social engagement.

Between March 2016 and March 2020, the total number of people completing registration questionnaires for all BAB projects was 2,918.

Of the 2,918 completing a registration form, 1020 (35%) also completed both a baseline and follow-up questionnaire.

The mean age of participants was 71 years old, with an age range of 42 to 103 years. About 30% of participants were in the age groups of 65-69 and 70-74. Further demographics show:

- 69.2% of participants were female, 28.3% were male.
- 73% of participants identified as White, while 22.5% were from BAME (Black Asian and Minority Ethnicity) backgrounds.
- 53.4% of participants reported having a long-standing illness or disability.
- 21.9% of participants were carers.
- 45.4% of participants lived alone; 43.7% lived with a spouse, partner or family member; 3.1% lived in residential accommodation.
- 67% participants were living in areas of higher multiple deprivation.

At entry to projects, 39% of participants scored as ‘intensely lonely’, 23.9% ‘moderately lonely’ and 37.1% ‘not lonely’, according to the DjG scores.

Before and after measures show statistically significant positive impacts on BAB projects for social and emotional loneliness (DjG and UCLA); wellbeing (SWEMWBS), health (EQVAS) and health related quality of life (EQ5D).

In addition, there were statistically significant positive effects on social contact with family and non-family members; social participation in formal groups; participation in social activities; involvement in activities and ability to influence decisions.

These changes are in line or greater than the outcomes for the national Ageing Better programme, of which BAB is a part.

When we assessed projects separately, there were differences in outcomes. Structured and intensive 1-1 projects (such social prescribing and talking therapies) tended to have greater impacts on health and emotional isolation. Group-based projects such as community development and community-based activity projects showed greater effects on social participation, co-design and influences on local decision-making.

The effects of BAB projects were broadly consistent across age groups, although the effects on isolation and health were clearer for younger age groups. It is noteworthy that those 70 years and over report positive changes in their ability to influence local decisions.

There are some broad patterns in which the outcomes examined tended to be better for females than males, White ethnic groups than BAME groups, those resident in areas of lower multiple deprivation than higher deprivation.

For other social categories, there were similarities in outcomes for those with long-standing illness and disability, caring responsibilities, and those living alone compared to those not experiencing these circumstances.

A minority of participants provided a third set of questionnaire responses after a longer period of involvement in BAB projects. The findings showed continued statistically significant improvements for reduced social isolation and loneliness.

These findings are important because they provide evidence on the effects of community-based projects led by voluntary sector providers across a range of outcomes. The findings indicate that these initiatives can make a positive contribution towards key aspirations in the city to improve the lives of older people, and particularly those experiencing loneliness and isolation.

Introduction: overview of participants in BAB projects

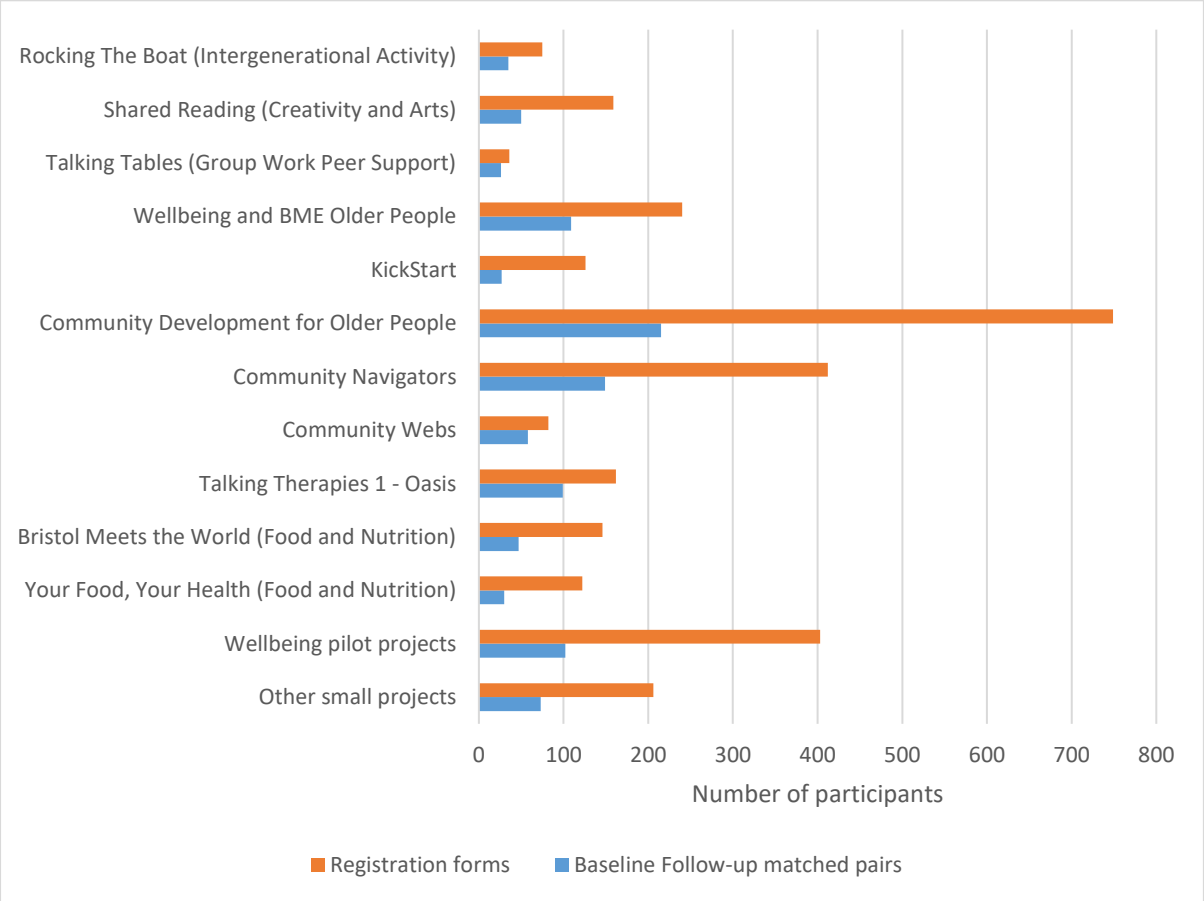
This report gives an overview of the characteristics of people taking part in the BAB projects. It presents evidence on whether the projects succeeded in reaching and engaging key groups. The report then analyses the role of the changes for participants in terms of social isolation and loneliness, health and wellbeing and social engagement.

Between March 2016 and March 2020, the total number of people completing registration questionnaires for all BAB projects was 2,918. Of those who responded, 27.8%% (n=811) had some form of assistance to complete the registration and baseline questionnaire.

