Faculty of Health and Social Care
The Centre for Ageing Studies
University of Chester

BRIGHTLIFE LEGACY REPORT

11 - BRIGHTLIFE QUANTITATIVE DATA

January 2018

The University of Chester Evaluation Team

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Contents

1 Introduction

The data utilised in this report is collected via the common measurement framework (CMF) and analysed using the Statistical Package for the Social Sciences (SPSS) software (IBM Analytics 1989); it should be noted not all Brightlife participants have fully completed a CMF questionnaire at both entry and follow-up, and some of those who have completed the CMF declined sharing data with the University evaluators. Consequently, except for demographic information, this report includes data for a sub-set of Brightlife participants, i.e. those who have fully completed the CMF at both entry and follow-up and agreed to share their data with the University.

The intention is not to simply present findings but to interpret them in a manner useful to the Brightlife partnership. Where appropriate, a colour system has been used; this indicates areas of success/positive outcomes (green) and areas which may need further consideration (orange). Rather than produce one overall discussion section at the end of the report, points for consideration have been noted where appropriate. The report also makes a number of recommendations for consideration by the Brightlife partnership, a number of which relate to information that may be useful for inclusion in the legacy Brightlife Repository.

2 Participants' demographic profile

The CMF collects participants' demographic information; headline demographic information provided by all Brightlife participants who shared data with the University evaluators is shown below:

- Participants' age range is between 50 to 99 with an average age of 73.4 years
- 72.3% identify as female
- 92.7% identify as heterosexual
- 96.6% identify as white British
- 56.5% state that they live alone
- 78.4% state that they are Christian
- 59.2% have a long term health condition
- 15.6% have caring responsibilities

Table 1 compares the Brightlife cohort characteristics with the Cheshire West and Chester (CWaC) population, where such data is available. Additionally, CWaC data should be taken to include all age groups unless stated otherwise.

Table 1 – Comparison of Brightlife cohort with CWaC borough population

Characteristics	Brightlife cohort	CWaC population
Gender - female	72.3% (of 408) female	52.7%
Sexuality	92.7% (of 399)	Not collected
Ethnicity	96.6% (of 407)	94.7%
Faith - Christian	78.4% (of 407)	70.1%
LT health condition	59.2% (of 412)	37%
Living alone	56.5% (of 414)	23.1%
Caring responsibilities	15.6% (of 411)	

In some respects the Brightlife cohort is reflective of the population of CWaC, i.e. ethnicity and faith; however there are particular differences in relation to gender, long term health conditions and living arrangements between the two populations.

While only 52.7% of the Borough's population aged 50 and over are female, 72.3% of Brightlife participants are female.

At entry to Brightlife, 59.2% of participants stated they have a long-term health condition compared with 37% of the Borough's population aged 50 and over. This suggests Brightlife is successful in engaging with people with long-term health conditions. This is especially positive as this cohort may be more likely to experience social isolation than individuals without such health issues.

At entry to Brightlife, 56.5% of participants stated they live alone compared with 23.1% of the Borough population aged 50 and over; this suggests Brightlife is successfully engaging with a group that may be at greater risk of social isolation.

2.1 Points to consider

Consistent with the ethos of test and learn, the Brightlife project team has already recognised there is a gender imbalance in recruitment of participants and has issued service specifications targeted at reducing the barriers to participation experienced by older men. It will be beneficial to follow-up with men who engage with services commissioned under this tender to understand what induced them to participate. It would also be useful to follow-up with men already accessing Brightlife, again to understand what encouraged them to engage with the project. This

information could be used to inform marketing and future commissioning; it will also be worthwhile information for the Brightlife Repository.

Moving forward, the CMF will incorporate a breakdown of health conditions; this will facilitate identifying whether Brightlife is engaging with people with specific long-term health conditions or whether Brightlife engages well with people living with long term health conditions per se. This information can inform future commissioning and engagement strategies. Additionally, Brightlife's success in engaging with people who live alone and with people with long term health conditions should be investigated to identify the strategies employed for incorporation into the Brightlife repository.

