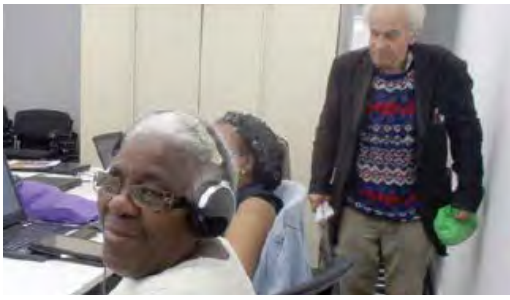
CONNECT HACKNEY
ageing better





Connect Hackney Phase 2: Programme reach and impact pre COVID-19

Prepared by: Angela Harden and Gopal Netuveli, School of Health Science, City, University of London and Institute for Connected Communities, University of East London (UEL)

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SUMMARY

Background

The Connect Hackney programme is addressing social isolation and loneliness for people aged 50 and over. It is part of the Fulfilling Lives: Ageing Better programme, funded by the National Lottery Community Fund in 14 areas in England. In Hackney, a total of 50 community-based projects have been commissioned in two Phases (Phase 1 and 2)[1]. Phase 2 projects, the focus of this report, provided activities and/or practical and emotional support on particular topics (e.g. digital inclusion, creative and sporting activities, coaching) and specific groups (e.g. men, older people with complex needs and ethnically diverse groups). A total of 3,505 Hackney residents aged 50 and over took part in Phase 2 project activities[2]. This report shares learning on the reach and impact of the Phase 2 projects (2018-2022) from the ongoing local evaluation of the Connect Hackney programme. It aims to inform commissioners and policy makers with a remit to tackle social isolation and loneliness[3] and promote health and wellbeing amongst older people.

Aims and methods

This report presents quantitative survey findings which contribute to answering 'test and learn' questions on the success of the programme concerning a) who the programme reached and b) changes in social isolation and loneliness and the health and wellbeing of participants. Data were collected from Connect Hackney participants using a self-reported questionnaire that contained standardised measures and was adopted by all Ageing Better sites. The survey covered a range of socio-demographics and outcome measures related to social isolation, loneliness, health and wellbeing. The evaluation used a baseline and follow-up design (pre- and post-intervention) in order to measure any changes in older people's outcomes after they have participated in the programme. At project entry, participants were asked to complete either a short survey that collected demographic information only or a longer version of the survey that collected demographic and outcome measures. Respondents to the longer version were asked to complete a follow-up survey, six months (on average) after they joined a project. Data were analysed from 940 participants at baseline and 219 participants at follow-up[4]. All data were collected between March 2018 and February 2020, prior to the onset of the COVID-19 pandemic. Findings on impact and

[1] 26 projects were commissioned in Phase 1 (2015-2018) and 24 projects were newly commissioned in Phase 2 (2018-2022).

[2] As reported in quarterly monitoring data. NB: These figures do not include members of the Older People's Committee. Furthermore, it was not possible to obtain an up to date number of participants from one of the ethnically diverse projects. The organisation running this project received additional funding during the COVID-19 pandemic to run a number of other projects for residents in Hackney and neighbouring boroughs. It was not possible to disaggregate Connect Hackney participants from those in other projects so only the number of participants completing a baseline survey are included from this project in the total number of participants..

[3] Social isolation and loneliness are distinct but related concepts. Social isolation refers to a lack of social contacts or support, whereas loneliness refers to the subjective feeling of being alone. Whilst an individual can have many social contacts, they can still feel lonely. Both can have adverse effects on health and wellbeing.

[4] Total numbers for individual items in the survey vary as not all participants completed all questions. At baseline, the total N for individual items on the short version of the survey varied from 698 to 917. Total N varied for the long version of the survey, ranging from 620 to 805. At follow-up, total N for individual items on the full version of the survey varied from 137 to 219. NB: The short version of the survey was not used at follow-up.

reach are therefore only relevant to the Connect Hackney programme as delivered prior to the pandemic. The premature end date for collection of participant surveys also means that the sample size is not as big or representative as originally expected. This has limited the scope of the impact analysis and puts limits on the confidence that can be placed on the reliability of the findings. Other studies in the Connect Hackney evaluation have explored perceived impacts across all projects within the programme using qualitative methods both before and during the pandemic.

Findings

Programme reach – baseline measures

- ***The most common ways that projects reached participants were through friends and family, GP practices, and project staff or volunteers***. Nearly a third of participants came through health and social care routes (social/care services, GP or sheltered housing or residential care). A lower proportion of participants (nine per cent) reported they found out about a project through printed media (leaflets or posters).

- ***The Connect Hackney programme has attracted residents from groups which are known to be more at risk of loneliness and social isolation (e.g. those living alone and those who have a longstanding illness or disability).*** Compared to older people living in Hackney overall, Connect Hackney participants are more likely to be living alone (54 per cent compared to 34 per cent) and have a longstanding illness or disability (61 per cent compared to 45 per cent).
- ***The programme is an inclusive one, attracting diverse groups of older people including those from marginalised groups who bear the greatest burden of social isolation, loneliness and poor health. The programme therefore has the potential to reduce inequalities in social isolation and loneliness and in health and wellbeing***. There were higher proportions of ethnically diverse groups and LGBTQ+ participants compared to what might be expected given the relative proportions of these groups in Hackney and England as a whole. Through its commissioning cycles, the Connect Hackney programme specifically targeted men, LGBTQ+, ethnically diverse communities, carers, and those with a long standing illness or disability.

- ***The programme attracted more women than men, although it attracted more men than Ageing Better programmes nationally***. Compared to older people living in Hackney overall, Connect Hackney participants are more likely to be female (65 per cent of Connect Hackney participants compared to 52 per cent of older Hackney residents). The Connect Hackney programme has specifically targeted men through its commissioning cycles.

- ***Connect Hackney has been successful in attracting participants who are already experiencing high levels of social isolation and loneliness and ill-health***. On average, Connect Hackney participants were more socially isolated and lonely and in poorer health compared to older Hackney residents overall and to older people more generally in England.

- ***Levels of loneliness differed across projects***. The Complex Needs and Community Connector projects had the highest proportion of participants classified as lonely and the Digital Inclusion and Media projects had the lowest. The former projects specifically targeted groups that are more likely to be already lonely such as those with poor mental health.

- ***At programme entry, there was room for improvement in terms of the extent to which older people in Hackney feel able to influence decision making in their local area***. Only a quarter of Connect Hackney participants felt that they were already able to have this kind of influence at programme entry, although this was higher than levels seen amongst older people in England more generally.

- Compared to those classified as not lonely or at risk of loneliness[5] at baseline, ***participants who were lonely at entry to the programme were significantly more likely to be younger (age 50-59), male, living alone and to have a long standing illness or disability***.

- ***Those who were classified as lonely scored significantly lower on all other health and wellbeing measures***. For example, they had less frequent contact with people in their neighbourhood, scored lower on well-being and were less likely to volunteer. This finding underscores the importance of the Connect Hackney programme in improving a whole range of outcomes in addition to loneliness.

Programme impacts – baseline and follow-up comparisons

- ***Analysis of data revealed that there were statistically significant improvements from programme entry to follow-up on five key self-reported outcomes:***

    - Loneliness
    - Quality of life
    - General health
    - Wellbeing
    - Engagement in social activities compared with others

  As noted earlier in the methods section, these findings need to be interpreted with caution due to the smaller than expected sample size at follow-up. Sample sizes for outcome comparisons were reduced even further due to the fact that not all participants responded to every question in the survey. Levels of missing data were particularly high for the wellbeing (37 per cent) and general health (26 per cent) measures.

- Baseline to follow-up comparisons showed:

[5] Loneliness was measured by the 3-item UCLA scale which asks: How often do you feel you lack companionship? How often do you feel left out?; and How often do you feel isolated from others? Possible response options were as follows: 'hardly ever or never' (scored 1), 'some of the time' (scored 2) and 'often' (scored 3). An overall loneliness score is calculated by adding the scores up across the 3 questions. This score ranges from 3 (least lonely) to 9 (most lonely). Following Steptoe et al. (2013) those scoring 6 or above are classified as 'lonely'; those scoring below 6 are scored as 'not lonely or at risk'

- ***a 12 per cent reduction in the proportion of participants classified as lonely.*** At follow-up the proportions of participants who were lonely moved from 56 per cent to 44 per cent. ***This reduction in loneliness translated to 22 per cent of participants lifted out of loneliness at follow-up.***
- ***a 14% increase in the proportion of participants assessing their engagement in social activities as more than or the same as other people of their age***. A lack of engagement in social activities is a potential precursor to social isolation. At follow-up a higher proportion of Connect Hackney participants saw themselves as more socially engaged than older residents in Hackney overall.
- ***a 16 per cent reduction in the proportion of participants classified with low mental wellbeing***. A classification of low mental wellbeing puts people at higher risk of depression. The average wellbeing score amongst participants increased from 21 at programme entry to 25 at follow-up. This increase brought average scores up to the same level as those of older people in England overall.
- ***Statistically significant increases in the average health related quality of life score and average self-reported health score***. Average levels of self-rated health increased 5 points (from 61.29 to 66.54). However, the improved scores were still much lower than for older people in England overall (75).

- ***There was an absence of any statistically significant impacts on average levels of contact with family and friends, contact with non-family members, membership of clubs, volunteering, co-design and perceived levels of influence over decision-making in the local area***. Relatively high entry level scores on these outcomes may have contributed to a lack of improvement. The lack of impact on co-design is surprising given the emphasis on co-production within the programme. The qualitative evaluation of co-production found that significant numbers of projects did not achieve sufficient depth in their co-production activities.

- ***More in-depth analysis to assess whether changes in loneliness varied across project themes or participant characteristics was limited by the small sample. Therefore, it was not possible to identify possible drivers of changes in loneliness.***

Conclusion

The Connect Hackney programme for people aged 50 and over is a community-based approach to address social isolation and loneliness and its adverse consequences for health and wellbeing. The projects delivered within the programme provided a wide range of social activities combined with practical and emotional support and skill development. The promising findings on project reach and impact described in this report support the continuation of a programme of social activities and support to reduce loneliness and improve health and wellbeing amongst diverse groups of older people in Hackney. This conclusion is qualified by consideration of the strengths and limitations of the evaluation methods. The results are bolstered by findings from the existing literature on loneliness interventions as well as similar positive findings reported from local evaluations in other Ageing Better areas. However, further research is needed to identify what types of community activities and support hold the most promise for older Hackney residents. Future commissioning should ensure continued attention to, and sufficient funding for: developing interventions that reach and engage the most marginalised groups, including

those at greatest risk of loneliness and social isolation and those who are less likely to access services and interventions.

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1. Background

The focus of this report is a programme of community-based projects aiming to address social isolation and loneliness amongst older residents (aged 50 and over) in Hackney, East London known as 'Connect Hackney'. The report describes analysis of quantitative data on the reach and impact of the programme and aims to inform commissioners and policy makers interested in addressing social isolation and loneliness. This chapter begins with an overview of the national and local policy contexts for addressing social isolation and loneliness. The Connect Hackney programme and the national Ageing Better programme in which it is situated are then described, followed by an overview of the projects within Connect Hackney. Previous relevant research is then summarised. The chapter concludes by highlighting the COVID-19 pandemic as the new context in which Connect Hackney is operating and its impact on the analysis in this report.

1.1 The national and local policy contexts

There has been a growing interest in the issue of social isolation and loneliness over recent years in recognition of the evidence linking these states with poor health and wellbeing and premature death[6]. There is also evidence that older people who are socially isolated and/or lonely are more likely to: frequently visit their GP, access emergency care, enter local authority funded residential care, be readmitted to hospital or have a longer stay[7]. The government's Loneliness Strategy in 2018[8] and the NHS Long Term Plan in 2019[9] set out ambitious plans for tackling loneliness through a more joined-up integrated care and support service agenda, focusing on a person-centred experience and recognising the importance of local and relevant delivery of services.

The Loneliness Strategy called on local authorities to consider how tackling social isolation and loneliness can be embedded in their strategic planning. The strategy anticipated commissioning boards responding to loneliness, working with local communities and civil society bodies, and addressing practical issues around community space and transport. The strategy also recognised the vital role of the voluntary sector in tackling loneliness and bringing people together to create strong, integrated communities and to challenge obstacles that isolate individuals or groups. Within the London Borough of Hackney, tackling social isolation and loneliness amongst older people is part of the borough-wide Ageing Well Strategy[10]. This is underpinned by three key principles: co-production and asset-based working; joined-up working across sectors (public, voluntary and business); and promotion of an age-friendly Hackney.

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[6] Holt-Lunstad, J. et al. (2015) Loneliness and Social Isolation as Risk Factors for Mortality: A Meta Analytic Review.

[7] Valtorta, N. et al. (2018). Older Adults' Social Relationships and Health Care Utilization: A Systematic Review. American Journal of Public Health. April 2018, 108(4).

[8] HM Government (2018). A connected society. A strategy for tackling loneliness – laying the foundations for change. London: DCMS.

[9] NHS (2019). The NHS long term plan (online). < https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/>[Accessed 02 February 2021]

[10] Hackney Council. DRAFT: Hackney's Ageing Well Strategy 2020-2025 Supporting older people to age well in Hackney. (online) <https://consultation.hackney.gov.uk/communications-and-consultation/ageing-well-strategy-consultation/supporting_documents/Draft%20Ageing%20Well%20Strategy.pdf>[Accessed 09 February 2021]

1.2 Ageing Better in Hackney

'Connect Hackney' is one of 14 'Ageing Better' programmes in England, funded by the National Lottery Community Fund[11]. It runs from 2015 – 2022[12] and this report focuses on projects commissioned in the second phase (2018-2022) of the programme. Aligned with the aims of Ageing Better overall, Connect Hackney has four intended outcomes (Box 1.1).

Box 1.1: Connect Hackney programme outcomes

1. Increased numbers of older people who are socially isolated engage in meaningful and enjoyable activities which result in new friendships, sustained networks, improved resourcefulness, more confidence and thus, ultimately, a better quality of life.
2. Increased numbers of older people who are at risk of social isolation engage in meaningful and enjoyable activities which result in new friendships, sustained networks, improved resourcefulness, more confidence and thus, ultimately, a better quality of life.
3. To embed an asset-based model towards ageing and older people, where the latter are more actively engaged in the community and valued for the contributions they make.
4. Increased direct involvement of older people and people as they age in shaping policy and holding key stakeholders to account, leading to stronger partnerships.

A total of 50 community-based projects were commissioned in Connect Hackney's two phases (Phase 1 and 2)[13]. In Phase 2, there were a total of 3505 participants[14]. All projects aimed to support the development of new social relationships and promote wellbeing amongst participants. In line with programme outcomes three and four (Box 1.1), the intention was for projects to contribute to increasing the extent to which older people are viewed as assets within the community and are involved in decision-making. Projects in Phase 2 were commissioned within several themes (Table 1.1).

Table 1.1: Phase 2 Connect Hackney projects

Theme	**Project name**
Community Activities – intergenerational social activities including theatre making skills, singing, and food sharing events.	1. The Posh Club 2. Theatre Exchange 3. Friends of Woodberry Down 4. Silver Saturdays 5. Social Singing
Community Connector – one-to-one coaching and group activities for already socially isolated and lonely older people.	6. Community Connections

[11] https://www.ageing-better.org.uk/

[12] The Ageing Better programme has recently been extended for 1 year to 2022 in a reduced number of areas across England including Connect Hackney.

[13] A total of 26 projects ran in Phase 1 (2015-2018) and 25 projects ran in Phase 2 (2018-2021). Projects that ran in phase 2 were different to those that ran in Phase 1 except for the Hackney Senior Media Group which was commissioned in Phase 1 and continued in Phase 2.

[14] As reported in quarterly monitoring data. NB: These figures do not include members of the Older People's Committee. Furthermore, it was not possible to obtain an up to date number of participants from one of the ethnically diverse projects. The organisation running this project received additional funding during the COVID-19 pandemic to run a number of other projects for residents in Hackney and neighbouring boroughs. It was not possible to disaggregate Connect Hackney participants from those in other projects so only the number of participants completing a baseline survey are included from this project in the total number of participants.

Theme	**Project name**
Digital Inclusion – group-based learning to develop skills in using mobile phones, tablets and the internet.	7. Silver Connections 8. @Online Club 9. Learning Together
Men – social activities and support for men including befriending and peer-led activities.	10. Gillet Square Elders 11. Hackney Dudes 12. Hackney Brocals 13. Living with a Hearing Loss
Learning disabilities – activities to improve skills and confidence and provide opportunities to socialise.	14. The Garden Social 15. Peter Bedford Over 50s
Ethnically diverse groups – social activities and practical support for older people of; South American, Turkish-Cypriot, French speaking African heritage, including Somalian, and Chinese.	16. Growing Project 17. Happy Living 18. Santé Sage 19. Somali Elders 20. Table Tennis Club
Complex needs – social activities for older people with extra support needs: carers; those with poor mental health; and those with difficulties leaving home.	21. Bringing the Outside In 22. Carers Collective 23. Connect at Core 24. Getting out and about locally
Media Group – participants produced a quarterly publication of the Hackney Senior magazine	25. Hackney Media Group

The programme also ran the Older People's Committee which provided a forum for older people to take part in the governance, design, delivery and evaluation of the programme.

1.4 Previous research

A range of approaches to tackle social isolation and loneliness amongst older people are described in the literature including[15]: psychological therapies (e.g. to develop social skills and challenge negative expectations around social relationships); befriending and other types of social support schemes, and; community approaches which increase the availability of, and access to, opportunities for meaningful social interaction. The Connect Hackney programme is an example of a community driven approach, with individual projects combining group activities and practical and emotional support. The evidence base for all these types of interventions is often characterised as weak or limited[16,17]. Research has highlighted various promising approaches: group interventions offering opportunities for active engagement and support; interventions informed by social-scientific theory and evidence on the causes of social isolation and loneliness and how they can be prevented, and activities developed with the input of older people[18,19,20]. Programmes supporting

[15] For more details on the evidence base underpinning specific Connect Hackney projects and approaches and within the wider Ageing Better programme, see previous reports at https://www.connecthackney.org.uk/evaluation-and-learning/programme-evaluation/

[16] Landeiro F, Barrows P, Nuttall Musson E, Gray A, Leal J (2020) Reducing social isolation and loneliness in older people: a systematic review protocol. *BMJ Open* http://dx.doi.org/10.1136/bmjopen-2016-013778

[17] Fakoya, O.A., McCorry, N.K. & Donnelly, M. Loneliness and social isolation interventions for older adults: a scoping review of reviews. *BMC Public Health* **20,** 129 (2020). https://doi.org/10.1186/s12889-020-8251-6

[18] Dickens A, Richards S, Greaves C, Campbell J (2011) Interventions targeting social isolation in older people: a systematic review. *BMC Public Health* 11(647).

[19] Windle K, Francis J, Coomber C (2011) Preventing Loneliness and Social Isolation: Interventions and Outcomes. Social Care Institute for Excellence (SCIE) Research Briefing 39. http://www.scie.org.uk/publications/briefings/briefing39/

[20] Franck L, Molyneux N, Parkinson L. Systematic review of interventions addressing social isolation and depression in aged care clients. *Qual Life Res* 2016;25.

participation in community activities are increasingly associated with a wide range of health and social benefits[21].

1.5 The onset of the COVID-19 pandemic

When the COVID-19 pandemic arrived in England, social contact was nationally restricted in March 2020 through the first 'lockdown', starting 23rd March 2020. At the time, Prime Minister Boris Johnson said all non-essential travel and public gatherings must stop, with people urged to leave home only for exercise, to shop for essential items, for medical care, or when their work could not be done at home. All shops selling non-essential items closed along with pubs, restaurants, theatres, cinemas and places of worship. Social restrictions were reduced and re-introduced throughout 2020 and 2021. There were restrictions on indoor and outdoor household mixing, compulsory mask wearing and continued shielding for those identified as vulnerable. All legal restrictions were lifted in England from 19th July 2021.

The onset of the COVID-19 pandemic has been life changing, impacting on older people's wellbeing and social resources, and including the projects offered by the Connect Hackney programme. All in-person activities were stopped during the lockdowns with delivery replaced by remote methods when possible. The administration of the participant survey also stopped with the onset of the pandemic. The findings of the analysis reported here are therefore relevant to the reach and impact of the programme *before* the onset of the COVID-19 pandemic. The premature end date for collection of participant surveys also means that the sample size is not as big as originally expected. This has limited the scope of the impact analysis and puts limits on the confidence that can be placed on the reliability of the findings.

The next chapter of the report lists the specific research questions the analysis was designed to address.

[21] Fancourt, D., Steptoe, A. (2019) The art of life and death: 14 year follow-up analyses of associations between arts engagement and mortality in the English Longitudinal Study of Ageing. *BMJ*; 367 doi: https://doi.org/10.1136/bmj.l6377

2. Research questions

The evaluation of the Connect Hackney programme is guided by a set of eight "test and learn" questions. The analysis of participant survey data in this report aimed to contribute to the following test and learn questions in particular:

What projects have had the most success in reducing social isolation and loneliness amongst older people living in Hackney?

What information, referral and access methods have been the most successful in reaching older people living with or at risk of social isolation and loneliness? How has the use of print media, leaflets or mailings increased the level of older people's involvement in activities?

Due to the limited size of the sample at survey follow-up, however, it was not possible to reliably address the first question on the impact of specific projects. Instead, programme impacts have been examined by combining project-level data. Data limitations mean not all projects or targeted groups are represented and the findings should not be generalised.