Of the 2,918 completing a registration form, 1,020 (35%) completed both a baseline and follow-up questionnaire[1].

Participants first encountered BAB projects through a wide range of routes, with at least 20% coming through a health, social care or social housing referral route.

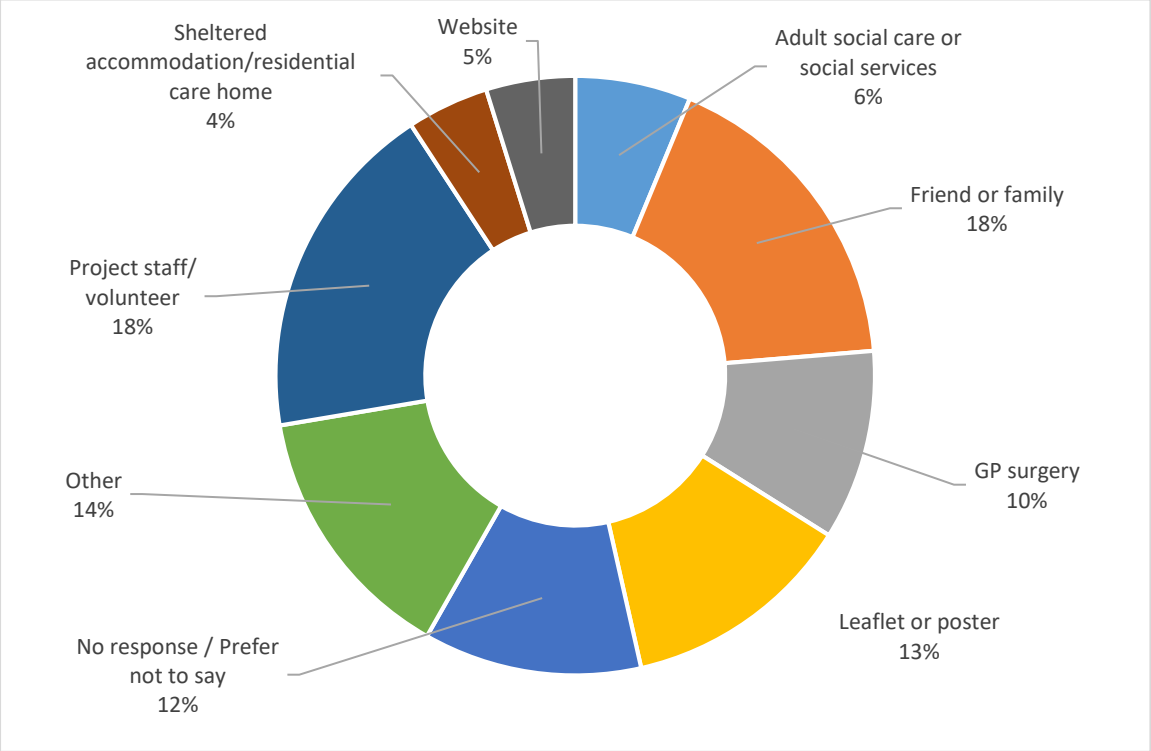
Chart 1: Registrations and matched follow-up questionnaire returns from BAB projects (n=2918)



[1] Not all questions were fully answered, which means that the number of responses for baseline-follow-up questions varies by measure.

Chart 2 shows that participants first encountered BAB projects through a range of routes, with at least 20% coming through a health, social care or social housing referral route.

Chart 2: Routes through which participants found BAB projects (n=2918)



Gender. 69.2% of participants identified as female, 28.3% identified as male. The percentage of females is higher than that of the national Ageing Better programme (61.9%).

Age. The mean age of participants was 71 years old, with an age range of 42 to 103 years. About 30% of participants were in the age groups of 65-69 and 70-74[2] (see Chart 3).

Ethnic group. 73% of participants were White, while 22.5% were from BAME (Black Asian and Minority Ethnicity) backgrounds. Discounting the BME Wellbeing project. This is higher than the general BME population in the UK (14%) and Bristol (16%).

Sexual orientation. 83.3% of participants identified as heterosexual, while 1.9% identify as being lesbian, gay, bisexual or other sexual orientation.

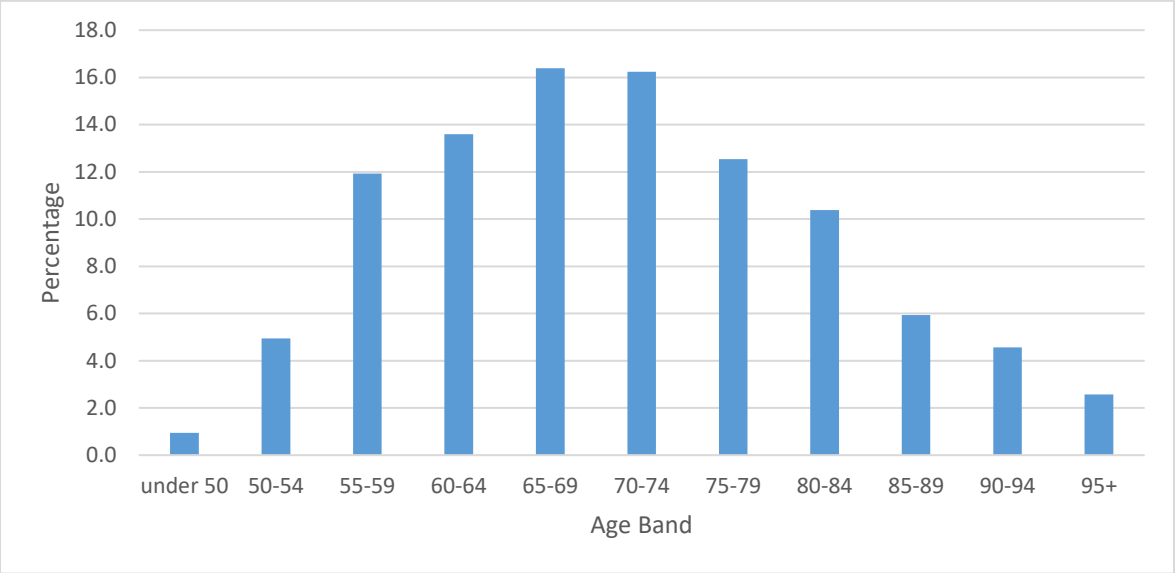
Religion. Christianity was the most common religion among participants (48.8%). 24.3% have no religion while the second most common religion among participants was Islam (7.9%).

Disability. 53.4% of participants reported having a long-standing illness or disability[3].