3 Social isolation and loneliness

This section reports the outcomes of two validated psychometric measures of loneliness: the University of California Los Angeles (UCLA) Loneliness scale (Russell D, Peplau LA & Ferguson ML 1978) and the de Jong Gierveld Loneliness Scale (de Jong-Gierveld J & Kamphuls F 1985).

3.1 The University of California Los Angeles (UCLA) Loneliness scale – scores can range from 4 to 12 with lower scores indicating lower levels of loneliness. One hundred and thirty-five (n=135) participants fully completed the UCLA Loneliness Scale at both entry and follow-up (see Table 2 and Figure 1).

Table 2 – UCLA loneliness scale scores (entry and follow-up)

UCLA score	No. participants - entry	% participants - entry	No. participants – fu	% participants – fu	% Change
4	32	23.7	38	28.1	+4.4
5	23	17.0	24	17.8	+0.8
6	14	10.4	16	11.9	+1.5
7	17	12.6	18	13.3	+0.7
8	30	22.2	28	20.7	-1.5
9	8	5.9	7	5.2	-0.7
10	8	5.9	1	0.7	-5.2
11	2	1.5	2	1.5	0
12	1	0.7	1	0.7	0
Totals	135	100	135	100	

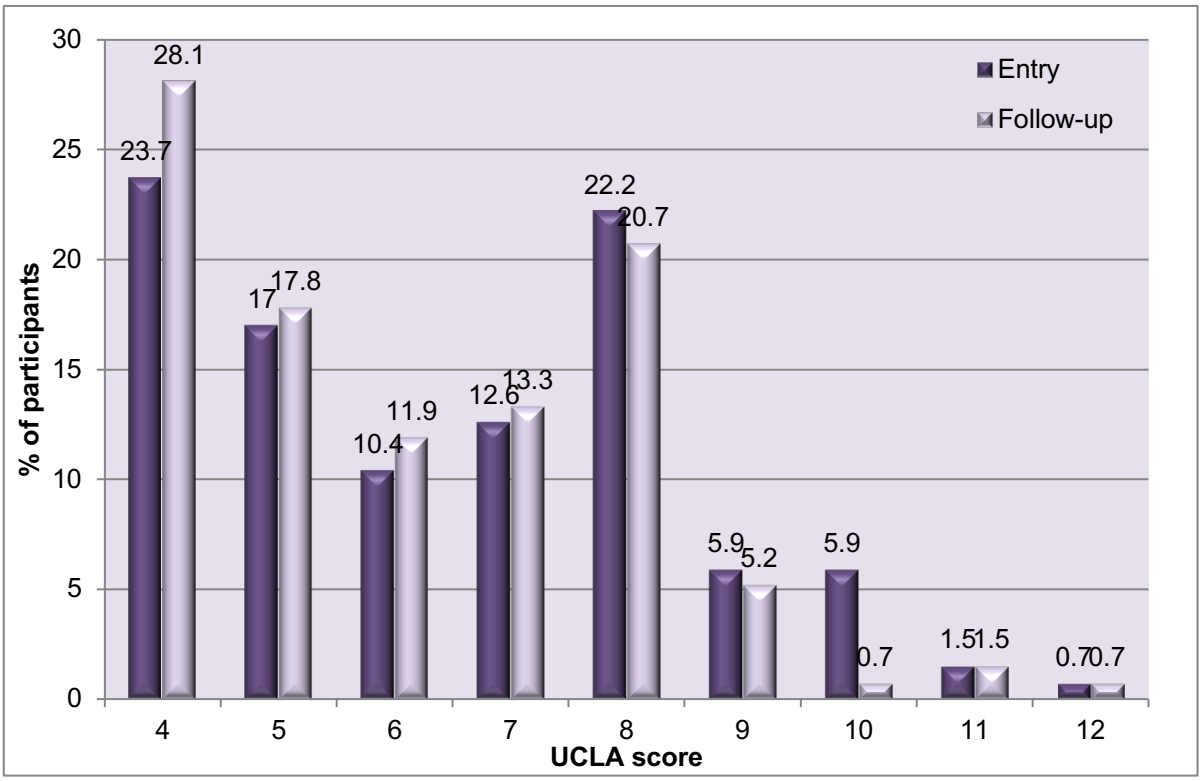

Figure 1- UCLA loneliness scale scores (entry and follow-up)