Indicative research questions and lines of inquiry for the analysis were co-developed with the Connect Hackney programme team and members of the evaluation advisory group.

1. What proportion of participants have been reached by which information, referral and access methods? Do methods vary across project themes?
2. What is the socio-demographic and baseline outcome profile of those participating in the Connect Hackney programme?
    a) How well does this reflect the profile of older residents in Hackney overall? Has the programme reached those at higher risk of loneliness and social isolation and those who are already socially isolated and lonely?
    b) Are there differences according to project theme?
3. Are the characteristics of those who are lonely different to those who are not lonely?
4. What impact did participation in the Connect Hackney project have on social isolation and loneliness, health and wellbeing and volunteering, involvement in co-design and perceived levels of influence over decision-making in the local area?
5. What are the drivers of any changes in loneliness? (e.g. socio-demographic profile, project theme, numbers of projects attended).

The next chapter sets out the research methods.

3. Methods

3.1 Design

The research described in this report analyses Phase 2 survey quantitative data collected from Connect Hackney participants as part of the national evaluation of the whole Ageing Better programme. The evaluation follows a baseline and follow-up (pre- and post-intervention) design in order to measure any changes in older people's outcomes after they have participated in the programme.

3.2 Data collection

A standardised survey was adopted by all Ageing Better sites to collect data on a range of socio-demographics and participant outcomes[22]. Staff at each Ageing Better site were asked to collect information on a number of core outcomes but could select additional optional outcomes. The participant survey administered to Connect Hackney participants covered socio-demographics and measures of loneliness, social isolation, health and wellbeing, and volunteering, co-design and influence on local decision making (**Appendix A**). A short version of the participant survey was also available which collected socio-demographic characteristics only. Both versions of the survey were distributed by project providers for completion at project entry (baseline). Only the full version of the participant survey was distributed at follow-up (e.g. either during the project, at project exit, or post project exit). The majority of follow-up surveys were completed within six months of the baseline (72%). Participants could self-complete the survey or were offered help to complete it if needed. Surveys were administered from the start of Phase 2 until the point of the first COVID-19 lockdown in March 2020. All projects distributed the survey except for the projects for those with learning disabilities. A separate adapted version of the survey was used for participants from these projects and this was administered at baseline only. The findings of this survey are reported separately as an annexe to this report[23].

3.3 Data preparation and analysis

Anonymised data from all surveys completed and returned to the Connect Hackney office and entered into the national database were shared with the local evaluation team. Data cleaning, preparation and analysis were carried out in STATA. Those participants taking part in Phase 2 of the programme were identified through project names and project entry data collection date (from 01/03/2018). Participants who had taken part in both Phase 1 and Phase 2 were excluded from the analysis[24]. T-tests and analysis of variance (ANOVA) were used to test for significant differences for continuous variables while chi-squared tests were used for categorical variables.

[22] ECORYS (2018) *Ageing Better Evaluation Common Measurement Framework (CMF): Outcome measures (June 2018)*. London: ECORYS.

[23] The Annexe will be available in the first quarter of 2022.

[24] These participants did not have comparable baseline and follow-up data as their entry surveys were collected during Phase 1 of the programme and their follow-ups were completed in relation to Phase 2 projects.

3.4 Description of the sample

Data were available for 940 Phase 2 participants at project entry. Of these, 135 (14%) had completed a short version of the survey and 805 (86%) had completed a full version. Of those completing a full baseline survey, 219 participants (27%) had also completed a follow-up survey.

Survey completion was uneven across the projects and project themes at both baseline and follow-up. This means the survey results are not representative of all the Phase 2 projects. All project themes were represented in the baseline full survey although numbers completed were lower for Community Connector and the Media Group themes as these themes consisted of only one project each (Table 3.1). The Complex Needs theme accounted for the largest proportion (51%) of the short survey baseline responses. These were dominated by surveys returned by one project in particular (Connect at Core) (**Appendix C**). At follow-up, over half (52%) of the responses were from the Digital Inclusion and Men's projects. This means the impact findings for the other project themes may be less reliable as the response numbers are small. This applies to the Ethnically Diverse projects in particular as there were only two follow-up respondents in this theme. These projects started later in Phase 2 than the other projects and had limited scope for administering follow-ups before the onset of the pandemic.

Table 3.1: Distribution of entry (full - N=805; short N=135) and follow-up surveys (N=219) by project theme

	Baseline (%)		Follow-up (%)
PROJECT THEME	Full survey	Short survey	Full survey[b]
Community Activities	115 (14)	13 (10)	24 (11)
Community Connector	80 (10)	0 (0)	21 (10)
Complex Needs	173 (21)	69 (51)	34 (16)
Digital Inclusion	109 (14)	24 (18)	70 (32)
Ethnically Diverse	150 (19)	13 (10)	2 (1)
Media Group	74 (9)	2 (1)	25 (11)
Men	104 (13)	14 (10)	43 (20)
TOTAL	805 (100)	135 (100)	219 (100)

[b] Does not sum to 100 due to rounding off errors

There were statistically significant differences for gender, ethnicity and carer status in the socio-demographic profile of those completing a baseline survey only and those completing both entry and follow-up surveys (**Appendix B**). A greater proportion of men and carers completed both entry and follow-up surveys compared to those who completed only the baseline survey. In terms of ethnicity, more white participants completed both an entry and follow-up survey. This finding is reflected in the low response from Ethnically Diverse projects.

There was also variation in the proportion of participants answering each question in the participant survey at baseline and follow-up (**Appendix D**). Missing data were between 0 and 20 per cent for most survey items, with the exception of three measures at project entry (sexual identity – 26 per cent missing; emotional wellbeing – 23 per cent missing; and health related quality of life – 21 per cent missing) and four measures at follow-up: (sexual identity – 28 per cent missing; social contact with family and friends – 37 per cent missing; emotional wellbeing – 37 per cent missing; and health related quality of life – 26 per cent

missing). Findings on these measures should be treated with caution as they may be less reliable.

37 per cent of respondents to the baseline surveys required assistance in the form of someone reading out the questionnaire to them, support and companionship or other types of assistance not further specified (Table 3.2).

Table 3.2 Numbers and per cent of participants needing assistance completing entry survey (N=796*)

PROJECT THEME	ASSISTANCE GIVEN		TOTAL
	No N (%)	Yes N (%)	N (%)
Community Activities	57 (53)	50 (47)	107 (100)
Community Connector	37 (54)	32 (46)	69 (100)
Complex Needs	177 (78)	49 (22)	226 (100)
Digital Inclusion	69 (67)	34 (33)	103 (100)
Ethnically Diverse	59 (44)	75 (56)	134 (100)
Media Group	45 (90)	5 (10)	50 (100)
Men	68 (63)	39 (37)	107 (100)
TOTAL	512 (63)	284 (37)	796 (100)

*Total N = 796 as there was no information on assistance for 144 survey participants

Participants from the Media Group and projects within the Complex Needs themes required the least assistance whilst participants in Ethnically Diverse, Community Activities and Community Connector projects required the most assistance.

The majority of survey participants at entry took part in one project only (95%), four per cent took part in two projects and less than one per cent took part in three projects. Of those also completing a follow-up survey 82 per cent took part in one project; 16 per cent took part in two; and two per cent took part in three projects.

3.5 Presentation of findings

Table 3.4 illustrates how the findings are presented in chapters 4 and 5, indicating the research questions addressed.

Table 3.4: Presentation of findings according to research question addressed

Findings section	Research questions
4.1 Routes to reaching participants	What proportion of participants have been reached by which information, referral and access methods? Do methods vary across project themes?
4.2 Participant socio-demographic profile at programme entry 4.3 Participant outcome profile at programme entry	What is the socio-demographic and baseline outcome profile of those participating in the Connect Hackney programme? How well does this reflect the profile of older residents in Hackney overall? Has the programme reached those at higher risk of loneliness and social isolation and those who are already socially isolated and lonely? Are there differences according to project theme?
4.4 Characteristics associated with loneliness	Are the characteristics of those who are lonely different to those who are not lonely?
Programme impact on: 5.1 Loneliness 5.2 Social isolation 5.3 Health and wellbeing 5.4 Volunteering, co-design and influence	What impact did participation in the Connect Hackney project have on: social isolation and loneliness, health and wellbeing and volunteering, involvement in co-design and perceived levels of influence over decision-making in the local area?
5.5 Further analysis of impact on loneliness	What are the drivers of any changes in loneliness? (e.g. socio-demographic profile, project theme, numbers of projects attended).

To aid interpretation, data on Connect Hackney participants are compared to Ageing Better participants overall[25], people aged over 50 years in Hackney and/or England as a whole using data from the 2011 Census. This is followed by a comparison of the socio-demographic profile of participants across project themes.

Probability (p) values are shown to indicate when differences between groups are statistically significant (i.e. unlikely to be due to chance). The value of p is given as $p< 0.05$ or $p< 0.01$. These are conventional reporting levels where $p<0.05$ indicates that the probability of a difference being due to chance is less than five per cent and <0.01 indicates that the probability of a difference being due to chance is less than one per cent.

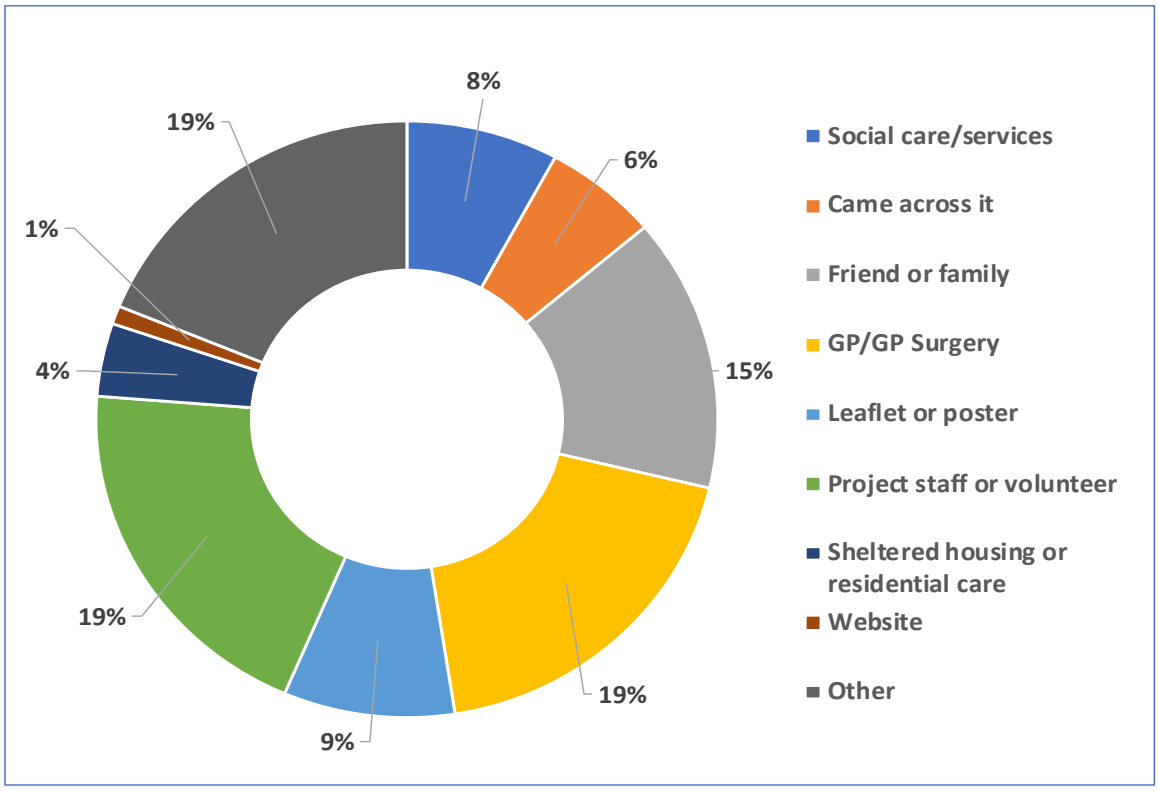
[25] Based on data collected from April 2015 to April 2019.

4. Programme reach – baseline measures

4.1 Routes to reaching participants

The most common ways that projects reached participants was through friends and family, GP practices, project staff or volunteers and 'other' not further specified (Figure 4.1). Nearly a third of participants came through health and social care routes (social/care services, GP or sheltered housing or residential care). Printed media (leaflets, posters) only accounted for nine per cent of the reported routes.

Figure 4.1: How participants (N=902) found out about Connect Hackney projects



There were some differences in communication routes according to project theme (**Appendix E**) but differences by project theme were only statistically significant for two of the routes. Referrals from GPs were more likely for participants from the Community Connector project and Complex Needs projects. Projects within these themes had established partnerships with local GPs. Some of the projects which did not receive many referrals from GPs reported struggling to do this, based on the qualitative evaluation findings[26]. Participants from the Community Activities projects, the Community Connector project, the Digital Inclusion projects and the Media Group were more likely to report reaching the project through 'other' routes compared to participants from other project themes. Without information on these other routes, this finding is difficult to interpret.

[26] Harden A, Salisbury C, Herlitz L, Lombardo C (2021) *Addressing social isolation and loneliness amongst older people before and during the COVID-19 pandemic: in-depth report on projects for men, people with learning disabilities, ethnically diverse groups, and complex needs.* London: Hackney CVS.

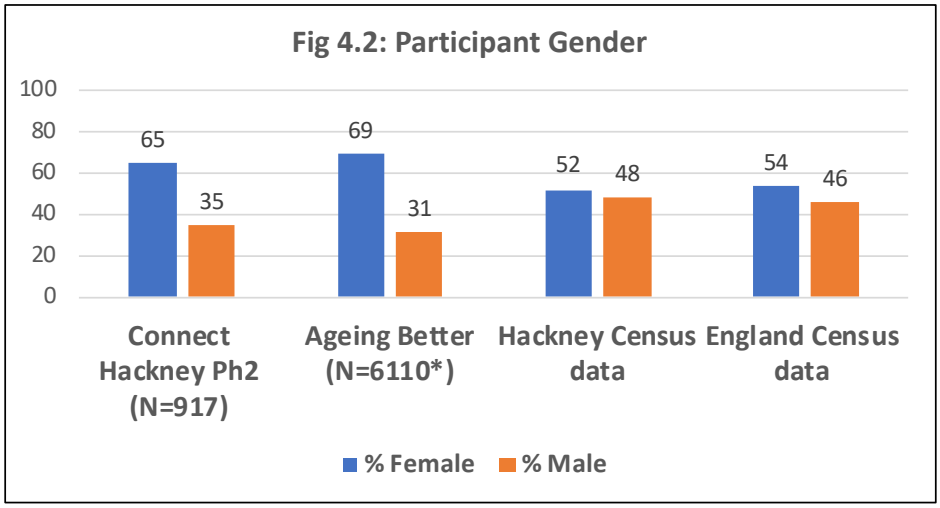
Other notable differences were:

- Ethnically Diverse projects had the highest number of participants who were reached through family and friends (39%) and adult social care (21%).
- Men's projects had the highest number of participants who reported finding out about the project via project staff or volunteers (31%).
- Across all project themes, websites or sheltered housing were the least reported routes.

4.2 Participant socio-demographic profile at entry[27]

a) Gender

There was a significantly higher number of participants identifying as female and this finding is consistent with participation rates by gender across the Ageing Better programme nationally (Fig 4.2). The Connect Hackney programme attempted to redress this gender imbalance through projects specifically targeting men. Four projects targeted men in the second phase of the programme. The proportion of men reached increased from 28 per cent in Phase 1 to 35 per cent in Phase 2. The higher proportion of men participating in Connect Hackney compared to Ageing Better overall suggests that this strategy has had some success (35 per cent men compared to 31 per cent).



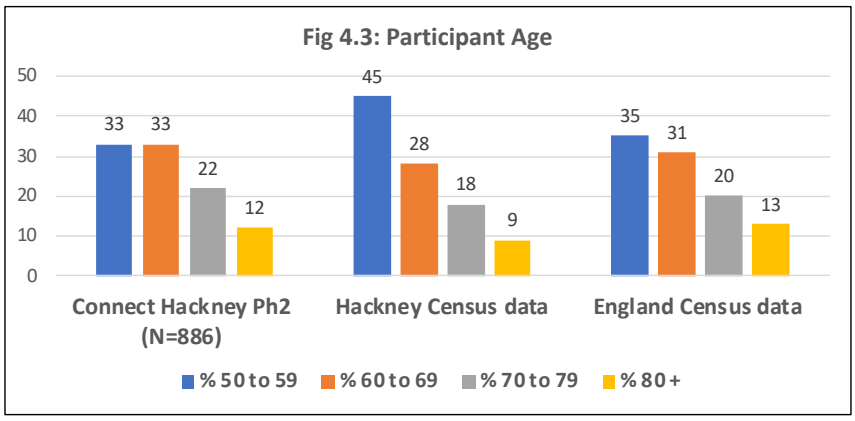
The numbers of men taking part varied across project themes with those targeting men the most successful (**Appendix F, Figure F.1**). Qualitative evidence from the Men's projects suggests that offering the opportunity to take part in practical and purposeful activities within a group setting and enabling men to share their expertise and skills were key to engaging and retaining men[28]. The Media Group and one of the projects within the Complex Needs theme also offered such activities and this is perhaps why these themes were more successful in attracting men than the other project themes.

[27] An '*' against the Ageing Better figures in the Tables indicates that N is an approximate total only.

[28] Harden A, Salisbury C, Herlitz L, Lombardo C (2021) *Addressing social isolation and loneliness amongst older people before and during the COVID-19 pandemic: in-depth report on projects for men, people with learning disabilities, ethnically diverse groups, and complex needs.* London: Hackney CVS.

b) Age

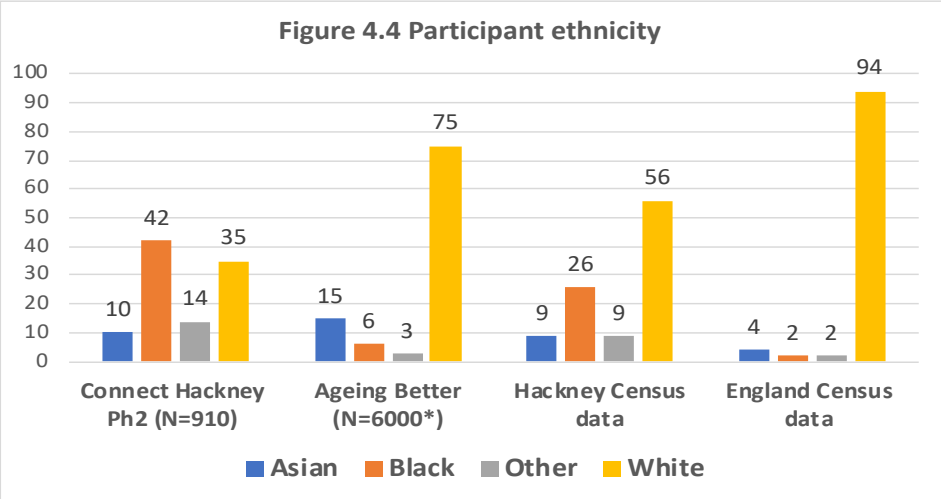
All older age groups were represented amongst survey participants with the greater proportion aged between 50 and 69, broadly reflecting the older age profile in Hackney overall (**Figure 4.3**).



The age distribution differed across projects (**Appendix F, Figure F.2**). The Media Group, Digital Inclusion and Community Activities projects attracted a greater proportion of participants aged 70 or over, whilst the Community Connector project and projects targeting men, those with complex needs and ethnically diverse groups attracted a greater proportion of participants under 70 years. These projects may have been more successful in reaching, or appealing to, younger groups of older people. It may also reflect the differing needs of age sub-groups (e.g. older people over 70 may have a greater need to develop digital skills) or the target populations. For example, the target group for the Community Connector project included, although was not limited to, those experiencing adverse life events such as losing a job and those with chronic health conditions who may be unable to work[29].

c) Ethnicity

Connect Hackney participants are more ethnically diverse compared to Ageing Better participants overall and older people in England more generally (**Figure 4.4**.).

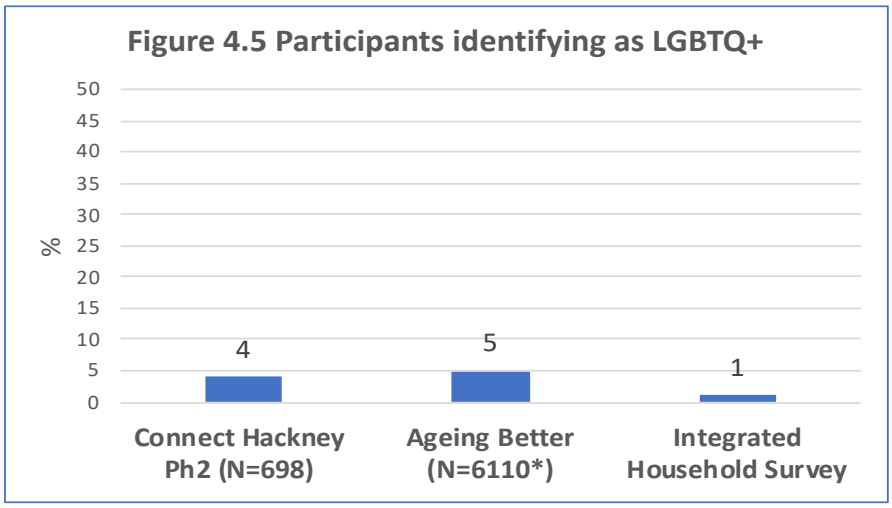


[29] See Harden and Herlitz (2021) 'An in-depth study of the Community Connectors project for older people in Hackney living with or at risk of loneliness and social isolation'. London: Hackney CVS.