[2] Missing data for 269 individuals

[3] Missing data for 46 individuals

Chart 3: Age of BAB project participants (n=2918)

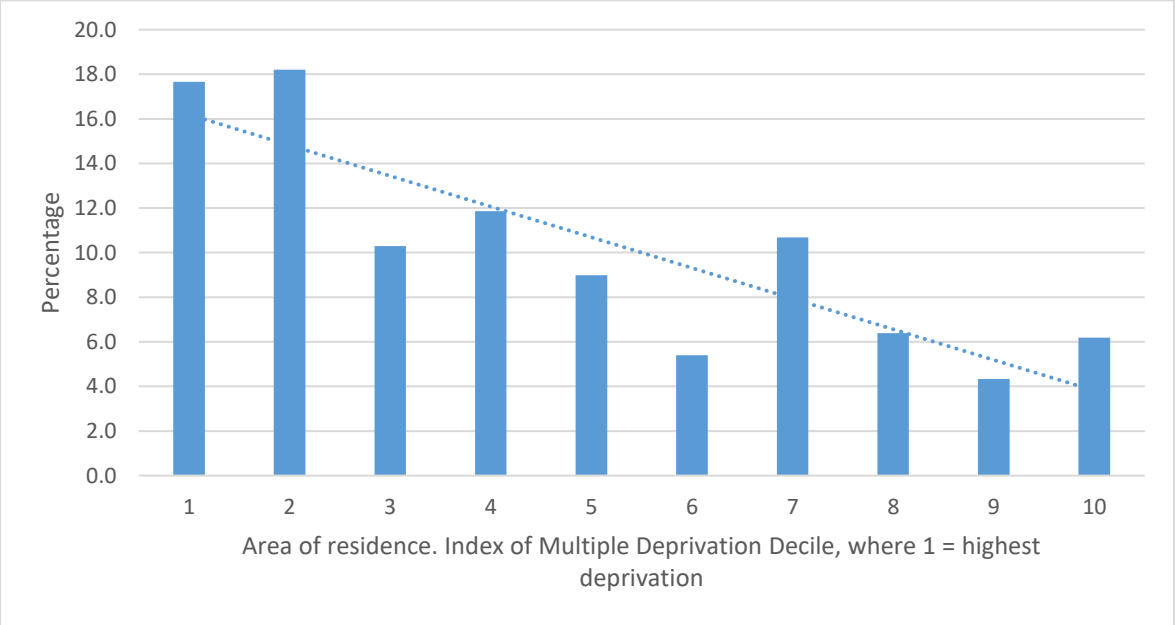


Caring responsibilities. 21.9% of participants were carers[4].

Living arrangements. 45.4% of participants lived alone; 43.7% lived with a spouse, partner or family member; 3.1% lived in residential accommodation[5].

Area of residence. Chart 4 shows that, based on postcode of residence, 67% participants were living in areas of higher multiple deprivation (67%, n=1700, living in top five deciles for the Index of Multiple Deprivation)[6].

Chart 4: Area of residence by multiple deprivation (n=2537)



[4] Missing data for 46 individuals
[5] Missing data for 46 individuals
[6] Missing data for 381 individuals

Methods for assessing outcomes

Measures

Outcome based questionnaires were developed as part of the national Ageing Better programme (the Common Measurement Framework), and termed “Wellbeing Questionnaires” in the BAB programme. Participants completing baseline and follow-up questionnaires responded to questions using twelve sets of validated measures. These are:

1. Loneliness: De Jong Gierveld (DjG) 6-item scale
2. Loneliness: UCLA 3-item scale
3. Social contact with children, family or friends
4. Social contact with anyone who is not a family member
5. Social participation: membership of clubs, organisations and societies
6. Social participation: comparison with others
7. Activities involved in (Co-design)
8. Volunteering and unpaid help
9. Ability to influence local decisions
10. Wellbeing: SWEMWBS
11. Quality of Life: EQ 5D 3L
12. Health score: EQ VAS

Administration and Responses

CDOP project staff, with the assistance of BAB staff and BAB Community Researchers were the main administrators of the baseline questionnaires. All administrators received training on how to complete the questionnaires. Participants were provided with an option to complete the questionnaires by post through direct contact with BAB staff.

Projects varied in the number of returned completed questionnaires, with the Greater Brislington CDOP project completing the largest number.

Analysis

Completed questionnaires were returned for data entry at the BAB office. BAB staff used the Ecorys Ageing Better online system to enter the data, with an SPSS software dataset then downloaded for analysis by the UWE team.

The primary outcomes of interest were loneliness and social isolation. However, given the focus of the CDOP projects, outcomes linked to social participation, involvement and influence were also important areas of focus.

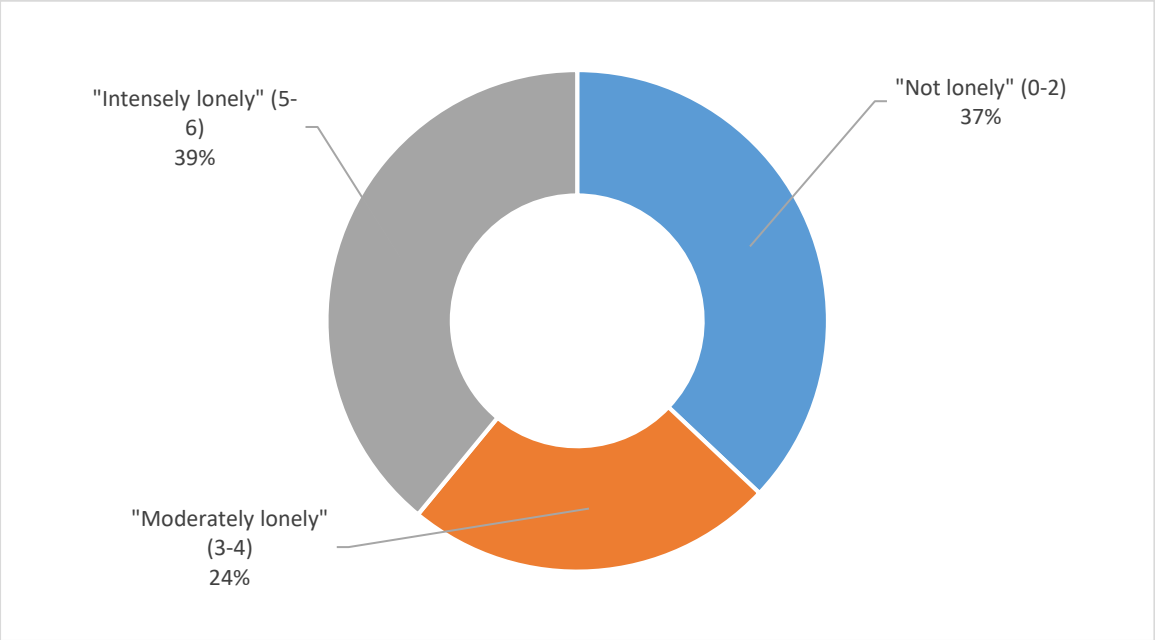
We used a number of statistical techniques to analyse the data dependent upon the type of measure and the distribution of the data. The main test was the paired sample t-test, although we also used other tests such as the Wilcoxon Signed-rank test for non-parametric data. Results were tested at the standard level of significance ($p<.05$), the higher level of significance ($p<0.001$) noted where appropriate. Where the result ‘p’ value is lower than .05 it is unlikely to have occurred by chance. However, it should be noted that a statistically significant difference does not necessarily show a difference that is meaningful from the perspective of participants, practitioners or decision makers.