Participants' average scores fell between entry and follow-up; this suggests participating in Brightlife activities may have had a positive influence on individuals' social isolation and loneliness.

3.2 The de Jong Gierveld Loneliness Scale - this scale comprises two sub-scales; social loneliness and emotional loneliness, scores can range from 0 to 6 on the full scale and 0 to 3 on the sub-scales; higher scores on both indicating greater levels of loneliness.

One hundred and twenty-nine (n=129) participants completed the scale at both entry and follow-up (see Table 3 and Figure 2). Participants' average scores for the scale fell between entry and exit. Scores also fell on the sub-scales for both emotional and social loneliness, although emotional loneliness showed a greater reduction. This suggests participating in Brightlife activities may have had a positive influence on individuals' social isolation and loneliness.

Table 3 – Participants' de Jong scale scores at entry and follow-up

De Jong score	No. participants - entry	% participants - entry	No. participants – fu	%f participants – fu	% Change
0	33	25.6	42	32.6	+7.0
1	25	19.4	22	17.1	-2.3
2	20	15.5	19	14.7	-0.8
3	19	14.7	13	10.1	-4.6
4	9	7.0	8	6.2	-0.8
5	8	6.2	14	10.9	+4.7
6	15	11.6	11	8.5	-3.1
Totals	129	100	129	100	