This reflects the ethnic diversity amongst older Hackney residents as a whole, although Connect Hackney participants show even greater diversity. The programme has purposefully targeted diversity through its commissioning and projects within the programme are run by organisations who are deeply embedded in their local communities enhancing their ability to be able to reach ethnically diverse older people. Projects targeting ethnically diverse groups were effective at reaching participants from a wider variety of ethnicities including those of Chinese, Turkish-Cypriot, and South American heritage (**Appendix F, Figure F.3**).

d) LGBTQ+

The programme has successfully reached older people identifying as LGBTQ+ compared to what might be expected, given the proportion of LGBTQ+ older people in England overall (**Figure 4.5**)[30]. Project themes reached between one and nine per cent of LGBTQ+ participants (**Appendix F, Figure F.4**) and the Connect Hackney proportion is similar to the Ageing Better programme overall.

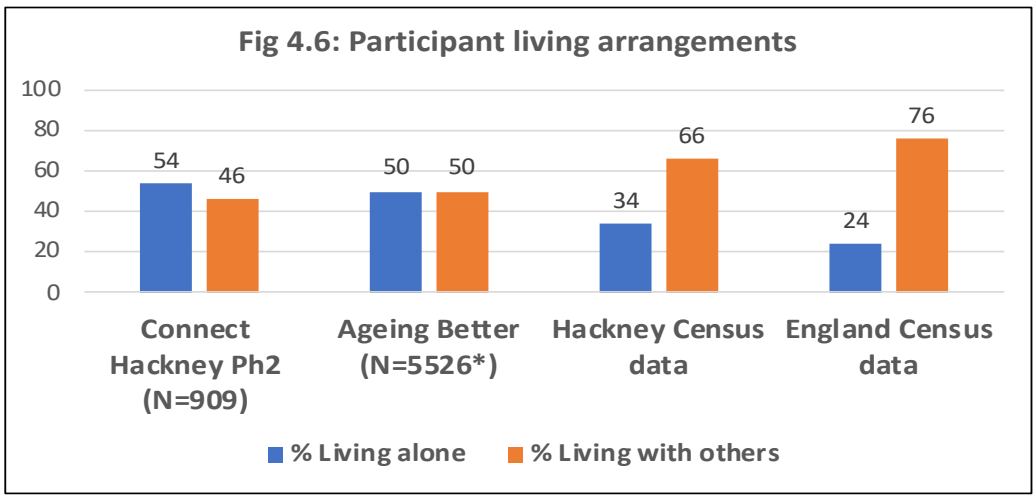


e) Living arrangements

Like the national Ageing Better programme, Connect Hackney reached older people living alone in greater proportions than might be expected from the profile of older people in Hackney and England as a whole (**Figure 4.6**)[31]. This indicates the success of the programme in reaching those at higher risk of loneliness and social isolation. There were fewer differences by project theme although projects targeting ethnically diverse groups and the Community Activities projects had higher proportions of participants living with others whilst the Community Connectors project had the highest proportion of participants living alone (**Appendix F, Figure F.5**).

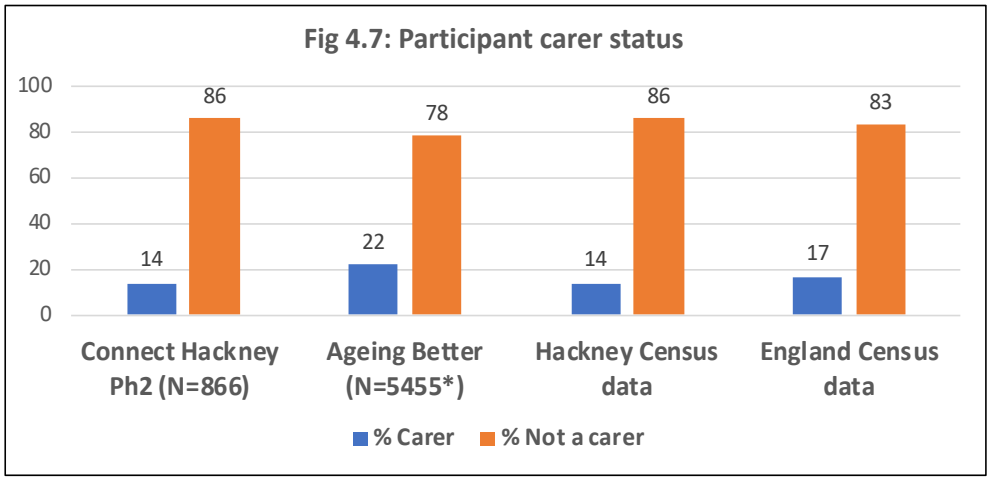
[30] Comparison figures at the national level are taken from the Integrated Household Survey, 2014. This survey is completed by approximately 325,000 individuals. The figure of 1% (rounded up from 0.94%) relates to those aged 50 or over. The survey only reports by LGB and 'other' category. Only figures for those identifying as LGB are reported by age group. The proportion of those identifying as 'other' across all age groups is reported to be 0.3%. Questions on sexuality are not included in the 2011 Census but will be included in the 2021 data. Comparative data are not yet available at the Hackney borough level.

[31] Living 'with others' combines 'with spouse, partner', 'with family', 'in residential accommodation' and 'other' response options.



f) Carer status

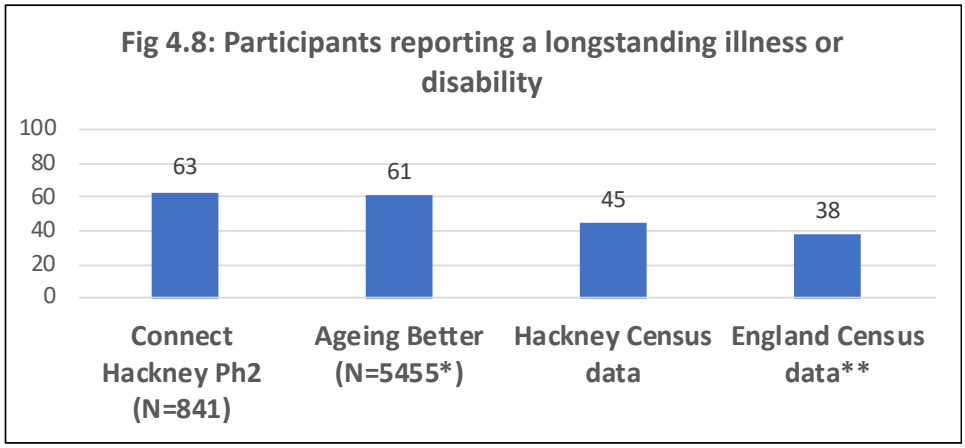
The Connect Hackney programme has reached participants who are carers[32] in a similar proportion to that seen amongst older residents in Hackney as a whole (**Figure 4.7**). Only one of the projects in the programme specifically targeted carers and this could explain why the proportion of carers is lower than that seen amongst Ageing Better participants as a whole. There was some variation across project themes (**Appendix F, Figure F.6**). A lower proportion of carers was found within projects targeting those with poor mental health (e.g. one of the Complex Needs projects and the Community Connector project). Another explanation for the lower proportion is the possibility that the concept of being a 'carer' may not have resonated across all cultures.



[32] Carer is defined in the census as a provider of "unpaid care giving help or support to family members, friends, neighbours or others because of long-term physical or mental ill health or disability or problems related to age". The statistic includes those providing unpaid care for one or more hours per week.

g) Longstanding illness or disability

Like Ageing Better participants overall, Connect Hackney participants are more likely to report a longstanding illness of disability[33] compared to older residents in Hackney and England as a whole (**Figure 4.8**). Due to their focus on people with health conditions, the Complex Needs projects and the Community Connector project had higher numbers of participants reporting a longstanding illness or disability (**Appendix F, Figure F.7**). Even though the Media Group project and projects within the Digital Inclusion theme had more older participants, these projects had lower proportions of participants reporting a longstanding illness or disability.



4.3 Participant outcome profile at programme entry

a) Loneliness

Levels of loneliness[34] at entry into the Connect Hackney programme were considerably higher amongst participants compared to Hackney residents in general. Over half (52%) of the survey respondents scored 6 or more on the UCLA scale, compared to 20% and 17% amongst older Hackney residents and nationally, respectively (**Table 4.1**). This finding suggests that the programme reached already lonely older residents as well as those at risk. Average loneliness at programme entry for Connect Hackney participants was similar to that seen amongst participants across all Ageing Better sites (mean score of 5.6, not shown in Table).

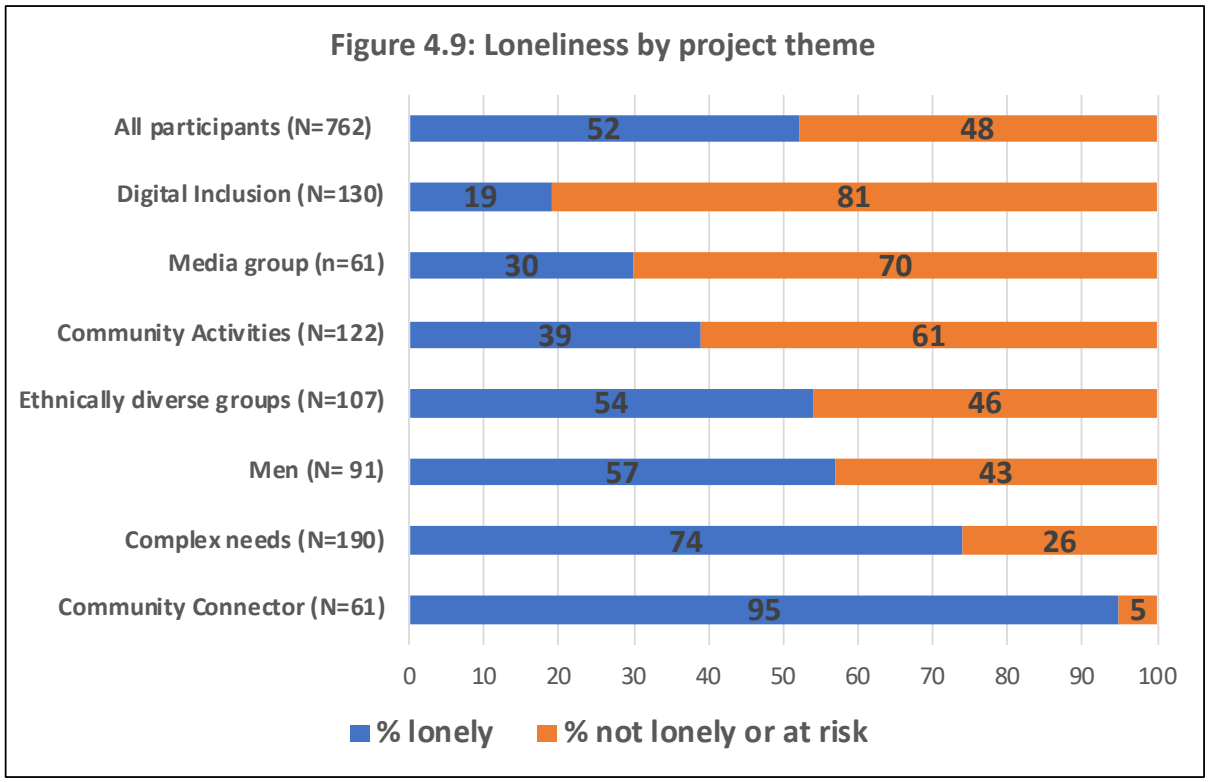
[33] Defined in the census as "A long-term health problem or disability that limits a person's day-to-day activities ['a lot' or 'a little'], and has lasted, or is expected to last, at least 12 months. This includes problems that are related to old age".

[34] Loneliness was measured by the 3-item UCLA scale which asks: How often do you feel you lack companionship? How often do you feel left out?; and How often do you feel isolated from others? Possible response options were as follows: 'hardly ever or never' (scored 1), 'some of the time' (scored 2) and 'often' (scored 3). An overall loneliness score is calculated by adding the scores up across the 3 questions. This score ranges from 3 (least lonely) to 9 (most lonely). Following Steptoe et al. (2013) those scoring 6 or above are classified as 'lonely'; those scoring below 6 are scored as 'not lonely or at risk'.

Table 4.1: Loneliness at programme entry

	Connect Hackney participants	Hackney Baseline profile[35]	National Picture (ELSA)
UCLA loneliness scale *Range 3 (least lonely) to 9 (most lonely)*			
Mean loneliness score	5.4	4.2	4.0
% lonely (scoring 6 or above)	52	20	17
% not lonely or at risk (scoring 3, 4 or 5)	48	80	83
Total N	*762*	*354*	*5881*

Levels of loneliness varied across project themes (**Figure 4.9**). Participants within the Complex Needs and Community Connector projects had the highest proportion of participants classified as lonely whilst the Digital Inclusion and Media Group projects had the lowest. The former projects specifically targeted groups that are more likely to be already lonely such as those with poor mental health.



b) Social isolation

Four measures in the participant survey assessed social contact and participation (**Table 4.2**). These can be considered as dimensions of, or pre-cursers to, social isolation. The first two measures focus on contact with friends and family and contact with non-family

[35] ECORYS, Brunel University and Bryson Purdon Social Research (n.d.) *Evaluation of Ageing Better Programme: Wave 1 population survey. Baseline profiling: Hackney.* London: ECORYS. NB: This survey was completed by 354 residents aged 63 and over and is therefore only a proxy comparator group for Connect Hackney participants.

members respectively[36]. There are no published local or national comparators for contact with family and friends. Compared to older Hackney residents in general and older people in England, proportionately fewer Connect Hackney participants reported they speak to non-family members on a regular basis (**Table 4.2**). There were significant differences across project themes (**Appendix G, figures G.1 and G.2**). The majority (76%) of participants across all project themes spoke to family and friends at least weekly. This was substantially lower for participants of Complex Needs projects (45%). In terms of non-family contacts, smaller proportions of participants reported they were in frequent contact (at least three times a week) among those in the Complex Needs projects (19 per cent); Ethnically Diverse projects (47 per cent) and the Community Connector project (41 per cent).

Table 4.2: Measures of social isolation at project entry

	Connect Hackney participants	Hackney Baseline profile	National Picture (ELSA/ TNS omnibus)
Contact with friends and family			
% speaking at least weekly	76	-	-
% speaking less often	24	-	-
Total N	*709*	-	-
Contact with non-family members			
% speaking at least three times a week	52	61[37]	63[38.]
% speaking less often	48	39	37
Mean score **(range 0-8)**			
Total N	*803*	*354*	*1630*
Social engagement *(Perception of whether doing more or less social activities than others of the same age)*			
% saying much less or less than most	51	40	44
% saying about the same	25	40	37
% saying much more or more than most	24	20	19
Mean score (range 0 to 4)	1.5	-	2.36[39]
Total N	*737*	*354*	*1630*
Membership of clubs and groups			
% member of a club, group or organisation	60	39	71[40]
Total N	*720*	*354*	*5881*

As shown in Table 4.2, a higher proportion (51%) of Connect Hackney participants see themselves as doing less or much less social activities than older Hackney residents in general (40%) and those in England as a whole (44%). The proportion of Connect Hackney participants who report being a member of at least one club, group or organisation is lower

[36] The final results from the Ageing Better programme evaluation will report the proportion of participants speaking with friends and family weekly and the proportion of participants speaking to non-family members at least three times a week.

[37] Baseline profile survey measured the proportion speaking to non-family members everyday rather than at least three times a week and focused on adults aged 63 and above.

[38] TNS survey. As above survey measured the proportion speaking to non-family members everyday rather than at least three times a week and focused on adults aged 63 and above.

[39] TNS survey.

[40] ELSA

at 60 per cent than older people in England as a whole (71%). However, the proportion is higher than older Hackney residents in general (39%). It is not clear why this might the case although one plausible explanation is that the Hackney residents figure is based on those aged 63 and over whereas figures for Connect Hackney participants and England residents as a whole are based on those aged 50+. Club membership for Connect Hackney participants is also higher than for participants across Ageing Better programmes nationally (41 per cent, not shown on Table). This could be explained by a greater number of clubs, groups and organisations within this dense urban area of London, compared to the rest of England. The memberships most often cited by Connect Hackney participants were: church or religious groups, charitable organisations, social clubs or sports clubs, and gyms or exercise classes (**Table 4.3**).

Table 4.3: Breakdown of clubs, organisations or societies membership

Type of membership	%	Type of membership	%
Political party, trade union or environmental group	10	Education, arts or music groups or evening classes	14
Tenants groups, neighbourhood groups, neighbourhood watch	12	Social clubs	21
Church or other religious groups	40	Sports clubs, gyms or exercise classes	25
Charitable organisation	22	Any other organisations, clubs or societies	14

c) Health and wellbeing

Connect Hackney participants have lower levels of health and wellbeing across all three measures used in the survey, compared to older people in England overall (**Table 4.4**).

There were no comparative data available at a local level. On all three measures, Connect Hackney participants reported worse health and wellbeing than older residents in England as a whole. The difference between Connect Hackney participants and the national picture for the Quality of Life measure is striking. Three times as many older people in England as a whole have no health problems. This is likely to reflect the diverse and disadvantaged nature of Hackney whereby those from ethnically diverse and/or socially disadvantaged groups bear the greatest burden of ill health. Mean wellbeing scores for participants across all Ageing Better programmes nationally were very similar to Connect Hackney at 21.4 (not shown in Table). Health-related quality of life and self-reported health were at slightly higher levels amongst Ageing Better participants overall (0.61 and 63.05 respectively)[41].

[41] As reported in Jones, M., Beardmore, A., White J. (2020) 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. UWE Bristol.

Table 4.4: Baseline health and wellbeing

	Connect Hackney participants	National Picture (Understanding Society/HSE)
Wellbeing (SWEMWBS)[42]		
Mean wellbeing score (7 to 35)	22.9	25.2
% High wellbeing	72	-
% Low wellbeing	28	-
Total N	*620*	-
Quality of Life (EQ-5D-L)		
% with no health problems	12	38
Mean quality of life score (1 to -0.594)[43]	0.54	-
Total N	*639*	-
Self-reported health (EQ-VAS)		
Median self-reported health score (0 to 100)	60.5	75
Total N	*681*	-

There were significant differences across project themes (**Appendix G, Figures G.3 to G.6**). Participants from Complex Needs, the Community Connector project and projects for men had much lower wellbeing scores on average. There was also a higher proportion of participants classed as having low wellbeing (scoring 20 or less) from these projects. In contrast, participants from all other project themes had similar levels of wellbeing to older people in England as a whole. Participants from the Complex Needs projects and the Community Connector project also reported significantly lower health-related quality of life scores.

c) Volunteering, co-design and influence

Three measures of older people's contribution to the wider community and decision-making[44] were included in the participant survey (**Table 4.5**). There was limited comparative data available for these measures so these figures are not shown in the Table.

[42]Measured using the shortened version of the Warwick Edinburgh Emotional Wellbeing scale. This is a seven-item scale focuses on wellbeing functioning (i.e. how well somebody thinks they are functioning). Scores range from 7 to 35 and those with a score of 20 or less are classified as having low wellbeing. The 'low well-being' category is also referred to as 'high psychological distress or risk of depression'.
(see https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/using/howto/ for more details on scoring)

[43] Where 1 indicates perfect health and -0.594 indicates the worst possible health.

[44] The co-design and ability to influence decisions measures are indicators to gauge the extent to which the Connect Hackney programme is achieving its goal to increase older peoples' involvement in shaping policy.

Table 4.5: Volunteering, co-design and influence at programme entry

	Connect Hackney participants
Past volunteering[45]	
% Volunteered in past year	44
Total N	*684*
Future volunteering intentions	
% Yes	40
% Maybe	36
% No	24
Total N	*580*
Co-design activities[46]	
% involved in any co-design activities	37
Mean co-design score	0.6
Total N	*762*
Ability to influence local decisions[47]	
% definitely/tend to agree	34
Mean score (0 to 5)	3.3
Total N	*753*

In terms of volunteering, compared to older residents in Hackney and to older people in England overall, Connect Hackney participants were more likely to report volunteering activity in the last year (44 per cent compared to only 10 per cent of the sample in the Hackney baseline profile and 33 per cent amongst participants in ELSA[48]). An even higher proportion of Connect Hackney participants had decided to, or were considering, volunteering in the future (76 per cent). Only 41 (five per cent) of the survey participants were also volunteers on the programme as well as being participants (data not shown in Table 4.5). The proportion of older people volunteering within the Connect Hackney programme is comparable to the proportion volunteering across Ageing Better programmes nationally[49].

[45] Participants were asked 'In the last 12 months, have you given unpaid help in any of the ways shown below'. Twelve ways are listed (Raising or handling money/taking part in sponsored events; leading a group/member of a committee; organising or helping to run an activity or event; visiting people; befriending or mentoring people; giving advice/information/counselling; secretarial, admin or clerical work; providing transport/driving; representing; campaigning; other practical help (e.g. helping out at school, shopping); any other help) plus an option to tick 'none of the above'.