Reach and engagement: addressing social isolation and loneliness

At baseline, the overall score for the 0-6 DjG scale was a mean of 3.37, which indicates that BAB participants were somewhat less lonely that participants for the national Ageing Better programme overall (3.2).

In total, 39% of participants scored as intensely lonely, 23.9% moderately lonely and 37.1% not lonely, according to the DjG scores (n=753).

Chart 5: Scores for the DjG loneliness scale at the beginning of taking part in BAB projects (n=753)



The UCLA 3-item loneliness scale gives a scale with a possible range of 3 to 9. For participants in all BAB projects 45.8% (n=486) scored between 3 and 5, which is classified as 'not lonely'; 54.2% (n=486) score between 6 and 9, which is classified as 'lonely'. While, the DjG and UCLA score classifications are somewhat different, they show a similar profile for the participants. The data provides evidence that the projects were reaching individuals that were the focus for the BAB programme, bearing in mind that most BAB projects were all designed to work with a range of older people rather than focus only on those experiencing loneliness.

Outcomes for participants

Table 1 presents a summary of the outcomes for BAB project participants alongside the outcomes for the national Ageing Better programme. At baseline, the overall pattern is that participants in BAB projects were - on average – somewhat more socially and emotionally isolated than the average for the national programme overall.

For the primary outcomes, the DjG and UCLA measures show that there was a statistically significant improvement in scores for social and emotional loneliness.

The other measures show statistically significant positive changes for wellbeing (SWEMWBS), health (EQVAS) and health related quality of life (EQ5D). There are also positive changes for social contact with family and non-family members; social participation in clubs etc; participation in social activities; involvement in activities and ability to influence decisions. It is notable that for social contact with children family and friends was one

outcome that did not show a significant change. This may be because the BAB projects were not directed at influencing these types of social contacts.

Table 1: Outcomes for participants in the BAB projects, alongside outcomes for the national Ageing Better programme. Statistically significant positive change highlighted in red

		BAB programme overall				National Ageing Better*		
Area of measurement	Measure	Number of matched pairs	Baseline mean	Follow up mean	Significance (p value)	Number of matched pairs	Baseline mean	Follow up mean
Social and emotional isolation	DEJONG	753	3.37	3.16	0.001	8290	3.2	2.9
Social and emotional isolation	UCLA	897	5.66	5.35	0.000	8277	5.5	5.1
Social contact with children, family and friends	CONTACT	808	3.27	3.30	0.442	8059	3.00	2.89
Social contact with non-family members	SPEAKLOCAL	1020	6.70	6.82	0.033	9576	6.68	6.89
Social participation in clubs etc	SOCIALSCORE	966	1.35	1.52	0.000	9477	1.1	1.3
Taking part in social activities	TAKEPART	1015	1.40	1.58	0.000	9456	1.49	1.73
Co-design. Activities involved in	INVOLVED	843	1.02	1.10	0.082	-	-	-
Ability to influence local decisions	INFLUENCE	915	2.85	3.00	0.004	-	-	-
Volunteering, unpaid help	HELP	981	1.26	1.41	0.002	-	-	-
Wellbeing	SWEMWBS	865	21.10	22.18	0.000	8493	21.5	22.9
Health/Quality of Life	EQ5DIndex	787	0.65	0.67	0.042	4485	0.61	0.63
Health	EQVAS	828	62.41	67.31	0.000	4477	63.05	67.00

* Ecorys Ageing Better national CMF dashboard, July 2021

Charts 6 and 7 present the same information in Table 1 to provide a clearer visual picture of these changes.

Chart 6. Positive changes for loneliness, wellbeing & health.

Notes. Matched pair range: 753-897. Statistically significant change for all measures (p<0.05). Data presented as percentage change. Not as values for each measure.