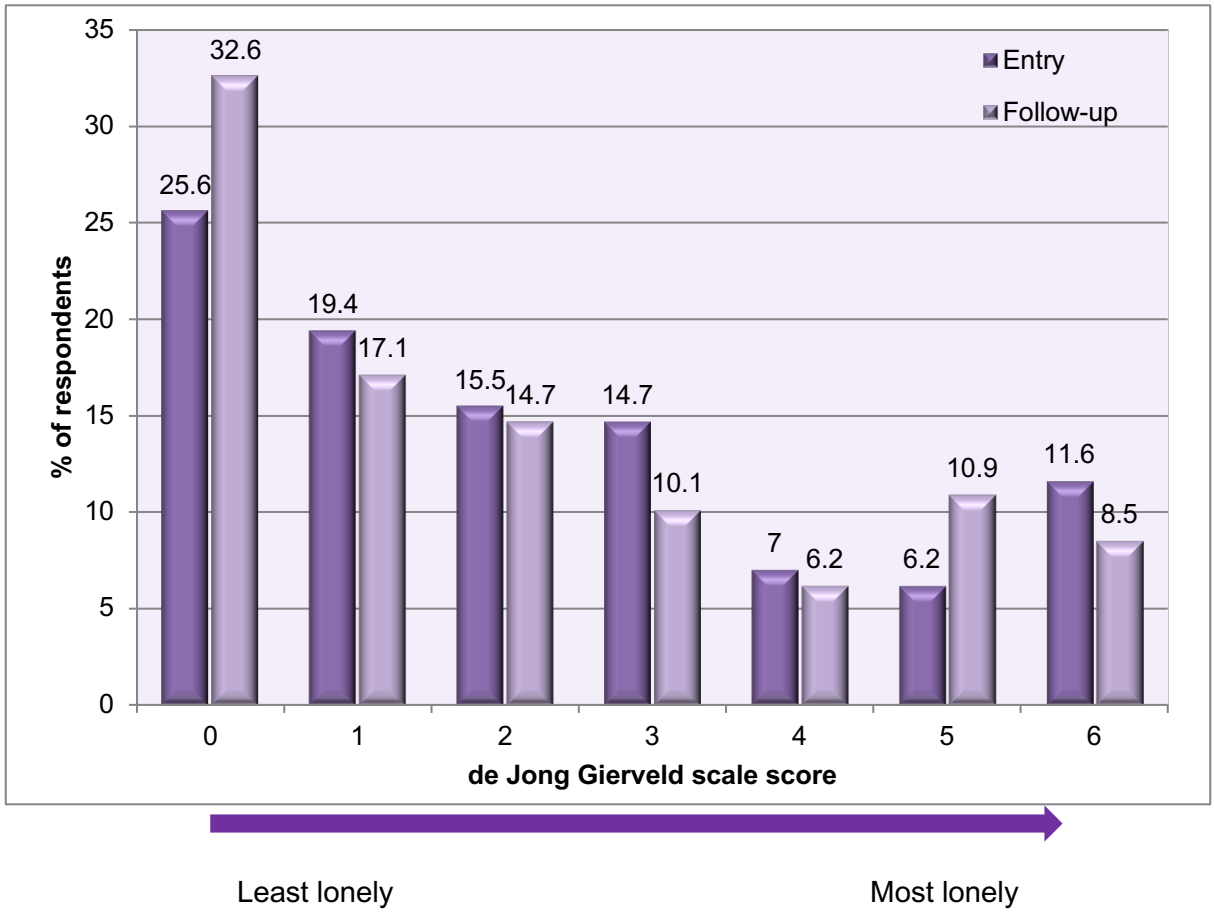

Figure 2 – Participants' de Jong scores at entry and follow-up

3.1 Points to consider

The outcomes for both the UCLA and the de Jong loneliness scales show a positive trend and therefore suggest participating in Brightlife may have resulted in a reduction in loneliness as

measured on these scales. As all participants initially recruited to Brightlife did not score highly for loneliness on these scales, it is positive an improvement has been seen. To improve recruitment from the Brightlife target population, commissioned service providers are now screening potential participants for social isolation and loneliness, thus greater improvements may be evidenced in the future.

Additionally, recently commissioned services, including Bright Ideas, are delivering in more disadvantaged locations within the Borough, as example Lache and Blacon in Chester, and Rossmore in Ellesmere Port. As there is some evidence social isolation may be associated with low socio-economic status (Age UK u.d.), it can be hypothesised individuals recruited from these areas may evidence higher levels of loneliness than those initially recruited to Brightlife. Consequently, if these Bright Ideas interventions are successful, greater changes in loneliness may be evidenced.

4 Social connectivity

The CMF measures participants' social connectivity using questions based on the English Longitudinal Study of Ageing (ELSA) survey. These questions investigate the type and number of contacts participants have with other people.

4.1 Not counting the people you live with how often do you do any of the following with children, family or friends?

Meet up in person

One hundred and forty (n=140) participants responded to this question at entry and follow-up (see Table 4 and Figure 3). An increase in the percentage of people seeing their family and friends three times a week and a reduction in those only seeing family and friends once or twice a year was seen at follow-up, although there was a reduction in people seeing their family and friends once or twice a week, this outcome shows a positive trend.

Table 4 – Frequency of meeting with children, family or friends

Frequency of meetings	No. participants entry	% participants entry	No. participants f.u.	% participants f.u.	% Change
3 times a week	54	38.6	60	42.9	+4.3
once or twice a week	58	41.4	53	37.9	-3.5
once or twice a month	17	12.1	19	13.6	+1.5
every few months	5	3.6	5	3.6	0
once or twice a year	4	2.9	1	0.7	-2.2
< once a year	2	1.4	2	1.4	0
Totals	140	100	140	100	