[46] Participants were asked to tick whether they have been involved in a range of four co-design activities as follows: (i) 'Decisions about what new activity the project runs'; (ii) 'Steering group meetings for the project/decisions about how an activity will be delivered'; (iii) 'Gathering information to see if the project is making a difference for people'; (iv) 'Focus group on how the project is going/consulted about policies or service'. Participants can also tick 'none of the above'. If any of the four co-design activities are ticked participants are considered to have been involved in co-design activities. The number of co-design activities a participants has been involved in is also added up to form a score. This score ranges from 0 (have not been involved in any co-design activities' to 4 (have been involved in all four activities).

[47] Participants were asked whether they agree or disagree that they personally can influence decisions affecting their local area on a scale from 0 ('definitely disagree') to 5 ('definitely agree')

[48] Although national guidance on the participant survey from ECORYS suggests that other cohort studies do not use comparable wording to assess volunteering it appears that the question on volunteering used in the Connect Hackney CMF is the same as the wording used in the ELSA cohort study (and this was also used in the Hackney baseline profile). A direct comparison has therefore been made at the local and national level.

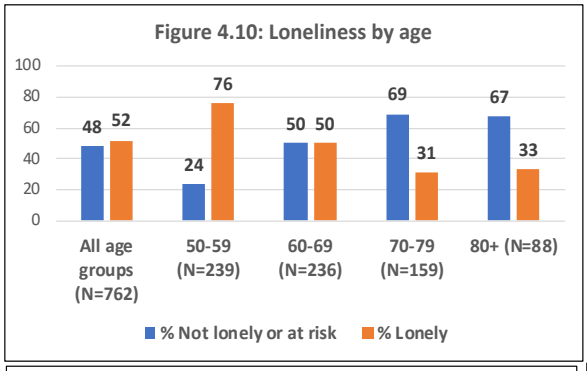
[49] Based on a 2019 snapshot across Ageing Better nationally, 336 (5.4%) of 6210 older people participants reported they were programme volunteers.

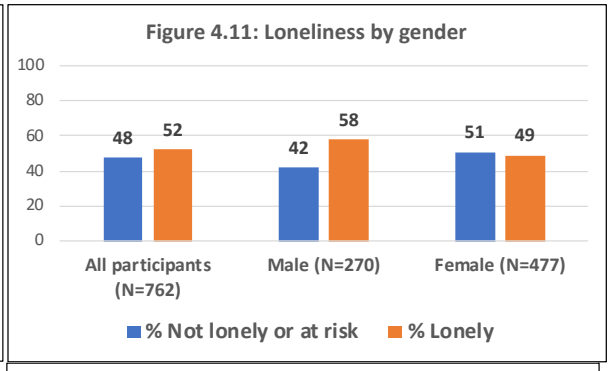
Just over a third (37%) of Connect Hackney participants have been involved in co-design activities prior to joining the programme. The average co-design score is slightly lower than for participants across Ageing Better programmes nationally (0.6 compared to 0.9). Just over a third (34%) of Connect Hackney participants 'definitely agreed' or 'tended to agree' with the statement that they are able to influence decisions about their local area. This is higher than for older people in England as a whole (26%), as measured in the Community Life Survey.

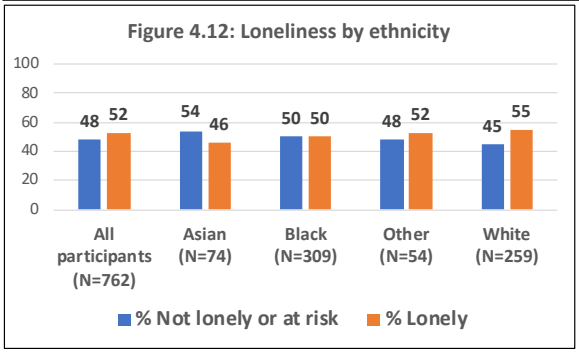
There were significant differences across project themes concerning these social participation measures (**Appendix H, Figures H.1 to H.4**). Complex Needs and Community Connector participants had the lowest levels of past volunteering, involvement in co-design activities, and agreement that they are able to influence decision-making in their local area. This is likely to reflect the higher levels of loneliness and poorer health and wellbeing of these participants.

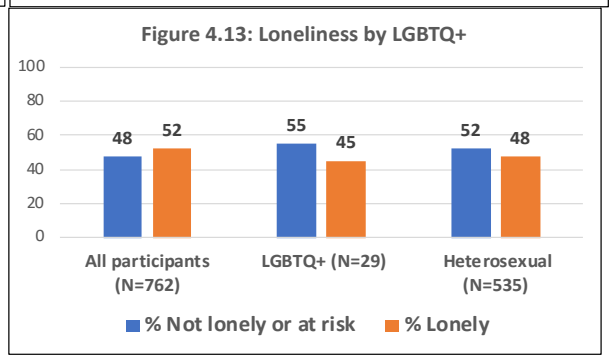
4.4 Characteristics associated with loneliness

Compared to those classified as not lonely or at risk of loneliness[50], participants who were lonely at entry to the programme were significantly more likely to be younger, male, living alone and have a long standing illness or disability. Differences by ethnicity and carer status were not statistically significant (**Figures 4.10 to 4.16**).

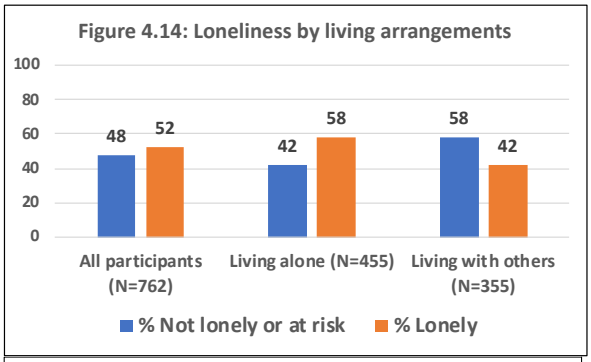


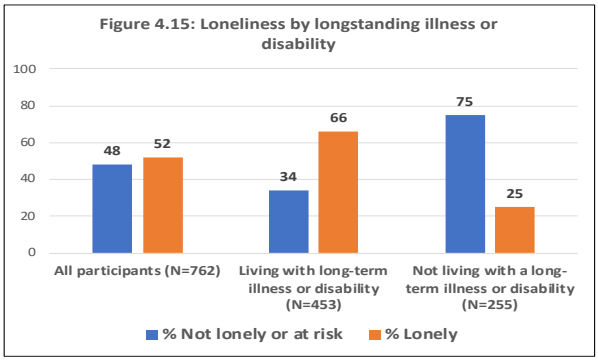


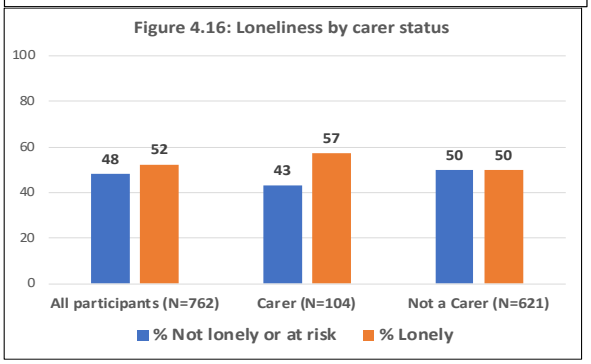




[50] Loneliness was measured by the 3-item UCLA scale which asks: How often do you feel you lack companionship? How often do you feel left out?; and How often do you feel isolated from others? Possible response options were as follows: 'hardly ever or never' (scored 1), 'some of the time' (scored 2) and 'often' (scored 3). An overall loneliness score is calculated by adding the scores up across the 3 questions. This score ranges from 3 (least lonely) to 9 (most lonely). Following Steptoe et al. (2013) those scoring 6 or above are classified as 'lonely'; those scoring below 6 are scored as 'not lonely or at risk'







Those who were classified as lonely scored significantly lower on all other outcomes at programme entry (**Table 4.5**). They had less frequent contact with people in their neighbourhood; perceived themselves as taking part in less social activities compared to others; were less involved in social groups, clubs or organisations; reported lower well-being, quality of life and self-reported health; were less likely to volunteer or be involved in co-design activities, and; perceived themselves as having less influence on local decision-making in their area. These findings underscore the importance of the Connect Hackney programme in improving a whole range of outcomes in addition to loneliness.

Table 4.5: Baseline outcomes by loneliness

Baseline outcome	N	Mean	P
Social isolation			
Contact with non-family			
Lonely	396	5.66	
Not lonely or at risk	363	6.89	P<0.01
Taking part in social activities			
Lonely	372	1.05	
Not lonely or at risk	343	1.98	P<0.01
Membership of groups, clubs and organisations			
Lonely	397	1.17	
Not lonely or at risk	365	1.47	P<0.01
Health and wellbeing			
Wellbeing (SWEMBS)			
Lonely	335	19.71	
Not lonely or at risk	274	26.61	P<0.01
Health related quality of life (EQ-5D-L)			
Lonely	302	0.41	
Not lonely or at risk	337	0.67	P<0.01
Self-reported health (EQ-VAS)			
Lonely	359	48.27	
Not lonely or at risk	322	72.96	P<0.01
Volunteering, co-design and influence			
Past volunteering			
Lonely	397	0.43	
Not lonely or at risk	365	1.03	P<0.01
Involvement in co-design			
Lonely	397	0.44	
Not lonely or at risk	365	0.82	P<0.01
Ability to influence local decisions			
Lonely	379	3.04	
Not lonely or at risk	353	3.46	P<0.01

5. Programme impacts – follow-up data

5.1 Loneliness

After taking part in the Connect Hackney programme, there was a statistically significant decrease in average loneliness levels (**Table 5.1**). Connect Hackney uses the UCLA as its main measure of loneliness but results for the DeJong measure are included to illustrate that the reduction in loneliness is consistent and not an artefact of one particular measure.

Table 5.1 Average loneliness scores at programme entry and follow-up

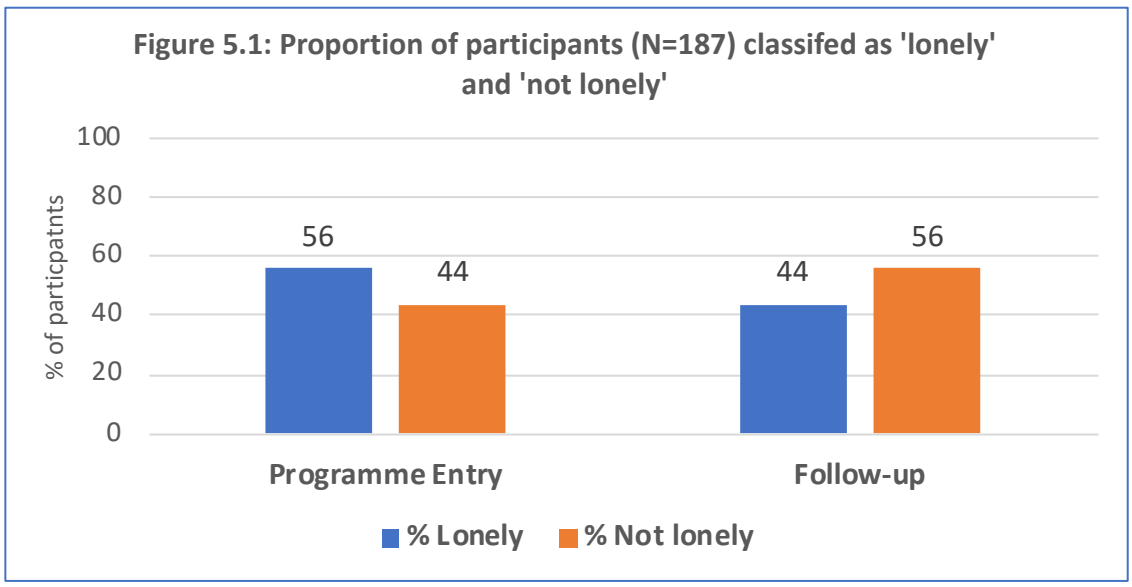
Outcome measure	Average score		Difference	N
	Entry	Follow-up		
Loneliness (UCLA) Scored 3 (least lonely) to 9 (most lonely)	5.60	5.13	↓0.47**	187
Loneliness (DeJong) Scored 0 (least lonely) to 6 (most lonely)	2.66	1.75	↓0.91**	168
Emotional Loneliness (DeJong) Scored 0 (least lonely) to 3(most emotionally lonely)	1.62	1.15	↓0.47**	168
Social Loneliness (DeJong) Scored 0 (least lonely) to 3 (most socially lonely)	1.04	0.60	↓0.44**	168

** Difference is statistically significant at p<0.01

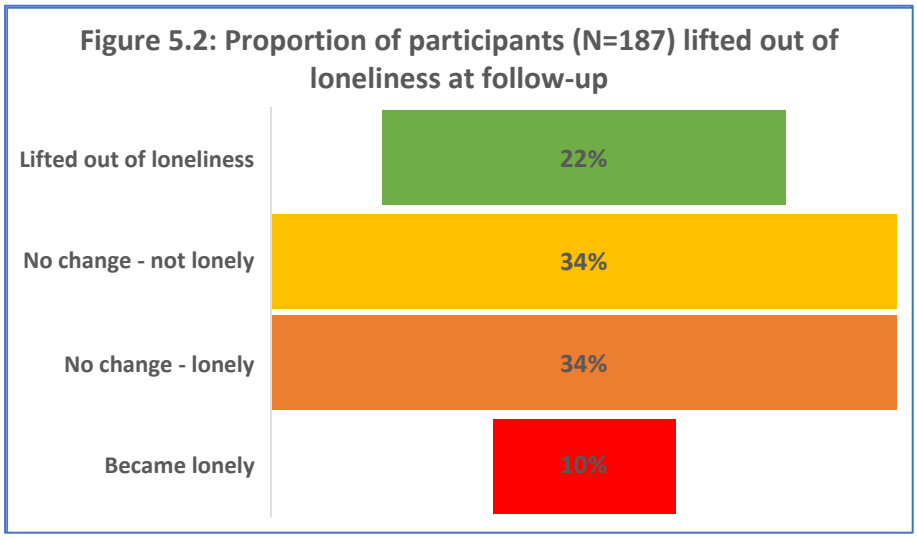
Whilst this is an important headline finding, it must be acknowledged that the underpinning data do not represent all project participants. In particular, there were no participants from the Ethnically Diverse projects included in this dataset. Moreover, a third of the participants are from the Digital Inclusion projects with a further quarter from the Men's projects. In addition, as noted earlier, a greater proportion of White participants completed both baseline and follow-up questionnaires. These limitations should be borne in mind when interpreting the follow-up findings as they cannot be generalised to all Connect Hackney project themes.

Overall, the UCLA measure shows a 12 per cent decrease in the proportion of participants classified as lonely[51] after taking part in Connect Hackney activities (**Figure 5.1**)

[51] Following Steptoe et al. (2013) those scoring 6 or above on the UCLA Loneliness scale are classified as 'lonely'; those scoring below 6 are scored as 'not lonely or at risk'. The 3-item UCLA scale asks: How often do you feel you lack companionship? How often do you feel left out?; and How often do you feel isolated from others? Possible response options were as follows: 'hardly ever or never' (scored 1), 'some of the time' (scored 2) and 'often' (scored 3). An overall loneliness score is calculated by adding the scores across the 3 questions. The UCLA score ranges from 3 (least lonely) to 9 (most lonely).



At follow-up the proportion of participants classified as lonely moved closer to the proportion seen amongst older residents in Hackney overall which is estimated to be 20 per cent[52]. However, rates of loneliness at follow-up are still more than double this rate. This 12% overall reduction translates to 22% of participants being lifted out of loneliness after they took part in the programme (**Figure 5.2**).



Two thirds of participants, however, reported no change in their level of loneliness (i.e. remained either lonely or not lonely) whilst 10 per cent became more lonely. This suggests that the programme may only work for some participants under some conditions. A more detailed descriptive analysis, comparing those lifted out of loneliness with those who became lonely or stayed at the same level is presented in section 5.5 below.

5.2 Social isolation

Although frequency of social contact with non-family members and social membership increased after taking part in the programme, only perceptions of taking part in more

[52] Evaluation of the Ageing Better Programme: Wave 1 Population Survey, Baseline Profiling: Hackney. Ecorys, Brunel University and Bryson Purdon Social Research (NB: residents surveyed were aged 63 years and over).

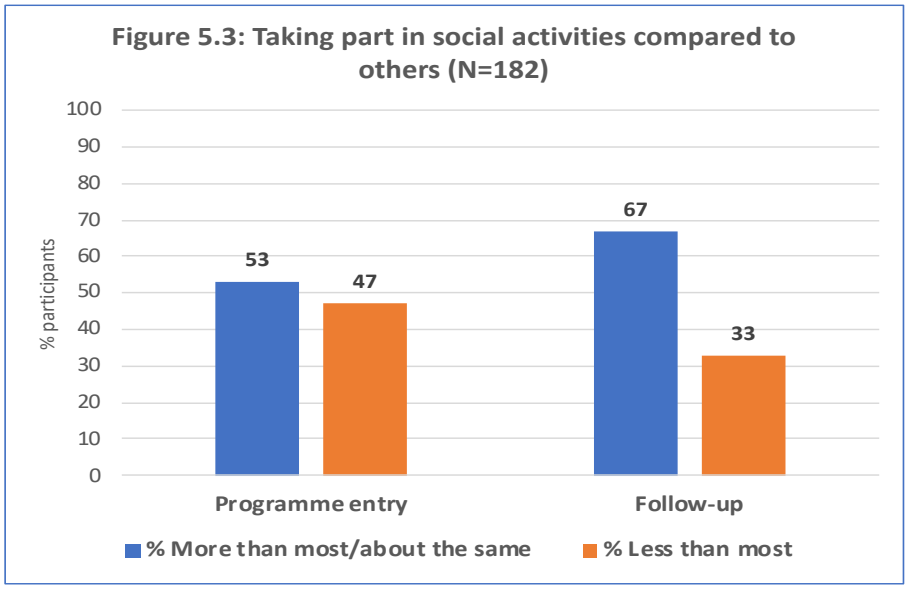
activities than others showed a statistically significant increase (**Table 5.2**). It is not clear why this was the case and may be an artefact of the measure.

Table 5.2 Average social contact and participation at programme entry and follow-up

Outcome measure	Average score		Difference	N
	Entry	Follow-up		
Social contact with family and friends (range 0-5, higher scores d= greater contact)	4.25	4.21	0.04	139
Social contact with non-family (range 0-8, higher scores = greater contact)	6.47	6.60	0.13	199
Membership of clubs, organisations or societies (range 0-5, higher scores = greater membership)	1.44	1.55	0.11	219
Perception of whether do more or less social activities (range 0-4, higher score = take part in more activities than others)	1.51	2.02	↑0.51***	182

*** Denotes that the difference is statistically significant at p<0.001

At follow-up there was a 14 per cent increase in the proportion of participants assessing their engagement in social activities as more than or the same as other people of their age (**Figure 5.3**). Sixty-seven per cent of Connect Hackney participants at follow-up saw themselves as taking part in social activities more than or about the same as other people their age, compared to 60 per cent of older residents in Hackney overall[53].



[53] ECORYS (2018) *Ageing Better Evaluation Common Measurement Framework (CMF): Outcome measures (June 2018)*. London: ECORYS.

5.3 Health and wellbeing

There were statistically significant improvements in health and wellbeing after taking part in the Connect Hackney programme across all three measures used (**Table 5.3**). However, impact on emotional wellbeing and quality of life should be interpreted with caution due to the relatively high rates of missing data on these two items (37 and 26 per cent respectively).

Table 5.3 Average health and wellbeing scores at programme entry and follow-up

Outcome measure	Average score		Difference	N
	Entry	Follow-up		
Emotional wellbeing (SWEMWBS) (range 7-35, higher scores = greater wellbeing)	21	25	↑4**	137
Quality of life (EQ5D)[54] (range 1 to -0.594, higher scores = greater quality of life)	0.53	0.63	↑0.10**	163
Self-reported health[55] (range 1 to 100, higher scores = greater health)	61.29	66.54	↑5.25*	181

*Difference is statistically significant at p<0.05
** Difference is statistically significant at p<0.01

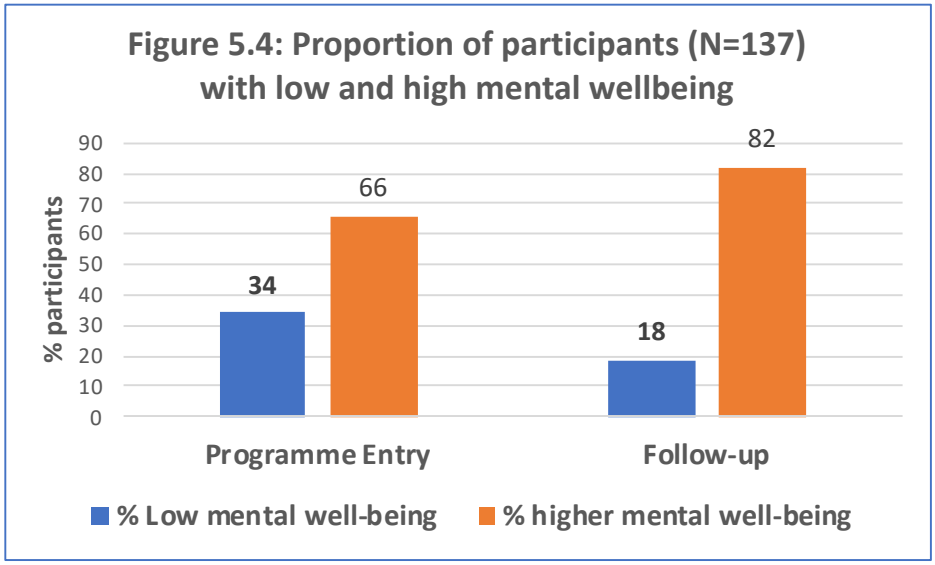
The average emotional wellbeing score amongst participants increased to the same level as those of older people in England overall (25)[56]. A classification of low mental wellbeing on the SWEMBS puts people at higher risk of depression[57]. At follow-up there was a 16% reduction in the proportion of participants classified with low mental wellbeing (scoring 20 or less on the SWEMWBS) compared to programme entry (**Figure 5.4**)

[54] Health related quality of life is measured by the widely used EQ-5D-3L. Five dimensions are measured: Mobility, Self-Care, Usual Activities, Pain / Discomfort, and Anxiety/Depression. Total scores are transformed to give a range from **1 to -0.594**, where a score of 1 represents perfect health and -0.594 represents the worst possible health.