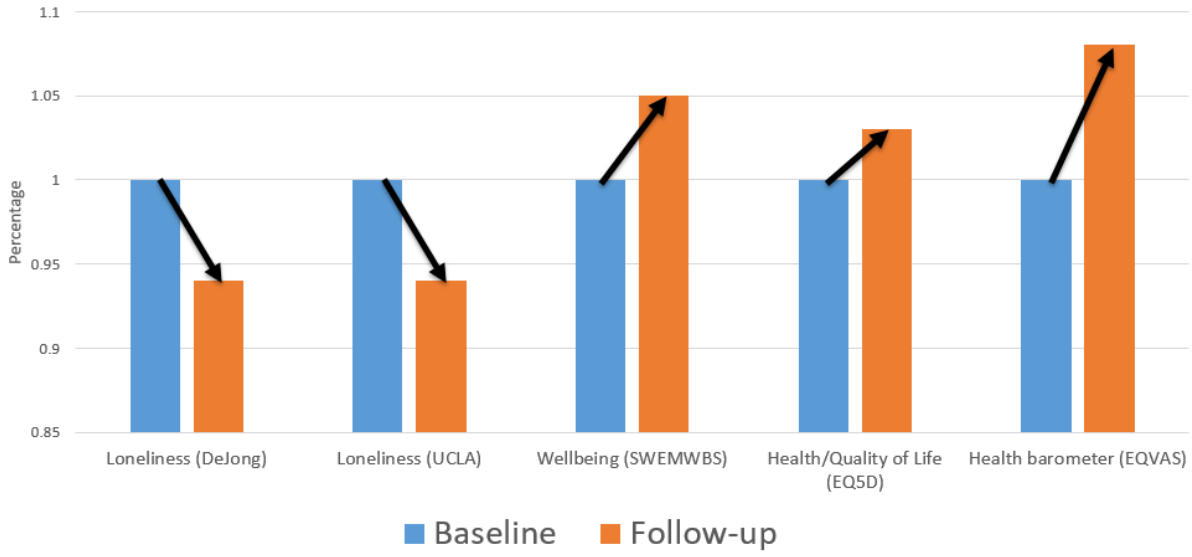
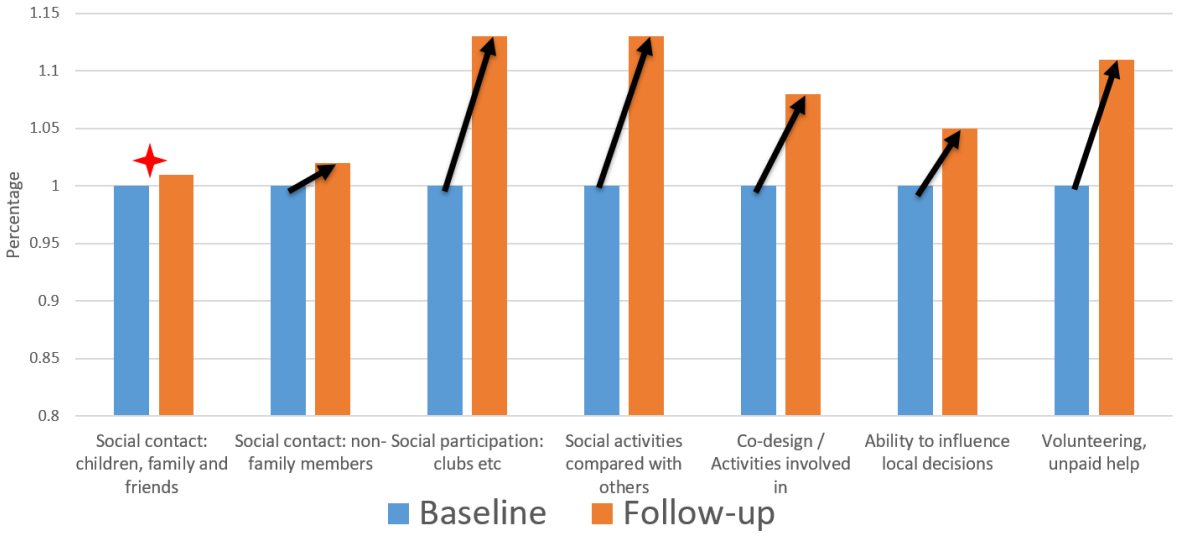


Chart 7. Positive changes for social engagement. Notes. Matched pair range: 808-1020. Statistically significant change (p<0.05) for all measures except "Social contact: children, family & friends". Data presented as percentage change. Not as values for each measure.



No significant change for this measure

Further analysis: projects and outcomes

Table 2 presents a summary of outcomes for the main BAB projects where there are sufficient matched pairs to test changes over time. The projects show a different pattern of evidence of change. Some key features are as follows:

- **Social and emotional isolation.** As well as the BAB programme overall, several of the projects show a positive impact on isolation and loneliness. The DjG and UCLA scales are largely consistent, but the differences are likely to be due to somewhat different measurement systems.
- **Health outcomes.** Community Navigators and Oasis Talking Therapies show positive effects on health related quality of life (EQ5D). This is a measure widely used in healthcare setting to determine the effectiveness of interventions. The positive outcomes for this measure may be due to the high health (mental and physical) needs of clients and the structured personal support delivered by the projects.
- **Health and wellbeing outcomes.** Most projects show positive outcomes for health (EQVAS) and wellbeing (SWEMWBS). Apart from indicating the benefits of these projects for a wide range of social groups, it should be noted that these measures are sensitive to, even small, changes.
- **Social contact with children, family and friends.** Only the Community Development projects show a positive impact using this measure. This is likely to be because most BAB projects were not designed to have an effect on these social groups: their focus has been on wider community social engagement. Positive changes in **Taking part in social activities** are widely demonstrated for the main BAB projects.
- **Influence on local decision-making** and **co-design in activities** are two areas of outcome that we can link to projects that have sought to empower older people as individuals and groups. Community development projects are a particularly good example.

Table 2: Outcomes compared for the main BAB projects. Key: Green = statistically significant positive change. Grey = no statistically significant change

Area of measurement	Measure	All projects	Community Webs	Community Navigators	Community Develop'nt	Oasis-Talking therapies	Shared reading	Bristol meets the world (food)	Come on board (physical activity)	Wellbeing & BAME Older People
	Minimum no. matched pairs	753	61	123	162	81	41	57	56	75
Social and emotional isolation	DEJONG						N/A			
Social and emotional isolation	UCLA									

Social contact with children, family and friends	CONTACT									
Social contact with non-family memb's	SPEAKLOCAL									
Social participation in clubs etc	SOCIALSCORE									
Taking part in social activities	TAKEPART									
Co-design. Activities involved in	INVOLVED		N/A							
Ability to influence local decisions	INFLUENCE		N/A							
Volunteering, unpaid help	HELP		N/A							
Wellbeing	SWEMWBS									
Health/Quality of Life	EQ5D Index		N/A							
Health	EQVAS		N/A							

We should note that there are a number of caveats involved in interpreting the outcomes. While the qualitative process evaluations and test and learn events provide evidence of how projects have created change, the baseline and follow-up design can only test associations and not determine whether projects cause change. There are also reason why there is no evidence of change for some projects. These include insufficient interval between questionnaires to detect change; the challenging nature of some changes measured; and the potential for some participant's health and wellbeing to decline over time due to factors outside the project, such as the ageing process. Therefore, absence of evidence of change does not necessarily mean that projects have not produced beneficial outcomes for participants.

Further analysis by demographic characteristics

The following sections examine the key outcomes in terms of the leading demographic variables of age, gender, living arrangement, area of residence, ethnicity, disability, and caring responsibilities. Due to low numbers of LGBT+ respondents we have not examined differences in terms of sexuality.

Age

We divided the respondents into two age groups: up to 69 years old, and 70 years and over. The following table shows that there is evidence of effects of the project for both younger and older respondent groups on social and emotional isolation, social participation, wellbeing and health (EQVAS). However, the effects health and isolation are clearer for those up to 69 years old. This group also show changes for volunteering. It is noteworthy that those 70 years and over report changes in their ability to influence local decisions.