[55] The EQ VAS records each respondent's self-rated health on a vertical, visual analogue scale (VAS) where the endpoints are labelled 'Best imaginable health state' (100) and 'Worst imaginable health state'.

[56] Average level for older people in England from the UK household longitudinal study https://www.understandingsociety.ac.uk

[57]Tthe shortened version of the Warwick Edinburgh Emotional Wellbeing scale (SWEMBS) is a seven-item scale focuses on wellbeing functioning (i.e. how well somebody thinks they are functioning). Scores range from 7 to 35 and those with a score of 20 or less are classified as having low wellbeing. The 'low well-being' category is also referred to as 'high psychological distress or risk of depression'.
(see https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/using/howto/ for more details on scoring)



The increase of 0.1 in health related quality of life is larger than that seen amongst participants across all Ageing Better programmes[58]. The increase of around five points on self-reported health was about the same as that observed amongst Ageing Better participants overall. Although improved, self-rated health at follow-up was still much lower than older people in England overall which stands at 75.

5.4 Volunteering, co-design and influence

There were no statistically significant impacts on any of the measures assessing volunteering, involvement in co-design and influence on local decisions (**Table 5.4**). As noted in section 4, the proportion of participants volunteering was high at programme entry in comparison to older Hackney residents overall so there may have been little scope for improvement. The lack of impact on co-design is surprising given the emphasis on co-production within the programme. However, in-depth analysis of co-production and asset-based working across projects within the programme suggests that not all projects set out to, or achieved, the level of co-production within their projects that might trigger an improvement in the co-design score[59]. There was an increase in participants perceptions of their ability to influence local decisions but this increase was not statistically significant. With a bigger sample, further analysis could explore whether those projects that did achieve a greater level of depth with their co-production activities reflected in an increase in co-design and ability to influence local decision-making.

[58] As reported in Jones, M., Beardmore, A., White J. (2020) 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. UWE Bristol.
[59] Harden A, Salisbury (2021) Co-production and asset-based working. London: Hackney CVS.

Table 5.4: Average volunteering, involvement in co-design and ability to influence local decisions scores at programme entry and follow-up

Outcome measure	Average score		Difference	N
	Entry	Follow-up		
Volunteered in past year (range 0-12, higher scores = greater volunteering)	1.23	1.12	0.11	219
Involved in co-design activities (range 0 to 5, higher scores = greater number of co-design activities involved in)	1.06	1.01	0.05	219
Ability to influence local decisions (range 1 to 5, higher scores = greater agreement with ability to influence local decisions)	2.15	2.31	0.17	188

5.5 Further analysis of impact on loneliness

More in-depth analysis to assess whether changes in loneliness varied across project themes or participant characteristics was limited by the small sample. Therefore, it was not possible to identify possible drivers of changes in loneliness.

An illustrative descriptive analysis, comparing those 'lifted out of loneliness' and those who 'stayed the same or became lonely' by project theme and participant socio-demographics, is shown in **Appendix I.** This is based on small samples and should be treated with caution. Projects within the Complex Needs theme showed the greatest proportion of participants lifted out of loneliness followed by the Community Activities and Community Connector projects. Participants within the Complex Needs theme had some of the highest levels of loneliness at project entry and this may partly explain why these projects saw the greatest improvement in loneliness scores. Qualitative data from these projects, especially Connect at Core which offered older people with mental health difficulties the opportunity to take part in creative and sporting activities, documented perceived increases in self-confidence and re-engagement in social activities beyond the project[60].

In terms of socio-demographics, greater proportions of the following groups were lifted out of loneliness: those aged 50 to 69; those of White or Asian ethnicity, and; those living with a longstanding illness or disability.

[60] Harden A, Salisbury C, Herlitz L, Lombardo C (2021) *Addressing social isolation and loneliness amongst older people before and during the COVID-19 pandemic: in-depth report on projects for men, people with learning disabilities, ethnically diverse groups, and complex needs.* London: Hackney CVS.

6. Discussion

This report has described evaluation research addressing the reach and impact of Phase 2 of the Connect Hackney programme. The programme consisted of a suite of community-based projects that offered a range of social activities, skill development workshops and/or practical and emotional support to Hackney residents aged 50 and over. The quantitative data analysed for this report were generated through a participant survey administered at programme entry (baseline) and follow-up. All data were collected before the onset of the COVID-19 pandemic. The findings of the analysis reported here are therefore relevant to the reach and impact of the programme *before* the onset of the COVID-19 pandemic. The premature end date for collection of participant surveys also means that the sample size at follow-up is not as big as originally expected. This has limited the scope of the impact analysis and puts limits on the confidence that can be placed on the reliability of the survey findings.

This section of the report discusses the key findings of the research in the context of previous relevant research, reflects on the strengths and limitations of the methods used and, in conclusion, addresses the overall reach and impact of the programme and considers any implications for future policy, practice and research. Due to data limitations, it was not possible to provide project level findings or identify factors that may contribute to the reported changes.

6.1 Programme reach

The programme has been successful in reaching diverse groups of older people, including substantial numbers of those already experiencing social isolation and loneliness as well as those at risk. Although the programme has attracted fewer men, in all other ways the profile of programme participants shows greater diversity and disadvantage than older residents in Hackney overall. The programme has reached marginalised groups, such as those with poor mental health or other types of disabilities and ethnically diverse groups, all of whom bear the greatest burden of social isolation and loneliness in society. The difficulties for services and intervention programmes in reaching men has been well documented in previous research[61,]. Connect Hackney therefore commissioned four projects which aimed to target men in the second phase of the programme (2018-2022). The proportion of men reached increased from 28 per cent in Phase 1 (2015-2018) to 35 per cent in Phase 2. This proportion is greater than other Ageing Better programmes and the national programme overall[62]. A targeted commissioning strategy was also applied to increase diversity in other ways such as projects for ethnically diverse groups and those with complex needs. Whilst this strategy increased diversity across the programme as a whole, it was evident that continued attention to the diversity of participants is still required at

[61] See for example, Yousaf O, Grunfeld E, Hunter M (2013) A systematic review of the factors associated with delays in medical and psychological help-seeking among men. *Health Psychology Review*. https://doi.org/10.1080/17437199.2013.840954 or Sagar-Ouriaghli I, Godfrey E, Bridge L, Meade L, Brown JSL. Improving Mental Health Service Utilization Among Men: A Systematic Review and Synthesis of Behavior Change Techniques Within Interventions Targeting Help-Seeking. American Journal of Men's Health. May 2019. doi:10.1177/1557988319857009

[62] Jones, M., Beardmore, A., White J. (2020) 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. UWE Bristol.

project level. For example, the Digital Inclusion and Ethnically Diverse[63] projects reached men in much smaller proportions (17 and 19 per cent respectively) compared to other project themes.

Strengthening the channels through which projects reach participants is one possible strategy for ensuring that projects maximise their inclusiveness. Analysis of the numbers of participants reached through different routes by project theme suggested that some projects do not receive many referrals from health and social care (e.g. primary care). Such referral routes take time and resources to develop on both sides of the referral partnership, and need to be factored into commissioning, funding and project planning. Qualitative research from elsewhere in the Connect Hackney evaluation found that referrals from statutory and the voluntary and community sector, continuous outreach (including street outreach) and word of mouth were the most effective at reaching the most marginalised groups. Central to all of these is reaching participants through existing or newly developed trusted relationships[64]. One part of the test and learn question around programme reach concerned the value of print media, leaflets or mailing. The findings suggest that such routes were not particularly popular channels of information about projects.

6.2 Programme impacts

Analysis of programme impact revealed that there were statistically significant improvements from programme entry to follow-up on five of the outcomes measured. As well as a reduction in loneliness – the primary outcome the programme intended to impact upon – there were improvements in one of the dimensions of social isolation measured (on average, participants' perceptions on how often they take part in social activities relative to others increased after project participation) and improvements in all three health and wellbeing measures (on average, participants' emotional wellbeing, health related quality of life and self-reported health increased after project participation). These findings should be treated with some caution, however, due to high levels of missing responses on the health related quality of life and emotional wellbeing measures and the lack of a control group in the evaluation design. This means that alternative explanations for the observed impacts – such as improvements with the passage of time regardless of the programme – cannot be completely ruled out.

The 12 per cent reduction in participants classified as lonely is in line with the reductions observed in other Ageing Better areas. The programme in Bristol for example, saw a 10 per cent reduction in those classified as most lonely using the DeJong measure of loneliness[65] and the Plymouth programme saw a 14 per cent reduction in those classified as lonely using the UCLA measure[66]. Findings from these local studies are promising and will be further elucidated by results from the national evaluation of the Ageing Better programme.

[63] It should be noted that one of the five ethnically diverse projects was for women only so this project will have increased the proportion of women for this project theme.

[64] Harden A, Salisbury C, Herlitz L, Lombardo C (2021) *Addressing social isolation and loneliness amongst older people before and during the COVID-19 pandemic: in-depth report on projects for men, people with learning disabilities, ethnically diverse groups, and complex needs.* London: Hackney CVS.

[65] Jones, M., Beardmore, A., White J. (2020) 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. UWE Bristol.

[66] Ageing Well Torbay: Overall Findings 2015-2020 - Technical Report, February 2021.

Previous research evaluating interventions to reduce loneliness amongst older people has generally found relatively small average reductions in loneliness using the UCLA measure which, when considered from the perspective of 'clinical' significance, would not be large enough to return study participants to average levels of loneliness in 'healthy' populations[67]. In other words, measured changes might not translate into noticeable or practical changes in behaviour or participants might be 'improved but not recovered'. The latter could be applied to Connect Hackney participants: at follow-up the proportion of participants classified as 'lonely' (44 per cent from 56 per cent) had moved closer to, but had not reached, the proportion of older residents classified as lonely in Hackney overall (20 per cent). Additionally, it is now known whether changes in levels of loneliness persisted after participants the projects.

Nevertheless, the results are encouraging. Loneliness is documented in previous literature as being notoriously difficult to shift, especially when using community-based approaches so the improvements seen as a result of the Connect Hackney programme should not be underestimated[68]. In comparison to psychological therapies (e.g. to develop social skills and challenge negative expectations around social relationships) community-based approaches have had a much lower impact on loneliness [54].

As loneliness has adverse consequences for health and wellbeing it is encouraging that measures on health and wellbeing also saw statistically significant improvements. (As noted earlier some degree of caution needs to be applied to these findings due to the small sample size and large amounts of missing data for two of the three health and wellbeing measures.) After project participation, levels of wellbeing had improved such that average levels were similar to those seen amongst older Hackney residents overall. Gains in health and wellbeing have cost-saving implications.

An economic evaluation was not part of the remit of the local evaluation for Connect Hackney, but other Ageing Better areas have found substantial returns on investment. Ageing Well Torbay, for example, found that for every £1 spent across the six years of the programme £1.62 in social value was created. Further modelling showed that if outcomes were sustained for a further year the return value would double to £3.24[69]. The evaluation for the programme in Torbay found that there was a reduction in the average number of GP visits, outpatient appointments and inpatient stays. Similarly, from outside of the Ageing Better programme, McDaid and colleagues modelled the cost-effectiveness of an intervention sign posting older people not in paid work to relevant local social activities after an assessment of their needs. The findings suggested that there was a return on investment of £1.26 for every £1 spent, with the authors noting this was a conservative estimate as it focused on mental health benefits and did not take into account

[67] Masai C, Chen H, Hawkley L, Cacioppo J (2011) A meta-analysis of interventions to reduce loneliness. *Pers Soc Psychol Rev* 15(3) doi: 10.1177/1088868310377394

[68] Community based approaches which increase opportunities for social interaction are suggested by Masai et al. (2011) as addressing social isolation rather than loneliness directly. Connect Hackney combines this approach with projects that are more similar to one-to-one psychological therapies such as the coaching element of the Community Connector project.

[69] Ageing Well Torbay: Overall Findings 2015-2020 - Technical Report, February 2021.

improvements in physical or cognitive health which would also accrue savings linked to costs of health services and residential care[70].

Despite the positive impacts, there was an absence of any statistically significant impacts on the three other measures assessing dimensions of social isolation (contact with family and friends, contact with non-family members and membership of clubs, organisations and societies) or on volunteering, co-design and perceived levels of influence over decision-making in the local area. Although all projects were expected to use co-production, none of the projects had a focus on increasing involvement in local decision-making which may explain the lack of change in this measure. Levels of social contact and membership of clubs and societies were comparable or higher than average levels amongst older residents in Hackney or England overall at project entry so there may have been little scope for improvement. This also applies to levels of volunteering at project entry and perceived levels of influence over decision-making in the local area. Furthermore, Connect Hackney projects were not primarily aimed at increasing participants contact with family and friends[71]. As noted in chapter 5, the lack of impact on co-design is surprising given the emphasis of co-production within the programme. This can be partly explained by results from the qualitative evaluation of Connect Hackney which revealed that that most projects did not achieve sufficient depth in their co-production activities[72]. With a bigger sample, further analysis could explore whether those projects that did achieve a greater level of depth with their co-production activities reflected in an increase in co-design scores.

6.3 Strengths and limitations

Programme reach was assessed through an analysis of a sample of 940 participants completing the survey at project entry. This enabled a robust and detailed assessment of programme reach. The diversity achieved in the baseline sample means that groups usually underrepresented in surveys were included and findings therefore reflect the experiences of marginalized as well as more privileged sectors of society.

The sample size (219) for assessing programme impact was much smaller than programme reach and was unevenly distributed across projects. This reflected the fact that the programme has been split into two phases meaning that the time period for assessment of impact was over a three year rather than six year period. The sample size would also have been bigger if data collection had not stopped due to the COVID-19 pandemic. Although findings based on smaller sample sizes can be less reliable if they are not large enough, the similarity of the findings on impact to other local evaluations of Ageing Better areas with bigger sample sizes lends confidence to the findings reported here. It is not possible to assess, however, whether the COVID-19 pandemic has mitigated some of the positive impacts observed.

As a result of the small sample size it was not possible to analyse impact by programme theme and type of programme activity, or to identify mechanisms for change. The

[70] McDaid, D., Park, A.-L., Knapp, M., Wilson, E., Rosen, B., & Beecham, J. (2017). *Commissioning cost-effective services for promotion of mental health and wellbeing and prevention of mental ill-health*. London: Public Health England.

[71] Digital inclusion projects, for example, could be expected to influence frequency of contact with family and friends through enabling older people to make greater use of digital technologies.

[72] Harden A, Salisbury (2021) Co-production and asset-based working. London: Hackney CVS.

qualitative parts of the local evaluation have, however, generated important insights into potential mechanisms based on project providers' and participants' perceptions of impact.

The lack of a control or comparator group for the local evaluation makes it impossible to rule out regression to the mean[73] or the adaptive function of loneliness[74] as an explanation for the changes observed. However, the national Ageing Better programme evaluation[75] does include a comparator group and the findings of this evaluation will complement and aid interpretation of the findings of the local evaluation. Furthermore, as noted above, previous research using stronger evaluation designs with a control group have found interventions similar to those used in the Connect Hackney programme to be effective in reducing loneliness[76]. A final limitation is that findings on impact were generated from data collected over a relatively short follow-up period and there were no data to indicate whether or not the observed positive impacts will persist.

6.4 Conclusion

The Connect Hackney programme for people aged 50 and over is a community-based approach to addressing social isolation and loneliness and its adverse consequences for health and wellbeing. The projects delivered within the programme provided a wide range of social activities combined with practical and emotional support and skill development. The promising findings on project reach and impact described in this report encourage the continuation of a programme of social activities and support to reduce loneliness and improve health and wellbeing amongst diverse groups of older people in Hackney. This conclusion is qualified by consideration of the strengths and limitations of the evaluation methods. The results are bolstered by findings from the existing literature on loneliness interventions as well as similar positive findings reported from local evaluations in other Ageing Better areas. However, further research is needed to identify what types of community activities and support hold the most promise for older Hackney residents. Future commissioning should ensure continued attention to, and sufficient funding for: developing interventions that reach and engage the most marginalised groups, including those at greatest risk of loneliness and social isolation and those who are less likely to access services and interventions.

[73] Regression toward the mean can occur when individuals who have extreme scores (low or high) on a particular measure at one point in time are likely to score less extremely at a second point even if no intervention had occurred (Masai et al. 2011).

[74] Loneliness may serve an adaptive function like hunger and thirst whereby feeling lonely prompts "reconnection with others such that the group, on average, improves over time without intervention". Masai et al. 2011).

[75] At the time of writing the findings from the participant survey in the national Ageing Better programme evaluation were not available.

[76] Masai C, Chen H, Hawkley L, Cacioppo J (2011) A meta-analysis of interventions to reduce loneliness. *Pers Soc Psychol Rev* 15(3) doi: 10.1177/1088868310377394

APPENDIX A: Summary of measures used in the participant survey

Type of data	Details
Socio-demographics	
	• Gender • Age • Ethnicity • Religion • LGBT+ • Living arrangements • Presence/absence of a long-standing illness or disability • Carer status
Outcomes *(Measured before and after participation in the programme to assess change)*	
Loneliness*	• Overall loneliness scale (UCLA) • Social and emotional loneliness scale (De Jong Gierveld (DJG))
Social isolation	• Social contact with children, friends and family • Social contact with non-family • Memberships of clubs organisations and societies • Participation in social activities compared to others
Health and wellbeing	• Wellbeing (Shortened Warwick-Edinburgh Emotional Wellbeing Scale) • Quality of Life (EQ-5D-3L) • Self-reported health score (EQ-VAS)
Co-production and volunteering	• Involved in co-design activities • Personal ability to influences decisions in local area • Volunteering in past year

* Loneliness is the primary outcome i.e. the key outcome that the programme is aiming to achieve a positive impact on.

APPENDIX B: Socio-demographic profile by survey completion at entry only and entry and follow-up

Table B.1a: Gender, age, ethnicity, LGBT+

	All participants at entry (%)	Entry only (%)	Entry and follow-up (%)	p[77]	Hackney Census (%)	England Census (%)
Gender						
Female	65	67	57		52	54
Male	35	33	43		48	46
Total N	*917*	*704*	*213*	*P<0.05*	-	-
Age						
50 to 59	33	35	27		45	35
60 to 69	32	33	33		28	31
70 to 79	23	20	28		18	20
80 and over	12	12	12		9	13
Total N	886	*672*	*214*	Ns	-	-
Ethnicity						
Asian	10	10	8		9	4
Black	42	43	40		26	2
Other	13	15	8		9	2
White	35	32	44		56	94
Total N	*910*	*699*	*211*	*P<0.01*	-	-
LGBT+						
Total LGBT+	4	4	7		-	1[78]
Heterosexual	96	96	93		-	99
Total N	*698*	*541*	*157*	Ns	-	-

[77] Significance of difference between socio-demographic profile of entry only v entry and follow-up; 'ns' denotes no significant differences.

[78] Comparison figures taken from the Integrated Household Survey (2014). Questions on sexuality are not included in the 2011 Census but will be included in 2021.

Table B.1b: Living arrangements, carer status, and longstanding illness or disability

	All participants at entry (%)	Entry only (%)	Baseline and follow-up (%)	p[79]	Hackney Census (%)	England Census (%)
Living arrangements						
Living alone	53	50	60		34	24
With others[80]	47	50	40		-	-
Total N	*928*	*713*	*215*	*P<0.05*	-	-
Carer [81]		10	8			
Yes	14	13	18		14	17
No	86	87	82		86	83
Total N	*866*	*665*	*201*	Ns		
Longstanding illness or disability[82]						
Have a longstanding illness or disability	63	62	68		45	38
Total N	*841*	*645*	*196*	ns		

[79] Significance of difference between socio-demographic profile of entry only v entry and follow-up. 'ns' denotes no significant differences

[80] "With others' combines 'with spouse, partner', 'with family', 'in residential accommodation' and 'other' response options.

[81] Carer is defined in the census as a provider of "unpaid care giving help or support to family members, friends, neighbours or others because of long-term physical or mental ill health or disability or problems related to age". Includes number reporting providing unpaid care for one or more hours per week.

[82] Defined in census as "A long-term health problem or disability that limits a person's day-to-day activities ['a lot' or 'a little'], and has lasted, or is expected to last, at least 12 months. This includes problems that are related to old age".

APPENDIX C: Numbers of participants completing entry surveys by project

Project theme[1]	Entry	Follow-up	Project theme[1]	Entry	Follow-up
Community Activities	***127***	***24***	***Ethnically diverse projects***	***162***	***2***
The Posh Club	15	2	Growing Project	29	1
Theatre Exchange	35	9	Happy Living	35	0
Friends of Woodberry Down	50	1	Santé Sage	27	0
Silver Saturdays	21	9	Somali Elders	34	0
Social Singing	6	3	Table Tennis Club	37	1
Community Connector	***80***	***21***	***Digital Inclusion***	***129***	***70***
Community Connections	80	21	Silver Connections	57	40
Complex needs	***242***	***34***	@Online Club	46	18
Bringing the Outside In	17	3	Learning Together	26	12
Carers Collective	15	3	***Men***	***118***	***43***
Connect at Core	186	25	Gillet Square Elders	27	7
Getting out and about locally	13	3	Hackney Dudes	37	19
Learning disabilities[4]	***49***	***0***	Hackney Brocals	38	11
Media group	***76***	***25***	Living with a Hearing Loss	16	6

15

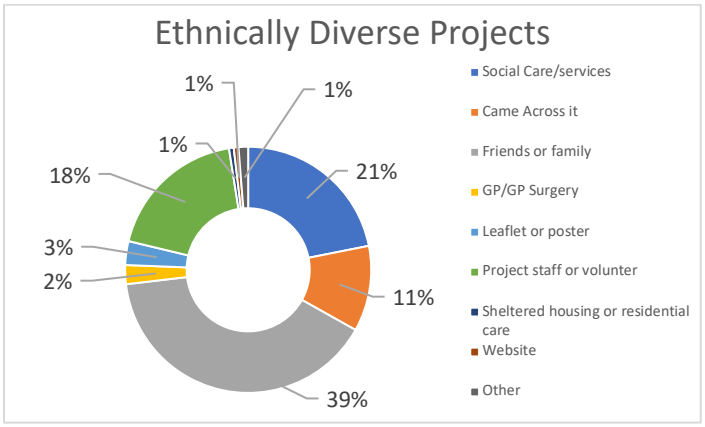
APPENDIX D: Numbers of participants completing each item in the participant survey

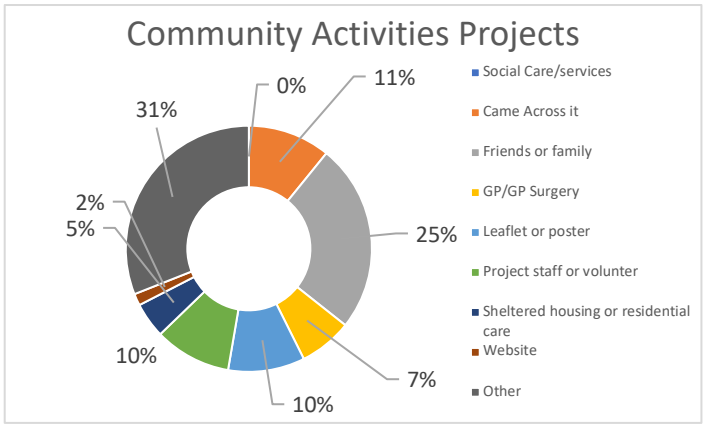
Item in participant survey	Entry N (%)[83]	Follow-up N (%)[84]
Socio-demographics		
Gender	917 (98)	214 (98)
Age	902 (96)	213 (97)
Ethnicity	910 (97)	211 (96)
Religion	903 (96)	209 (95)
Sexuality	698 (74)	157 (72)
Living arrangements	903 (96)	215 (98)
Long standing illness or disability	841 (89)	196 (90)
Carer status	866 (92)	201 (92)
Outcomes –loneliness		
De Jong Gierveld (DJG) scale	759 (94)	168 (77)
UCLA scale	762 (95)	187 (85)
Outcomes – social contact and participation		
Social contact with children, family and friends	709 (88)	139 (63)
Social contact with non-family members	803 (100)	199 (91)
Social participation in clubs, organisations and societies	805 (100)	219 (100)
Taking part in social activities	737 (92)	182 (83)
Outcomes – health and wellbeing		
Shortened Warwick-Edinburgh Emotional Wellbeing Scale	620 (77)	137 (63)
Quality of life (EQ-5D-3L)	639 (79)	163 (74)
Health self-reported score (EQ-VAS)	702(87)	181 (83)
Outcomes – Co-production and influence		
Volunteering	805 (100)	219 (100)
Co-design	805 (100)	219 (100)
Ability to influence local decisions	753 (94)	197 (90)

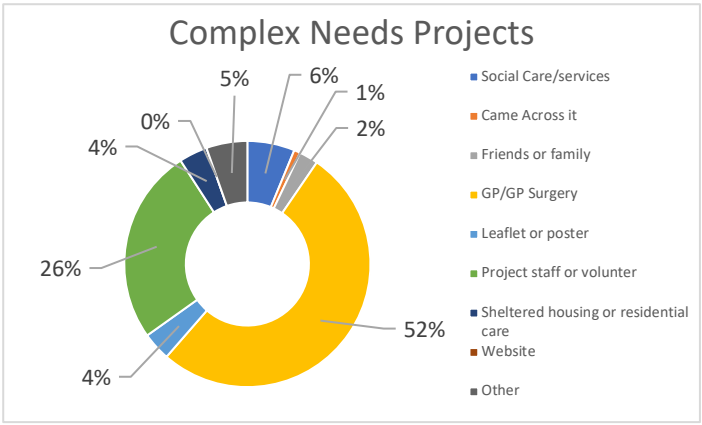
[83] For socio-demographics the numerator is 940; for outcomes the numerator is 805.

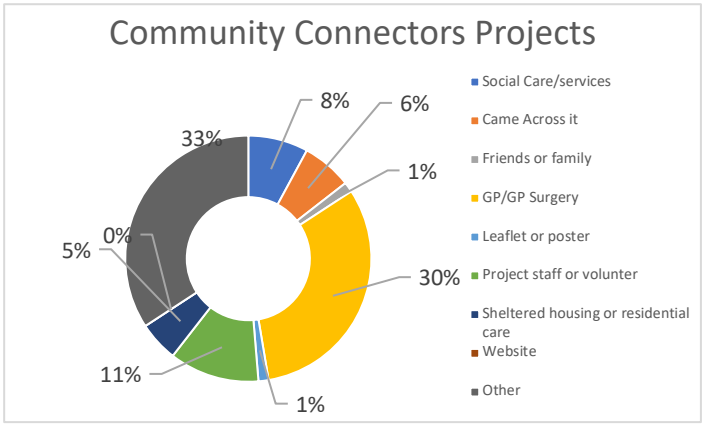
[84] Numerator is 219 for all items.

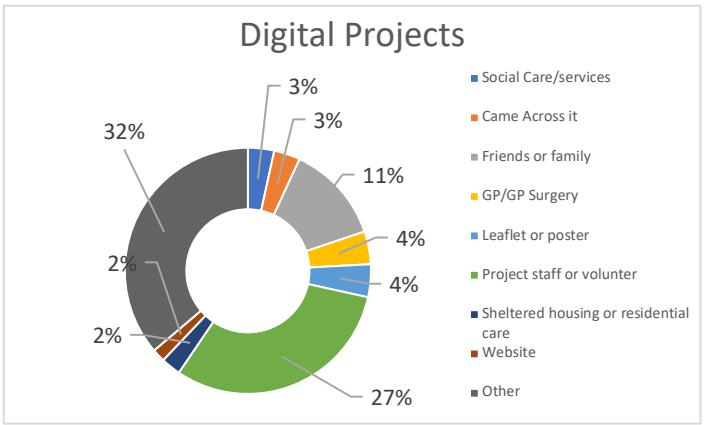
Appendix E: Routes to reaching participants across project themes

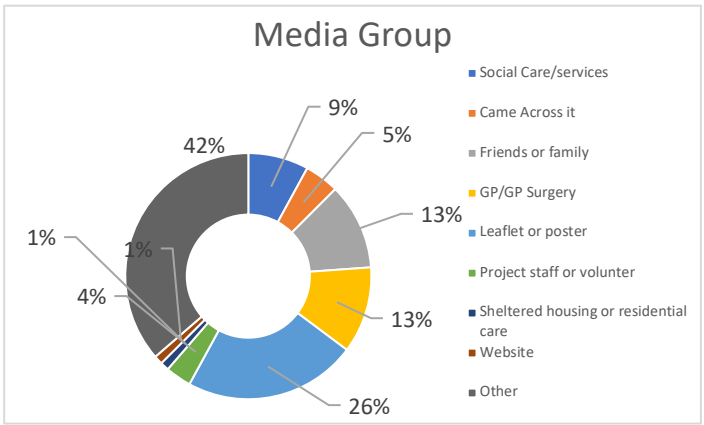


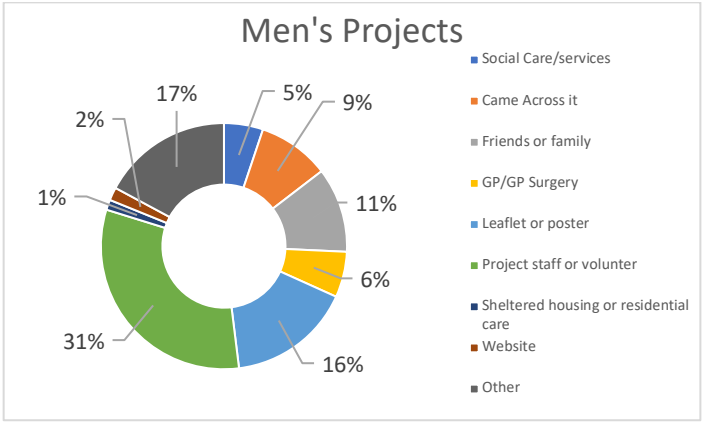






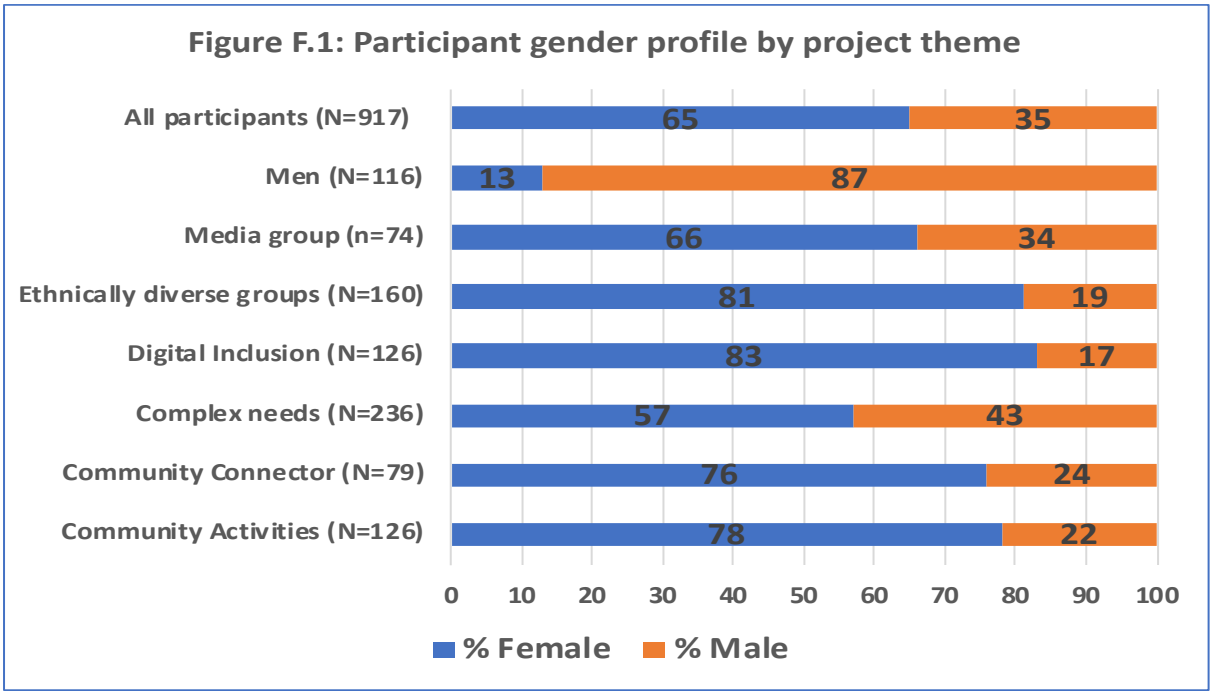




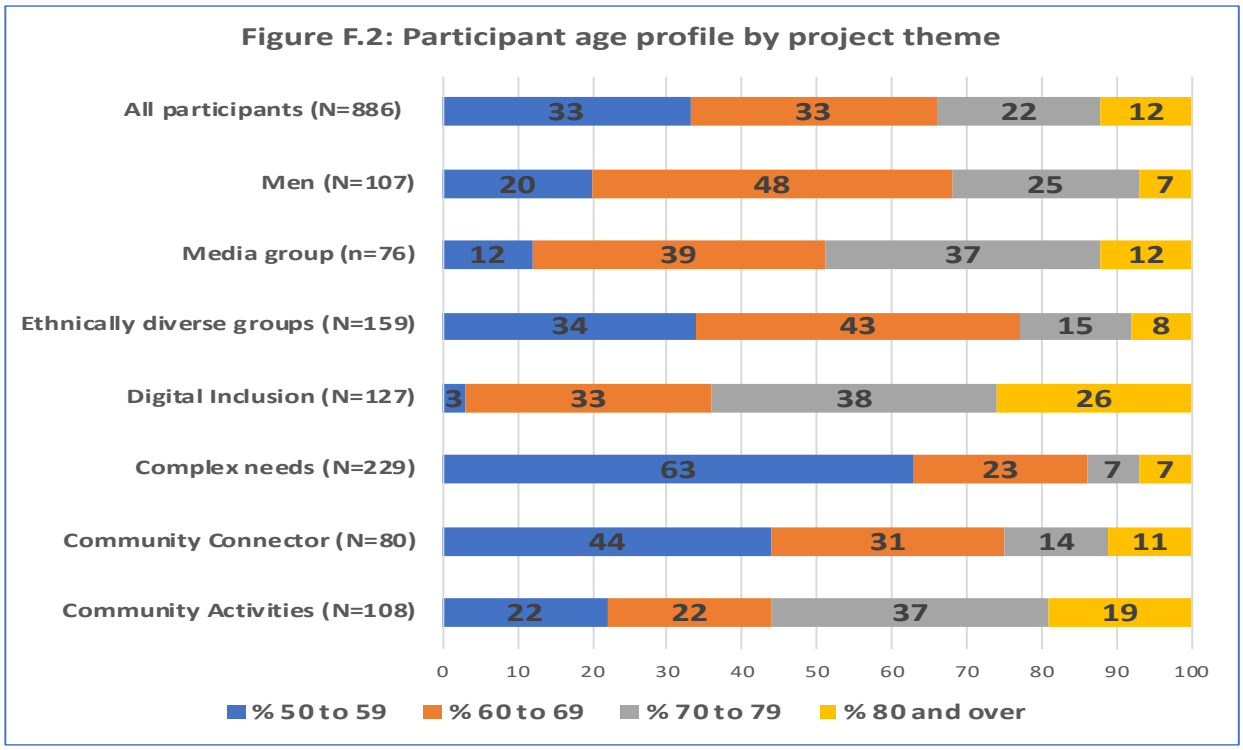


Appendix F: Participant socio-demographic profile at project entry by project theme – short and long surveys (n=940)

Differences by project theme were statistically significant across all socio-demographics.



NB: Projects target to men did not exclude women and so some participants in the men's projects were female



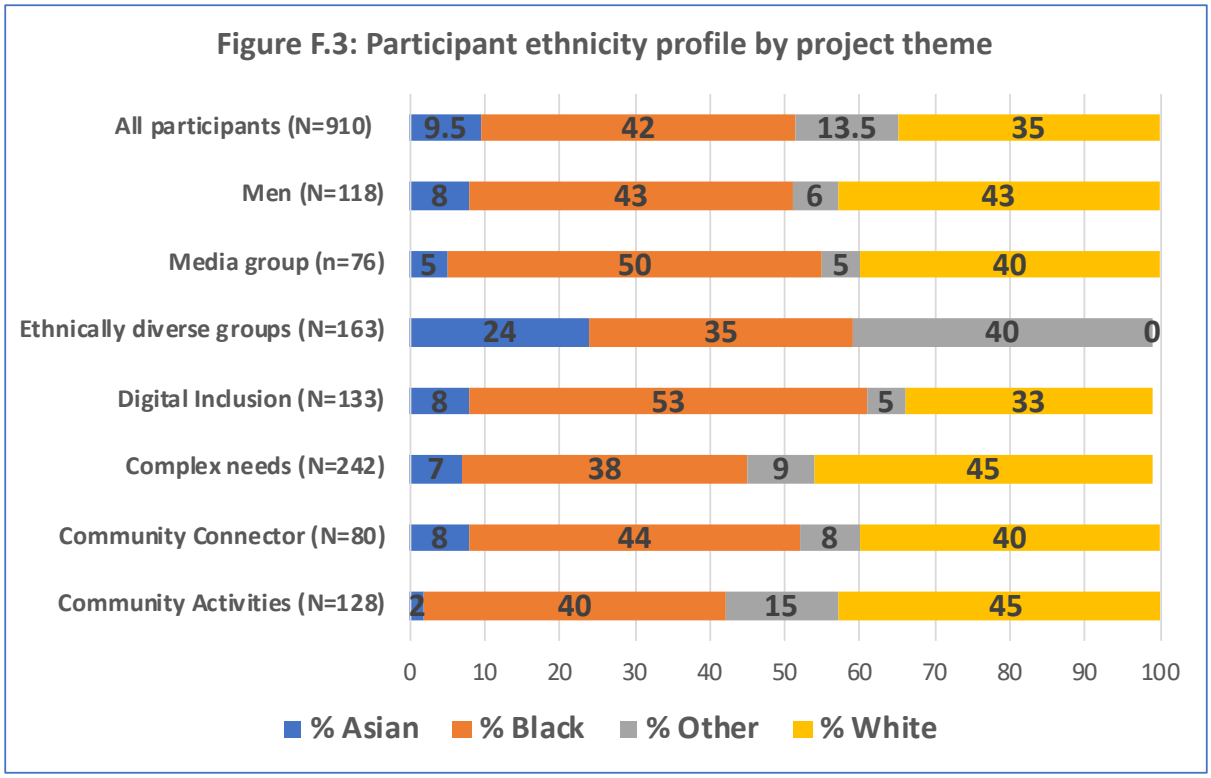


Figure F.3: Participant ethnicity profile by project theme
All participants (N=910)
9.5
42
13.5
35
Men (N=118)
8
43
6
43
Media group (n=76)
5
50
5
40
Ethnically diverse groups (N=163)
24
35
40
0
Digital Inclusion (N=133)
8
53
5
33
Complex needs (N=242)
7
38
9
45
Community Connector (N=80)
8
44
8
40
Community Activities (N=128)
2
40
15
45
0 10 20 30 40 50 60 70 80 90 100
% Asian
% Black
% Other
% White

1

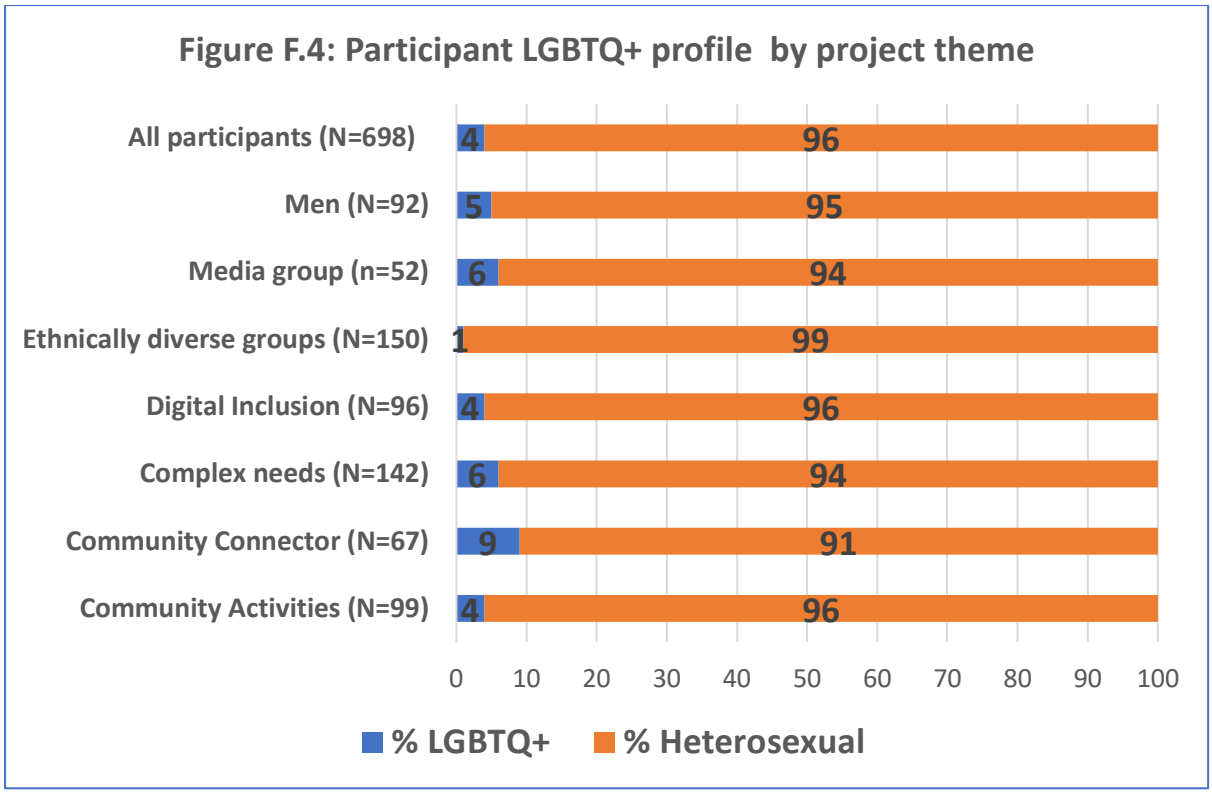


Figure F.4: Participant LGBTQ+ profile by project theme
All participants (N=698)
4
96
Men (N=92)
5
95
Media group (n=52)
6
94
Ethnically diverse groups (N=150)
1
99
Digital Inclusion (N=96)
4
96
Complex needs (N=142)
6
94
Community Connector (N=67)
9
91
Community Activities (N=99)
4
96
0 10 20 30 40 50 60 70 80 90 100
% LGBTQ+
% Heterosexual