Table 3. Outcomes assessed by age group

Area of measurement	Measure	Up to 69 yrs pairs	Baseline mean	Follow up mean	P value	70 plus yrs pairs	Baseline mean	Follow up mean	P value
Social and emotional isolation	DEJONG	372	3.61	3.32	.001	347	3.04	2.95	.324
Social and emotional isolation	UCLA	426	5.89	5.50	.000	425	5.46	5.21	.001
Social contact with children, family and friends	CONTACT	402	3.43	3.50	.145	366	3.11	3.08	.512
Social contact with non-family memb's	SPEAKLOCAL	463	6.64	6.47	.234	494	6.84	6.94	.181
Social participation in clubs etc	SOCIALSCORE	440	1.27	1.50	.000	469	1.44	1.55	.034
Taking part in social activities	TAKEPART	459	1.27	1.50	.000	492	1.51	1.66	.002
Co-design. Activities involved in	INVOLVED	370	1.11	1.20	.194	417	0.94	1.01	.300
Ability to influence local decisions	INFLUENCE	399	2.96	3.10	.064	450	2.76	2.92	.029
Volunteering, unpaid help	HELP	439	1.39	1.58	.002	480	1.17	1.25	.230
Wellbeing	SWEMWBS	410	20.46	21.62	.000	393	21.78	22.67	.000
Health/Quality of Life	EQ5D Index	336	0.65	0.69	.004	398	0.65	0.65	.999
Health	EQVAS	363	60.73	67.52	.000	412	64.21	67.46	.000

Gender

We explored differences in outcomes for females and males. The following table broadly shows that there were clearer positive effects of the programme for females than males – notably for social isolation and health. This may be due to the smaller sample sizes for males, although there are other potential explanations such as the gender relevance of projects or the higher levels of needs for males.

Table 4: Outcomes assessed by gender

Area of measurement	Project	Female pairs	Baseline mean	Follow up mean	P value	Male pairs	Baseline mean	Follow up mean	P value
Social and emotional isolation	DEJONG	532	3.27	3.04	.001	205	3.64	3.47	.188
Social and emotional isolation	UCLA	634	5.63	5.26	.000	240	5.78	5.62	.116
Social contact with children, family and friends	CONTACT	568	3.38	3.43	.167	216	2.98	2.93	.494
Social contact with non-family memb's	SPEAKLOCAL	721	6.78	6.96	.003	267	6.53	6.46	.594
Social participation in clubs etc	SOCIALSCORE	689	1.41	1.50	.029	249	1.19	1.53	.000
Taking part in social activities	TAKEPART	713	1.43	1.61	.000	273	1.32	1.53	.004
Co-design. Activities involved in	INVOLVED	579	1.08	1.12	.474	237	0.87	1.00	.082
Ability to influence local decisions	INFLUENCE	631	2.84	3.03	.003	252	2.88	2.96	.410
Volunteering, unpaid help	HELP	691	1.29	1.46	.002	262	1.20	1.30	.237
Wellbeing	SWEMWBS	618	21.26	22.46	.000	227	20.65	21.41	.006
Health/Quality of Life	EQ5D Index	544	0.65	0.67	.010	219	0.67	0.65	.365
Health	EQVAS	570	62.93	67.90	.000	230	60.73	65.93	.000

Living arrangement

We examined the differences between those participants who reported living alone and those living with others. The following table suggests a very similar pattern of outcomes for both groups. This is a positive finding for the programme overall, because it indicates that there are clear benefits for the main target beneficiary group.

Table 5: Outcomes assessed by living arrangement

Area of measurement	Project	Living alone pairs	Baseline mean	Follow up mean	P value	Living with spouse, family or other pairs	Baseline mean	Follow up mean	P value
Social and emotional isolation	DEJONG	351	3.64	3.43	.010	365	3.16	2.96	.027
Social and emotional isolation	UCLA	427	6.11	5.72	.000	423	5.29	5.05	.001
Social contact with children, family and friends	CONTACT	380	3.19	3.17	.795	384	3.42	3.45	.486
Social contact with non-family memb's	SPEAKLOCAL	484	6.72	6.79	.369	483	6.66	6.79	.102
Social participation in clubs etc	SOCIALSCORE	470	1.21	1.41	.005	452	1.40	1.60	.000
Taking part in social activities	TAKEPART	490	1.37	1.58	.000	473	1.40	1.57	.000
Co-design. Activities involved in	INVOLVED	410	0.86	0.90	.493	390	1.19	1.29	.107
Ability to influence local decisions	INFLUENCE	442	2.69	2.86	.023	427	3.05	3.14	.202
Volunteering, unpaid help	HELP	466	0.98	1.15	.005	464	1.54	1.68	.045
Wellbeing	SWEMWBS	407	20.65	21.82	.000	414	21.41	22.39	.000
Health/Quality of Life	EQ5D Index	374	0.61	0.64	.058	370	0.68	0.71	.054
Health	EQVAS	395	60.69	64.27	.000	391	64.14	70.77	.000

Area of residence

We divided participants into those living in areas of higher multiple deprivation (Index of Multiple Deprivation deciles 1-3) and those in areas of lower deprivation (Index of Multiple Deprivation deciles 4-10). The following table indicates that those living in less deprived areas showed a clearer pattern of positive changes according to the leading outcomes. This may reflect wider evidence of barriers towards reaching those experiencing higher levels of deprivation. Nevertheless, we note that those in areas of higher deprivation do show positive changes for isolation (UCLA), health (EQVAS), as well as social participation scores.

Table 6: Outcomes assessed by area of residence

Area of measurement	Project	IMD 1 to 3 pairs	Baseline mean	Follow up mean	P value	IMD 4-10 pairs	Baseline mean	Follow up mean	P value
Social and emotional isolation	DEJONG	332	3.50	3.42	.338	358	3.25	2.90	.000
Social and emotional isolation	UCLA	383	5.91	5.55	.000	441	5.52	5.22	.000
Social contact with children, family and friends	CONTACT	345	3.10	3.08	.726	404	3.46	3.51	.169
Social contact with non-family members	SPEAKLOCAL	450	6.73	6.72	.942	489	6.72	6.97	.000
Social participation in clubs etc	SOCIALSCORE	430	1.25	1.40	.005	460	1.52	1.66	.009
Taking part in social activities	TAKEPART	445	1.53	1.53	.001	488	1.47	1.66	.000
Co-design. Activities involved in	INVOLVED	368	1.05	1.03	.813	411	1.04	1.16	.038
Ability to influence local decisions	INFLUENCE	406	2.88	2.94	.446	441	2.86	3.04	.014
Volunteering, unpaid help	HELP	437	1.16	1.28	.082	466	1.43	1.57	.035
Wellbeing	SWEMWBS	370	21.06	21.91	.000	427	21.09	22.34	.000
Health/Quality of Life	EQ5D Index	333	0.59	0.62	.100	394	0.70	0.72	.056
Health	EQVAS	361	59.71	65.20	.000	405	64.74	69.28	.000

Ethnicity

To explore potential differences in outcomes in terms of ethnicity, we divided participants between those identifying themselves as any White group and those identifying themselves as any BAME group. The following table indicates that the pattern of outcomes are more positive for White groups. It is not clear why this might be the case, although it is worth noting that the sample sizes are smaller for the BAME group and it is possible that they are not large enough to detect a change. Alternatively the lack of evidence of outcomes for BAME groups may indicate the greater level of health and social disadvantages experienced by these groups.