Figure F.5: Participant living arrangements by project theme

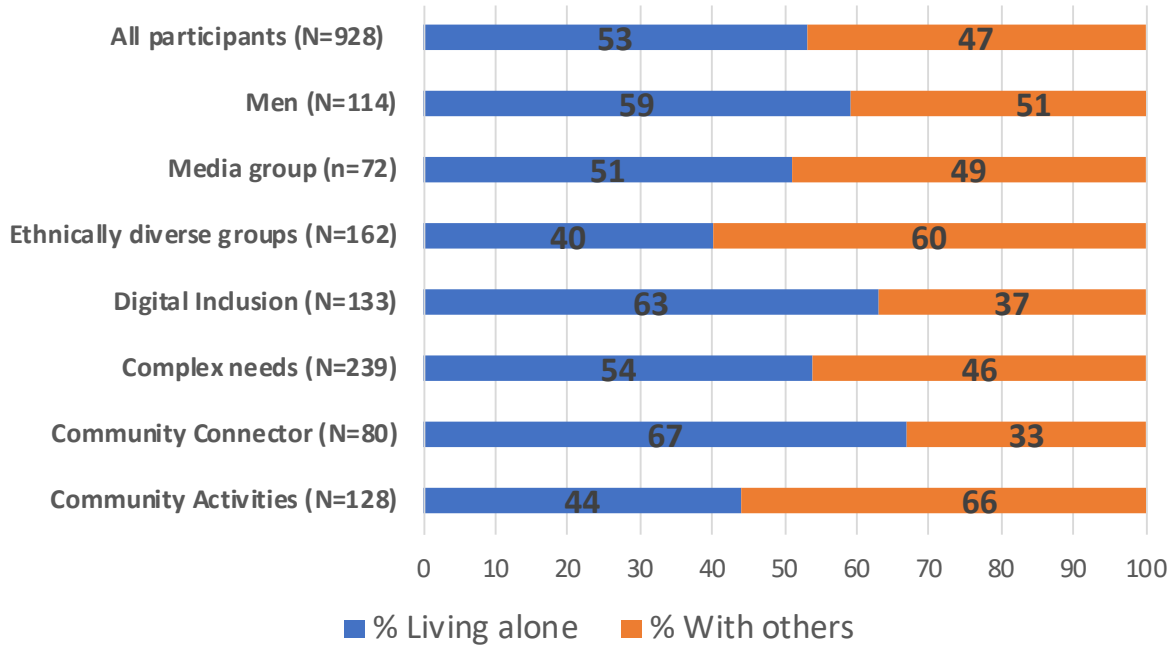


Figure F.6: Participant carer status by project theme

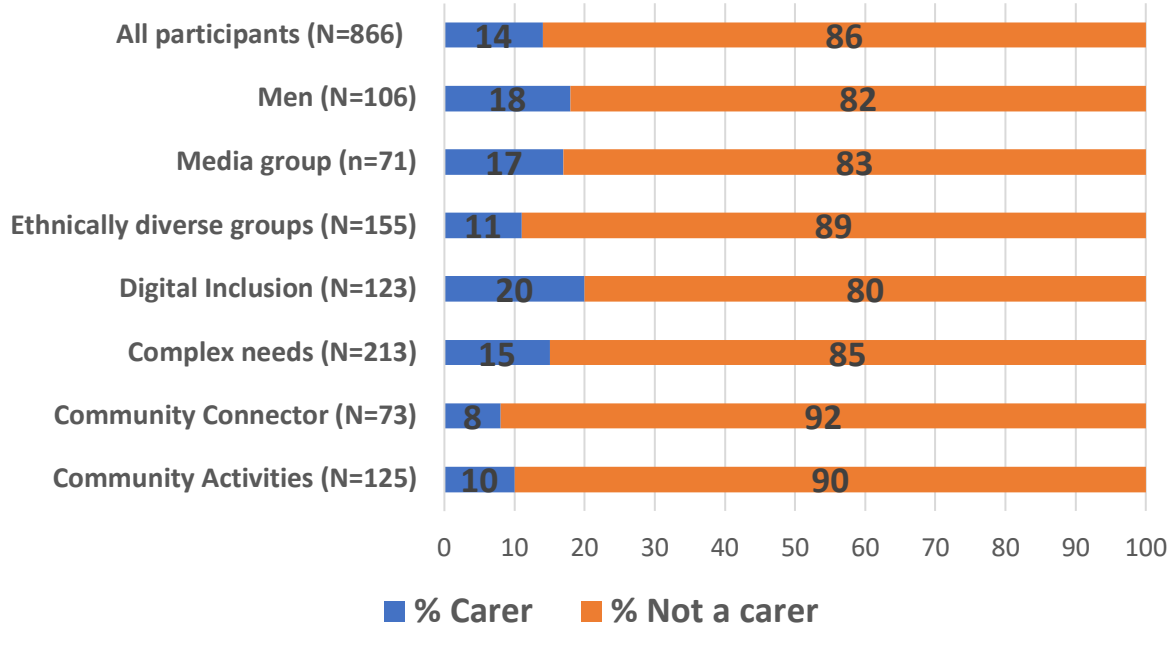
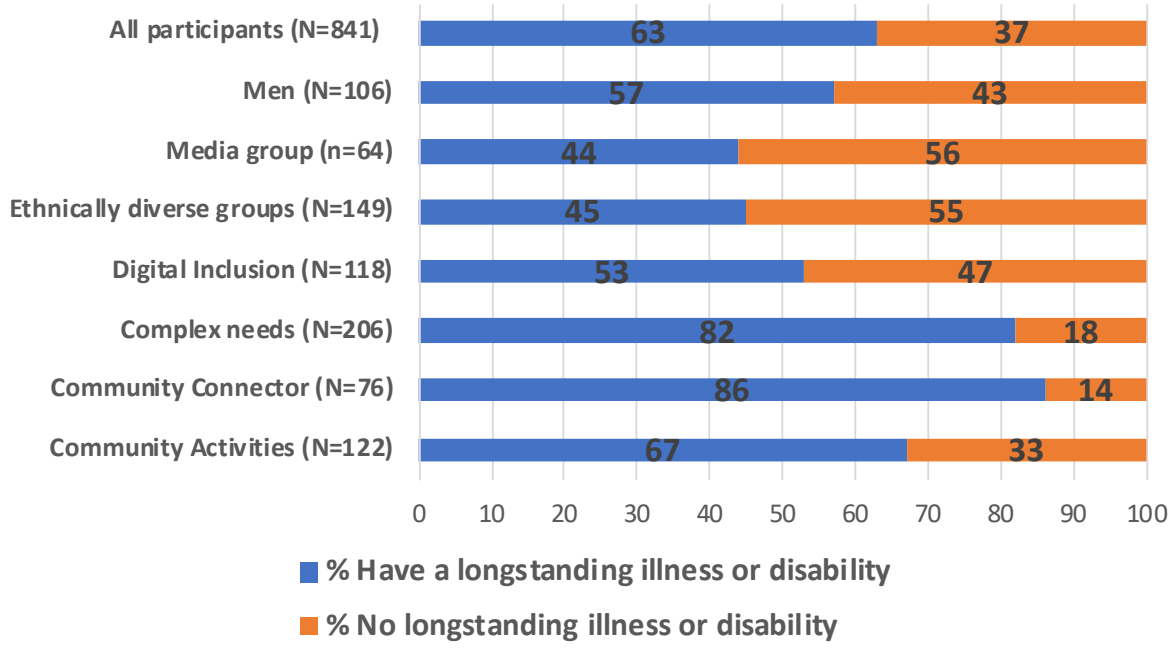
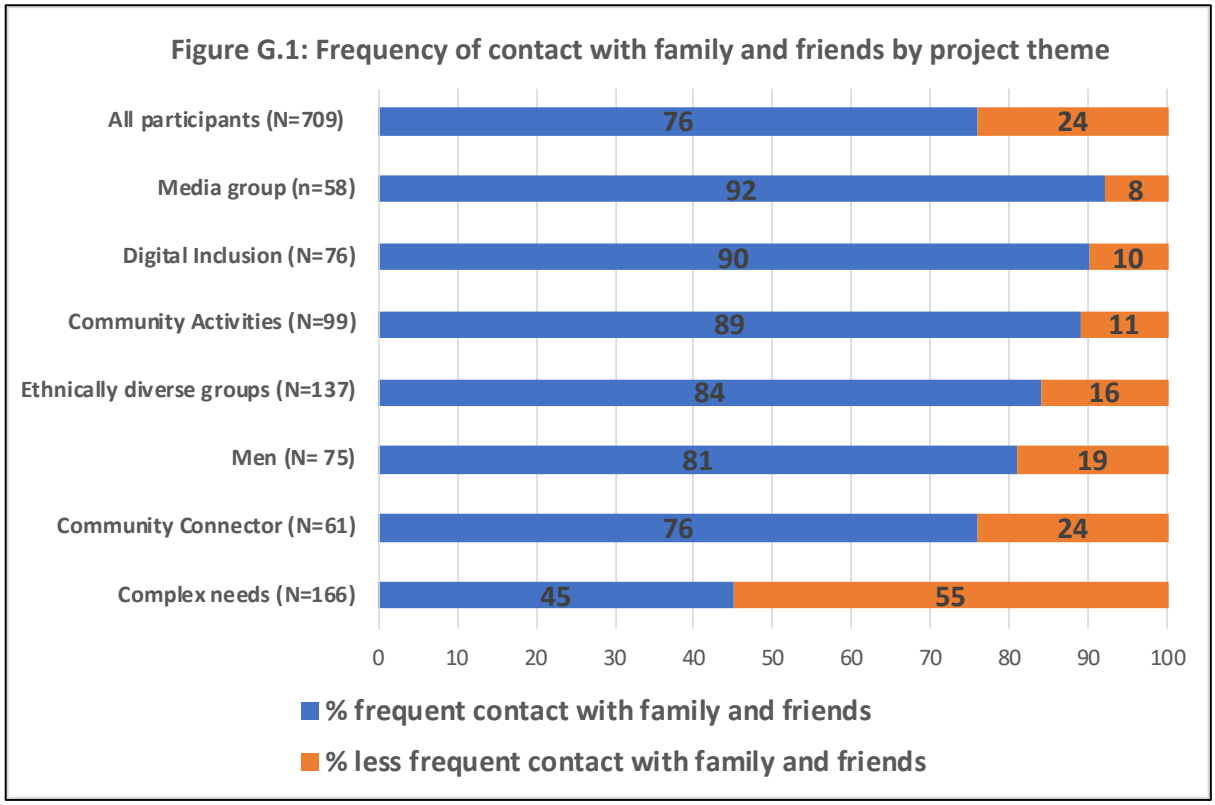


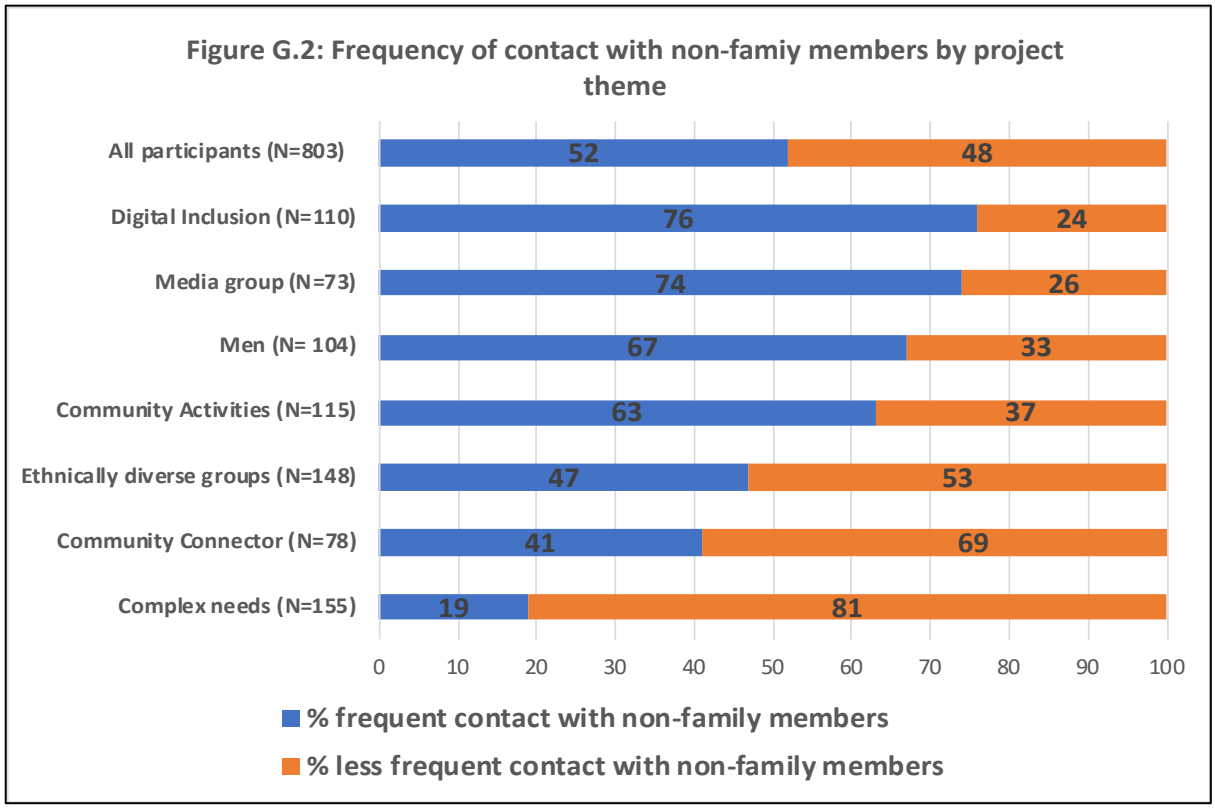
Figure F.7: Participant longstanding illness or disability status by project theme



APPENDIX G: Social isolation and health and wellbeing at project entry by project theme – long survey (n=805)



-



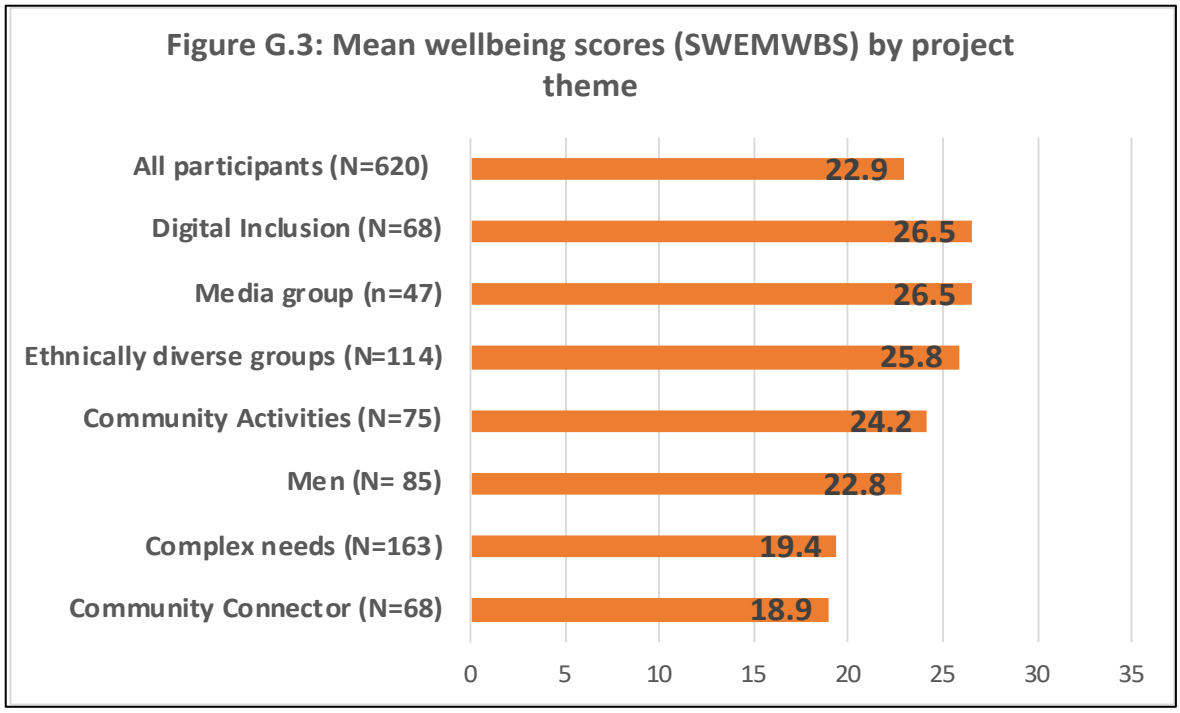


Figure G.3: Mean wellbeing scores (SWEMWBS) by project theme
All participants (N=620)
Digital Inclusion (N=68)
Media group (n=47)
Ethnically diverse groups (N=114)
Community Activities (N=75)
Men (N= 85)
Complex needs (N=163)
Community Connector (N=68)
22.9
26.5
26.5
25.8
24.2
22.8
19.4
18.9
0
5
10
15
20
25
30
35

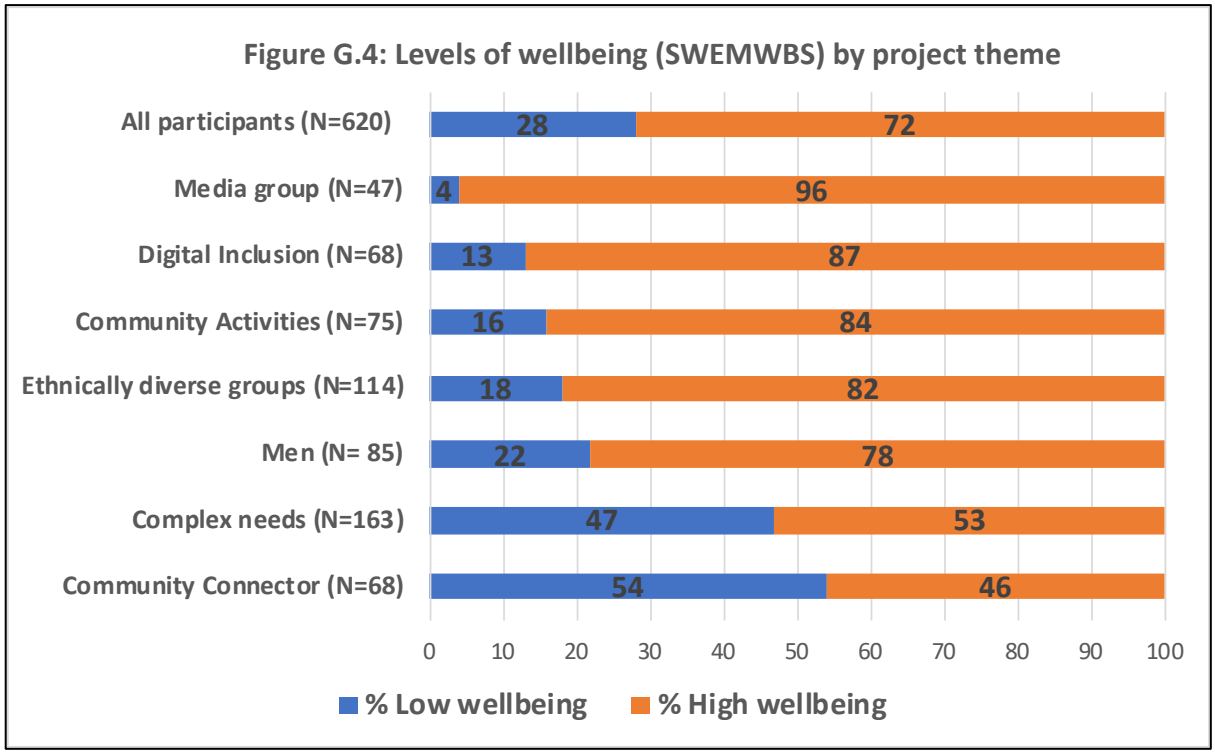
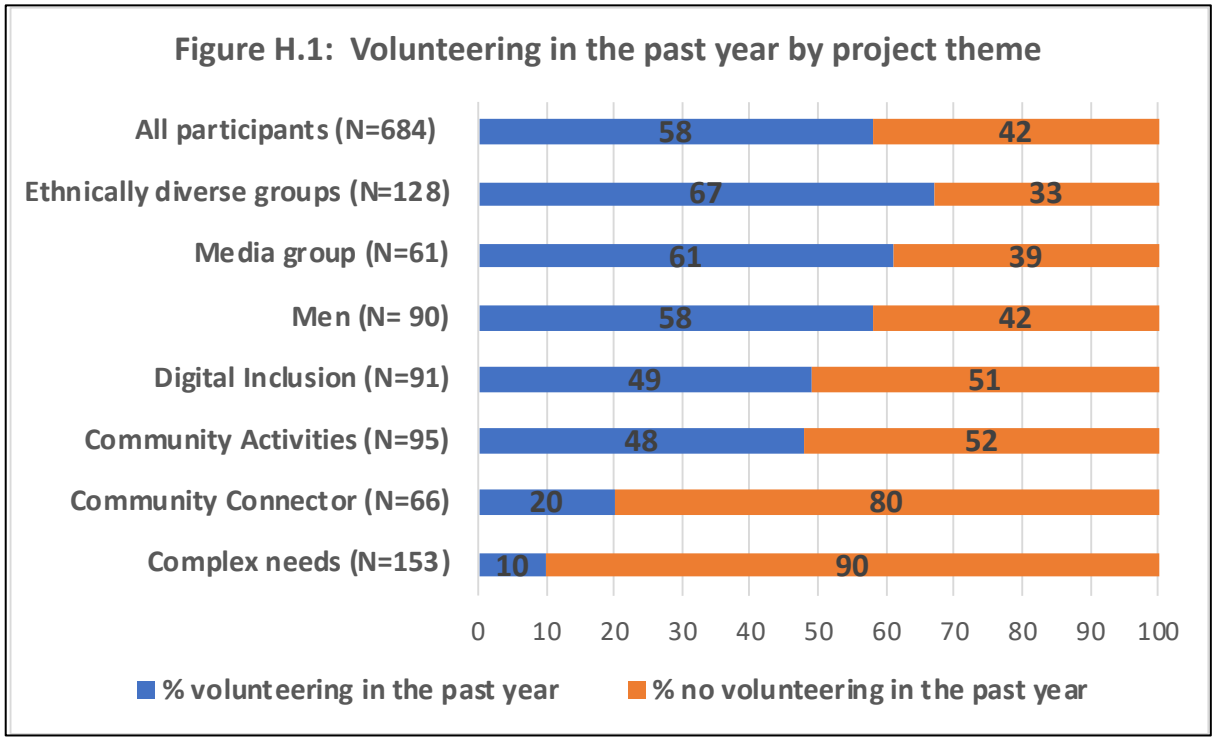