Table 7: Outcomes assessed by ethnicity

Area of measurement	Project	White (All) pairs	Baseline mean	Follow up mean	P value	BAME pairs	Baseline mean	Follow up mean	P value
Social and emotional isolation	DEJONG	580	3.36	3.09	.000	152	3.34	3.36	.868
Social and emotional isolation	UCLA	680	5.73	5.38	.000	184	5.40	5.21	.124
Social contact with children, family and friends	CONTACT	630	3.28	3.32	.224	147	3.25	3.15	.226
Social contact with non-family memb's	SPEAKLOCAL	748	6.80	6.93	.019	227	6.46	6.41	.702
Social participation in clubs etc	SOCIALSCORE	707	1.30	1.51	.000	220	1.49	1.50	.854
Taking part in social activities	TAKEPART	740	1.33	1.56	.000	232	1.63	1.65	.740
Co-design. Activities involved in	INVOLVED	596	1.01	1.07	.238	209	1.04	1.17	.175
Ability to influence local decisions	INFLUENCE	637	2.75	2.92	.004	232	3.12	3.22	.379
Volunteering, unpaid help	HELP	711	1.23	1.32	.062	228	1.35	1.61	.027
Wellbeing	SWEMWBS	661	20.80	22.01	.000	173	22.31	22.57	.472
Health/Quality of Life	EQ5D Index	567	0.64	0.66	.127	183	0.67	0.69	.288
Health	EQVAS	583	62.04	66.60	.000	204	62.99	69.25	.000

Long standing illness and disability

Despite reporting less positive health and social circumstances at the start of their entry to projects, the following table shows that individuals reporting long standing illness and disability were clearly likely to report positive changes in terms of isolation, health and wellbeing as well as social engagement. Indeed the pattern of positive changes is stronger for this group than those without long standing illness or disability.

Table 8: Outcomes assessed by long standing illness and disability

Area of measurement	Project	Disability (Yes) pairs	Baseline mean	Follow up mean	P value	Disability (No) pairs	Baseline mean	Follow up mean	P value
Social and emotional isolation	DEJONG	437	3.93	3.64	.000	292	2.51	2.46	.609
Social and emotional isolation	UCLA	513	6.24	5.87	.000	358	4.85	4.64	.007
Social contact with children, family and friends	CONTACT	459	2.99	3.04	.251	322	3.66	3.64	.779
Social contact with non-family memb's	SPEAKLOCAL	581	6.54	6.64	.114	405	6.99	7.05	.329
Social participation in clubs etc	SOCIALSCORE	558	1.11	1.32	.000	382	1.69	1.78	.135
Taking part in social activities	TAKEPART	580	1.12	1.35	.000	402	1.80	1.91	.058
Co-design. Activities involved in	INVOLVED	457	0.84	0.91	.182	356	1.24	1.34	.188
Ability to influence local decisions	INFLUENCE	498	2.67	2.79	.077	385	3.12	3.29	.018
Volunteering, unpaid help	HELP	557	1.07	1.15	.145	392	1.52	1.73	.008
Wellbeing	SWEMWBS	497	19.87	21.19	.000	338	22.87	23.54	.005
Health/Quality of Life	EQ5D Index	414	0.49	0.53	.009	346	0.83	0.83	.460
Health	EQVAS	455	53.60	59.36	.000	345	73.94	77.71	.000

Caring

As with the analysis of outcomes for people with long standing illness and disability, those reporting carer responsibilities clearly showed a positive pattern of outcomes for isolation, health and wellbeing, along with other issues such as an ability to influence local decisions.

Table 9: Outcomes assessed by caring responsibility

Area of measurement	Project	Carer pairs	Baseline mean	Follow up mean	P value	Not a carer pairs	Baseline mean	Follow up mean	P value
Social and emotional isolation	DEJONG	194	3.86	3.51	.003	540	3.19	3.06	.065
Social and emotional isolation	UCLA	234	5.98	5.61	.000	638	5.57	5.29	.000
Social contact with children, family and friends	CONTACT	207	3.33	3.41	.179	575	3.25	3.25	.869
Social contact with non-family memb's	SPEAKLOCAL	260	6.71	6.78	.480	728	6.69	6.81	.065
Social participation in clubs etc	SOCIALSCORE	243	1.30	1.43	.050	695	1.36	1.53	.000
Taking part in social activities	TAKEPART	261	1.19	1.37	.005	723	1.47	1.65	.000
Co-design. Activities involved in	INVOLVED	182	1.04	1.16	.263	633	1.01	1.07	.193
Ability to influence local decisions	INFLUENCE	201	2.77	3.01	.037	683	2.90	3.01	.063
Volunteering, unpaid help	HELP	253	1.64	1.66	.848	698	1.12	1.30	.001
Wellbeing	SWEMWBS	226	20.48	21.66	.000	613	21.28	22.27	.000
Health/Quality of Life	EQ5D Index	169	0.63	0.67	.070	591	0.62	0.67	.144
Health	EQVAS	184	59.93	66.64	.000	617	63.11	67.47	.000

Longer term outcomes

A smaller number of individuals completed a third questionnaire at approximately 6 months after enrolling with a BAB project. With a focus on loneliness, Chart 8 shows a continued reduction in scores over time. Participant responses on the De Jong Gierveld Loneliness Scale found that the mean participant score at baseline was 3.37 (n=753). At the third questionnaire point the score was 3.10 (n=403). This difference was statistically significant (Z= -2.184; p=0.029).

Chart 8. Continued positive impacts on loneliness over time using the De Jong Gierveld Loneliness Scale. Note that chart presents as percentage change, not as values for the measure.