Figure G.4: Levels of wellbeing (SWEMWBS) by project theme
All participants (N=620)
Media group (N=47)
Digital Inclusion (N=68)
Community Activities (N=75)
Ethnically diverse groups (N=114)
Men (N= 85)
Complex needs (N=163)
Community Connector (N=68)
28
72
4
96
13
87
16
84
18
82
22
78
47
53
54
46
0
10
20
30
40
50
60
70
80
90
100
% Low wellbeing
% High wellbeing

Appendix H: Volunteering, involvement in co-design and perceived influence over local decision-making by project theme – long survey (n=805)



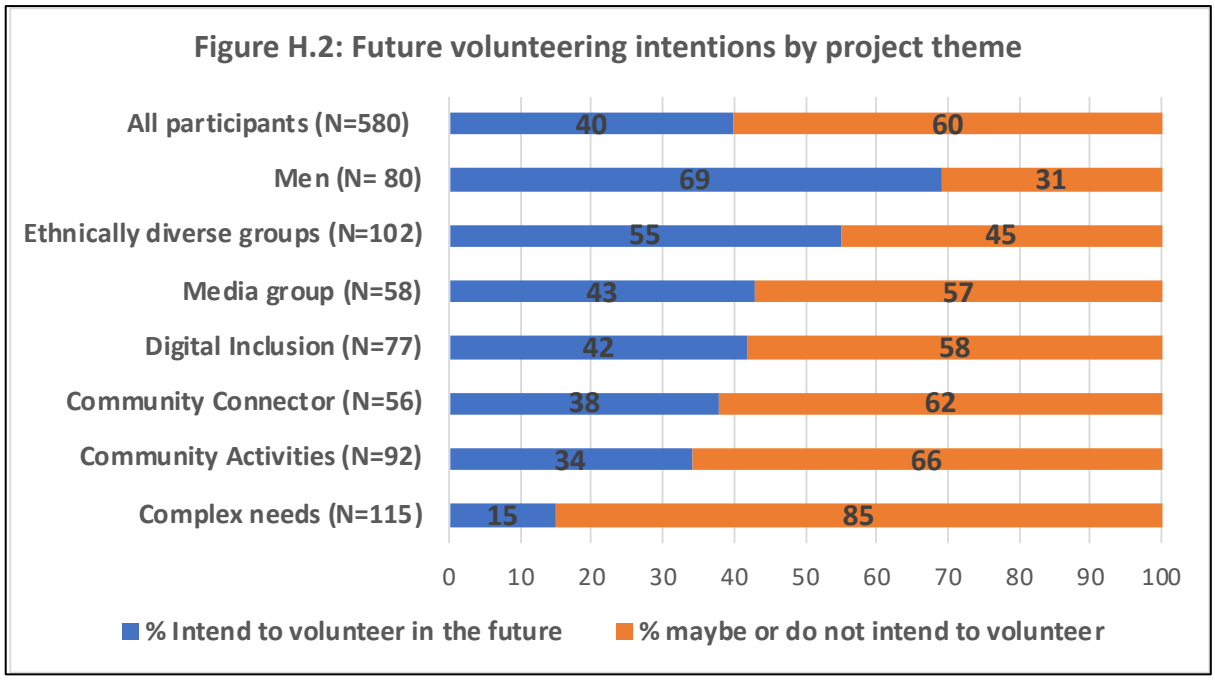


Figure H.3: Involvement in co-design by project theme

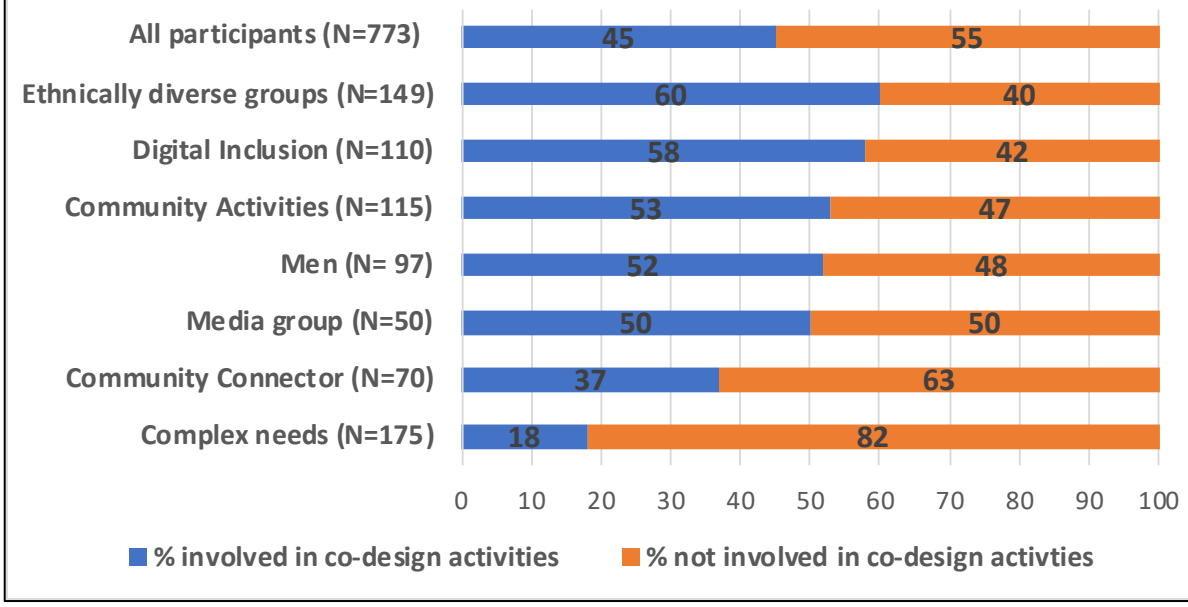
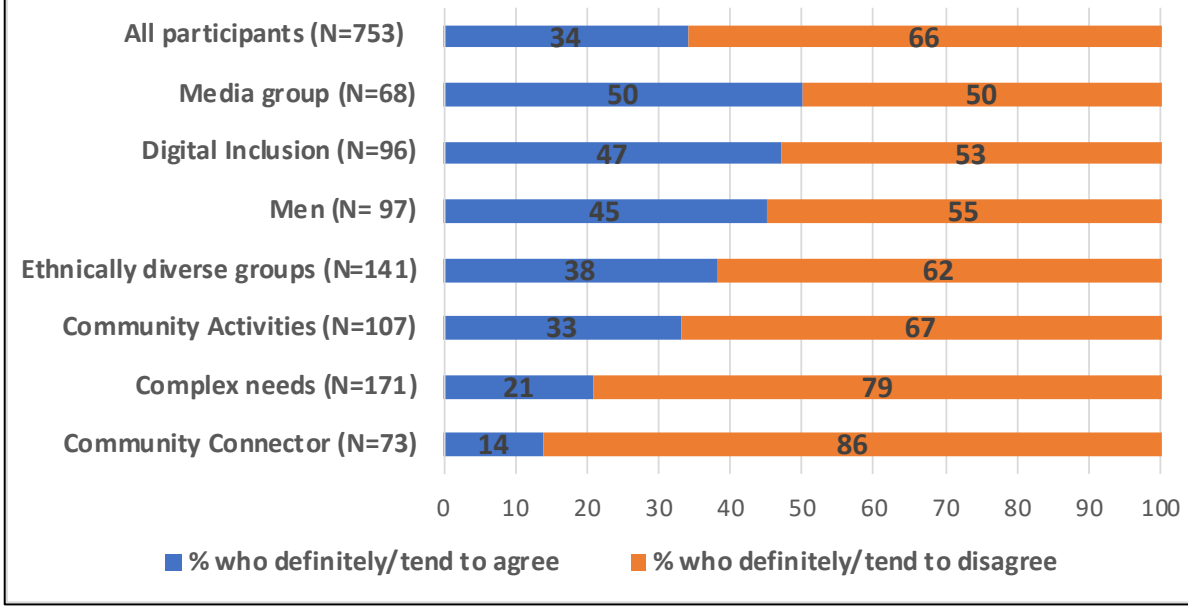
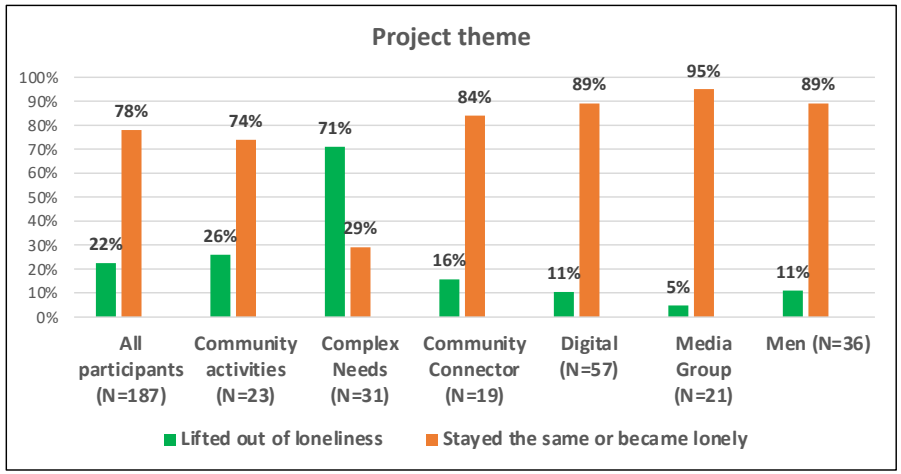
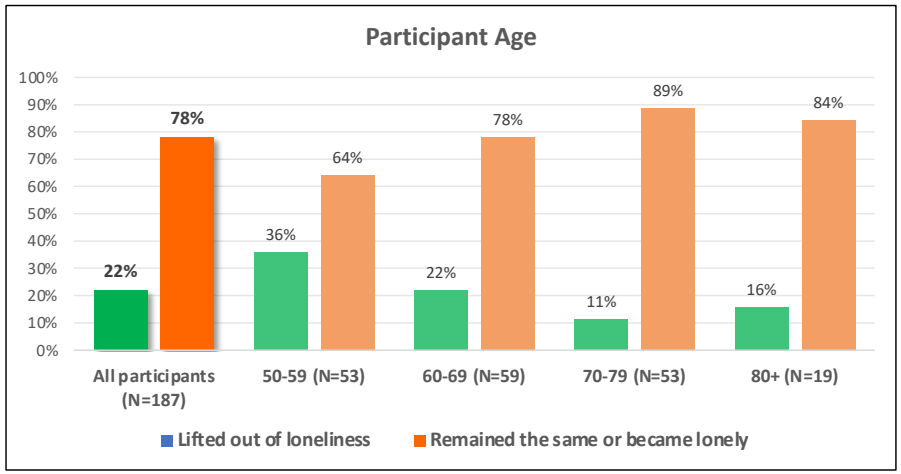


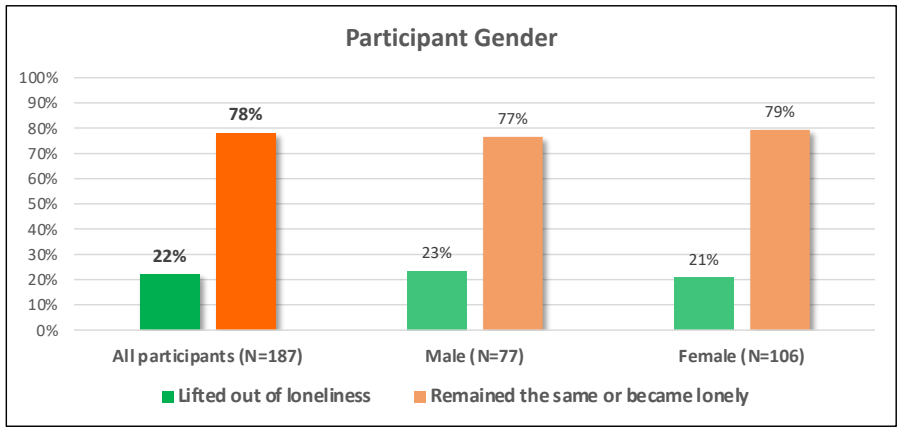
Figure H.4: Perceived influence over decision-making in local area by project theme

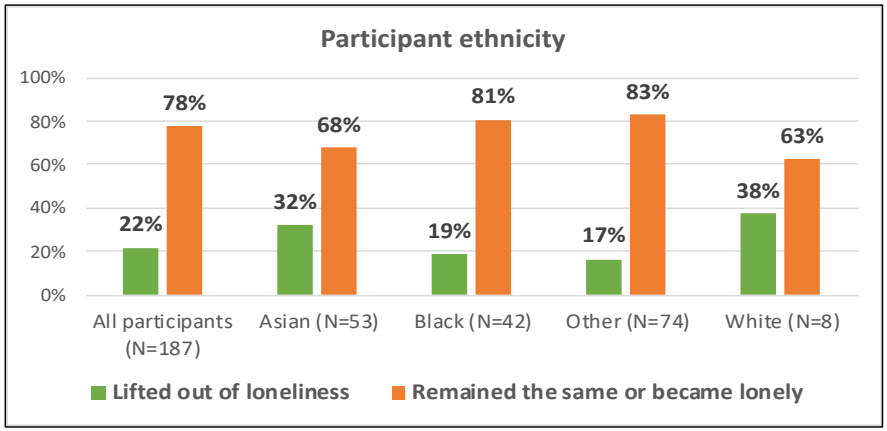


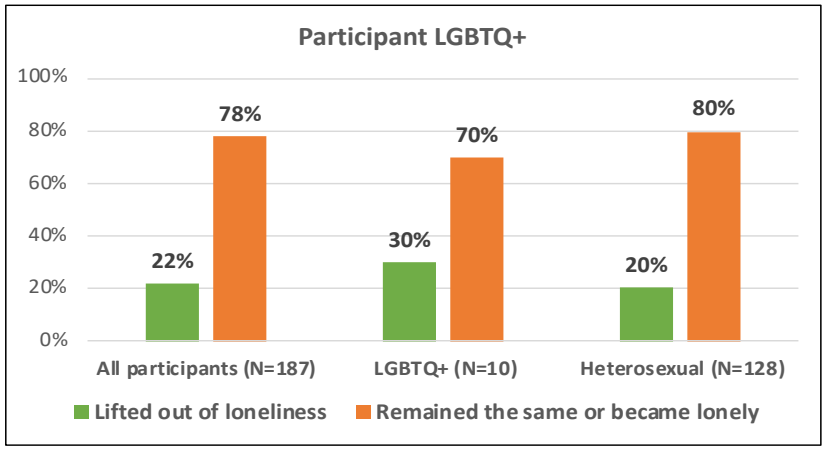
APPENDIX I: Project theme and socio-demographic characteristics associated with participants lifted out of loneliness

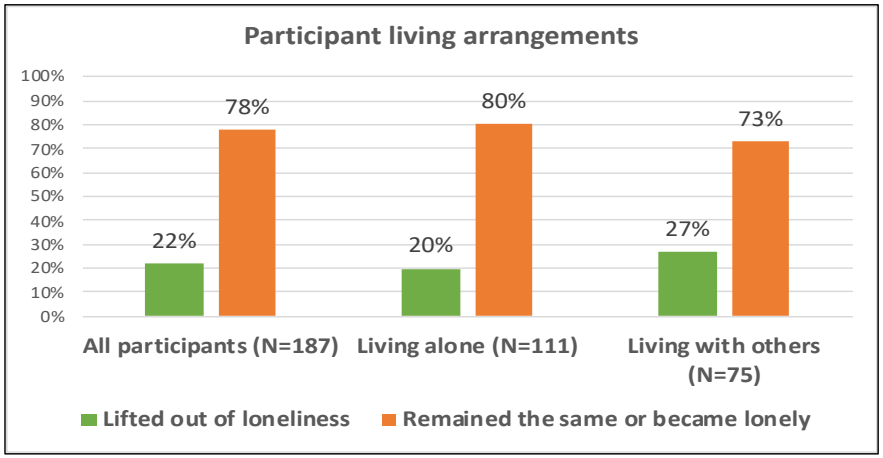


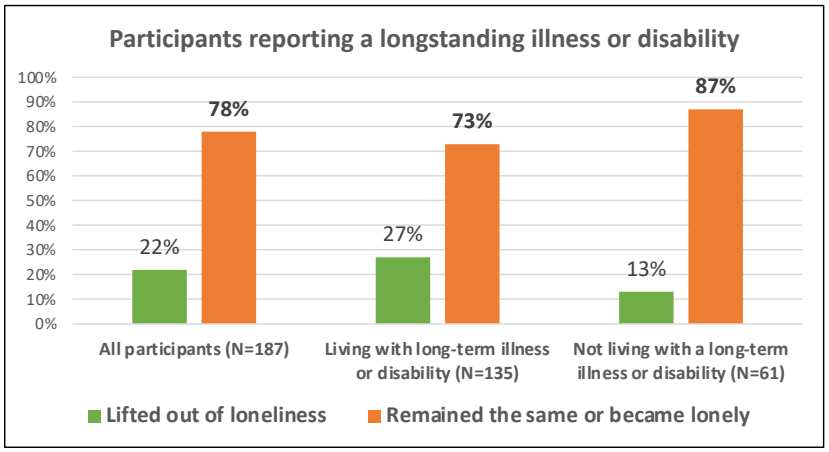


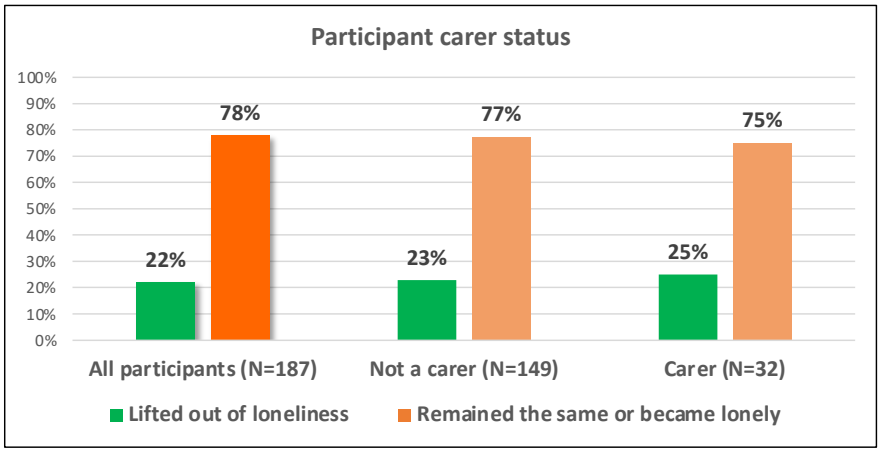





Participant LGBTQ+
100%
80%
60%
40%
20%
0%
78%
70%
80%
22%
30%
20%
All participants (N=187)
LGBTQ+ (N=10)
Heterosexual (N=128)
Lifted out of loneliness
Remained the same or became lonely


Participant living arrangements
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
78%
80%
73%
22%
20%
27%
All participants (N=187)
Living alone (N=111)
Living with others (N=75)
Lifted out of loneliness
Remained the same or became lonely


Participants reporting a longstanding illness or disability
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
78%
73%
87%
22%
27%
13%
All participants (N=187)
Living with long-term illness or disability (N=135)
Not living with a long-term illness or disability (N=61)
Lifted out of loneliness
Remained the same or became lonely


Participant carer status
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
78%
77%
75%
22%
23%
25%
All participants (N=187)
Not a carer (N=149)
Carer (N=32)
Lifted out of loneliness
Remained the same or became lonely

CONNECT
HACKNEY
ageing better