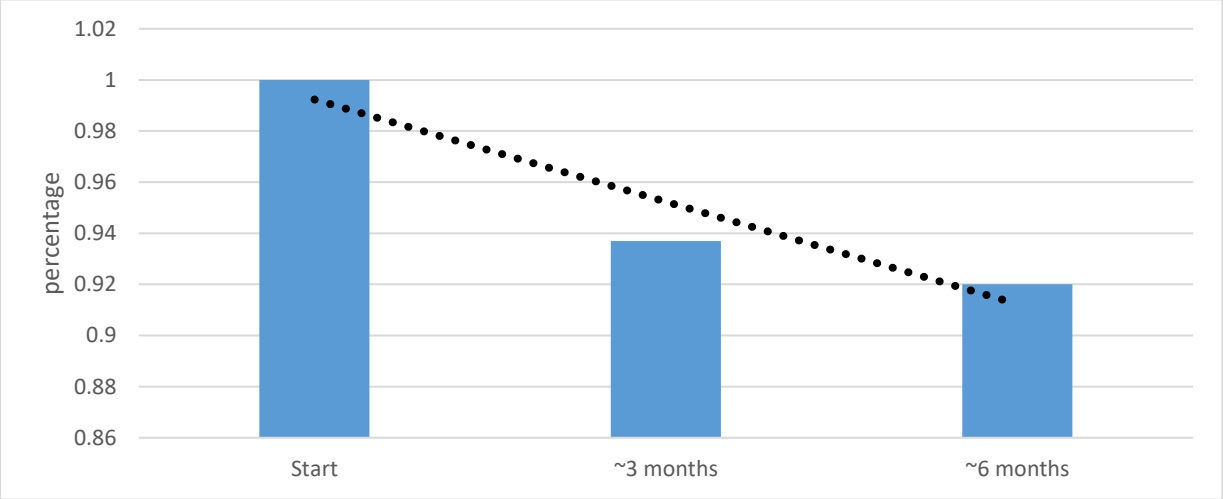
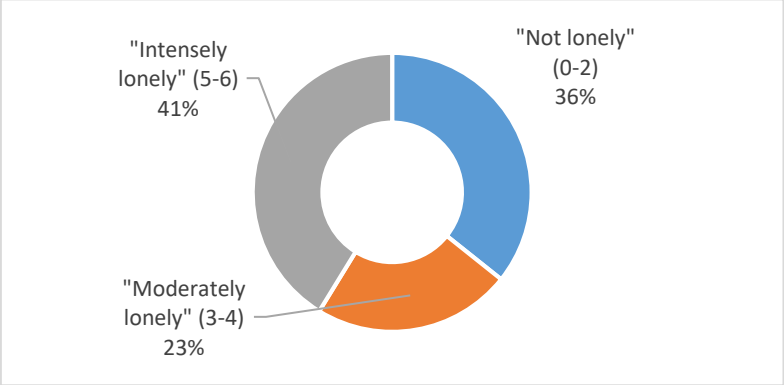


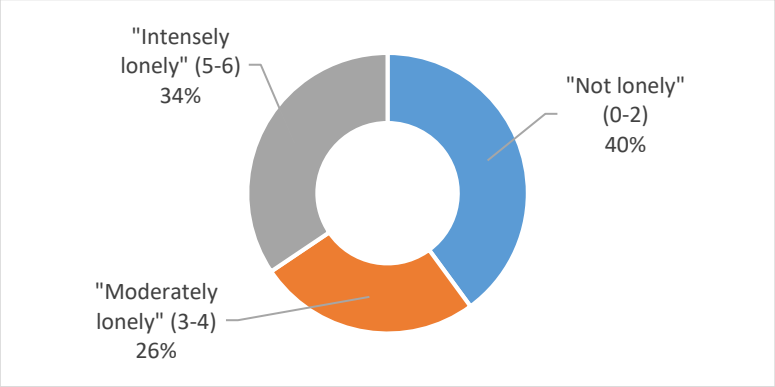
Chart 9 presents similar data to Chart 8, but focuses on the set of respondents that completed questionnaire at approximately 6 months. For this set, it shows a reduction in reported 'intense loneliness' from 41% at the start, to 34% after approximately 3 months, to 31% after approximately 6 months.

Chart 9. Continued positive impacts on loneliness over time using the De Jong Gierveld Loneliness Scale. Comparison of the same group of respondents at three time points (n=403)

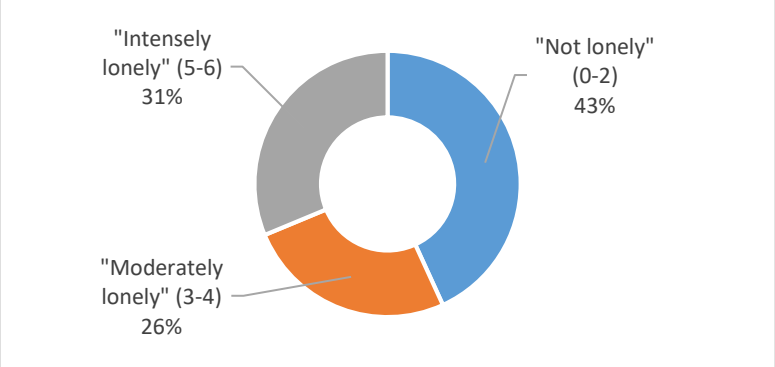
Start



~3 months



~6 months



Conclusions

The BAB projects were successful in engaging a large number of participants in their projects, although we do not have evidence of registration from the majority reported in monitoring returns to BAB.

There were variations between projects in the completion of registration forms and wellbeing questionnaires. Some variations are clearly a consequence of the project model. For example, the CDOP Strategic Coordination project was not primarily engaged in direct work with groups of community participants, whereas the CDOP Greater Brislington project was heavily activity focused. However, low data returns from some projects appear to be due to issues with project planning, delivery and skills, as well as value-based objections and ethical concerns with the use of questionnaires in community development practice.

BAB projects show success in reaching out and engaging older people who report high levels of social and emotional isolation, illness, disability and caring responsibilities. The overall patterns show that participants have a range of social needs and reflect some priority groups for the programme.

Analysis shows that there were statistically significant improvements for:

- loneliness,
- wellbeing,
- general health,
- social contact and participation,
- co-production and influence of decision–making.

This evidence indicates that the BAB projects were addressing the central goals of the programme overall. However, it should be noted that there are some limitations with the evidence in terms of uncertainty about how representative the questionnaire respondents were of all those taking part. Also, other limitations need to be recognised in terms of the duration of the changes over the longer term. Nevertheless, the outcomes findings in this evaluation show very encouraging evidence of the effectiveness of a range of initiatives on the wellbeing of older people in the city of Bristol.

These findings are important because they provide evidence on the effects of community-based projects led by voluntary sector providers across a range of outcomes. The findings indicate that these initiatives can make a positive contribution towards key aspirations in the city to improve the lives of older people, and particularly those experiencing loneliness and isolation.