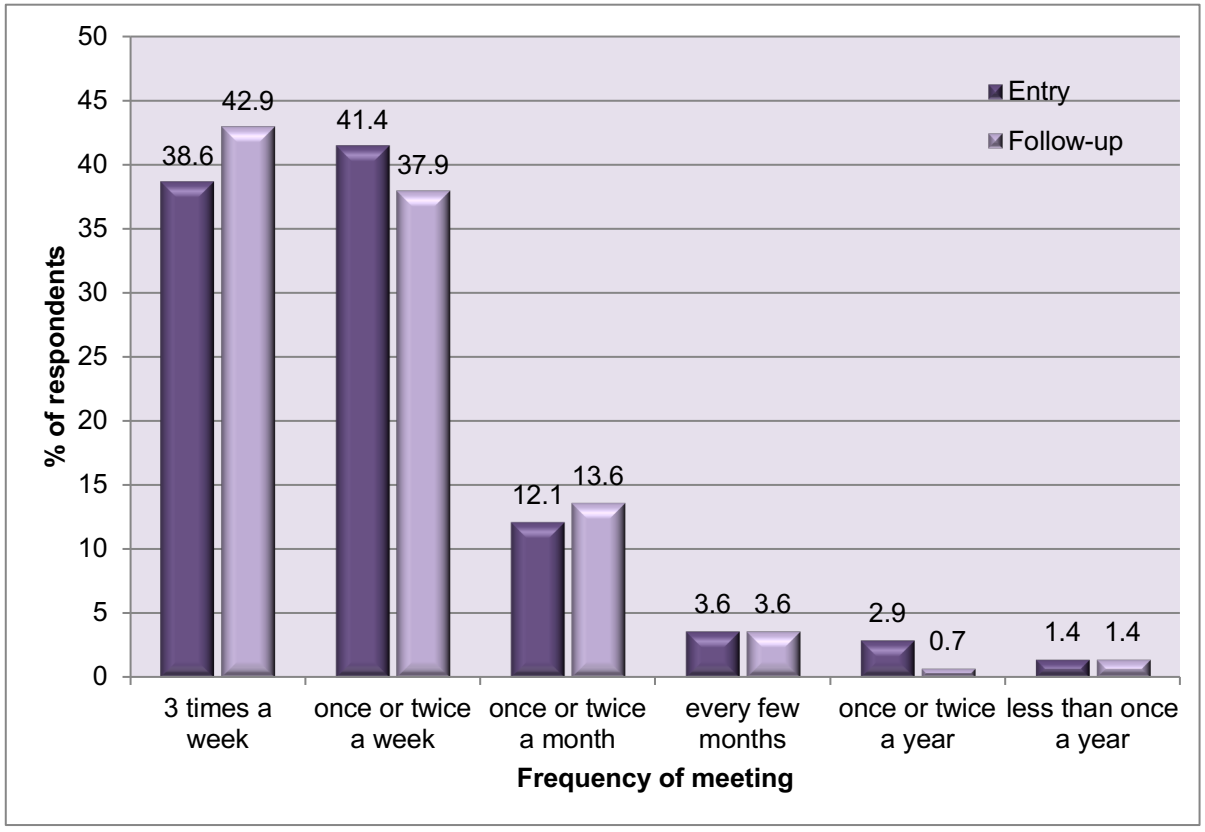

Figure 3 - Frequency of meeting with children, family or friends

Speak on the phone

One hundred and forty (n=140) participants responded to this question at entry and follow-up (see Table 5 and Figure 4).

Table 5 – Frequency of phone calls with children, family and friends

Frequency of phone calls	No. participants entry	% participants entry	No. participants f.u.	% participants f.u.	% Change
3 times a week	71	50.7	78	55.7	+5.0
once or twice a week	48	34.3	39	27.9	-6.4
once or twice a month	11	7.9	16	11.4	+3.5
every few months	2	1.4	5	3.6	+2.2
once or twice a year	4	2.9	0	0	-2.9
< once a year	4	2.9	2	1.4	-1.5
Total	140	100	104	100	

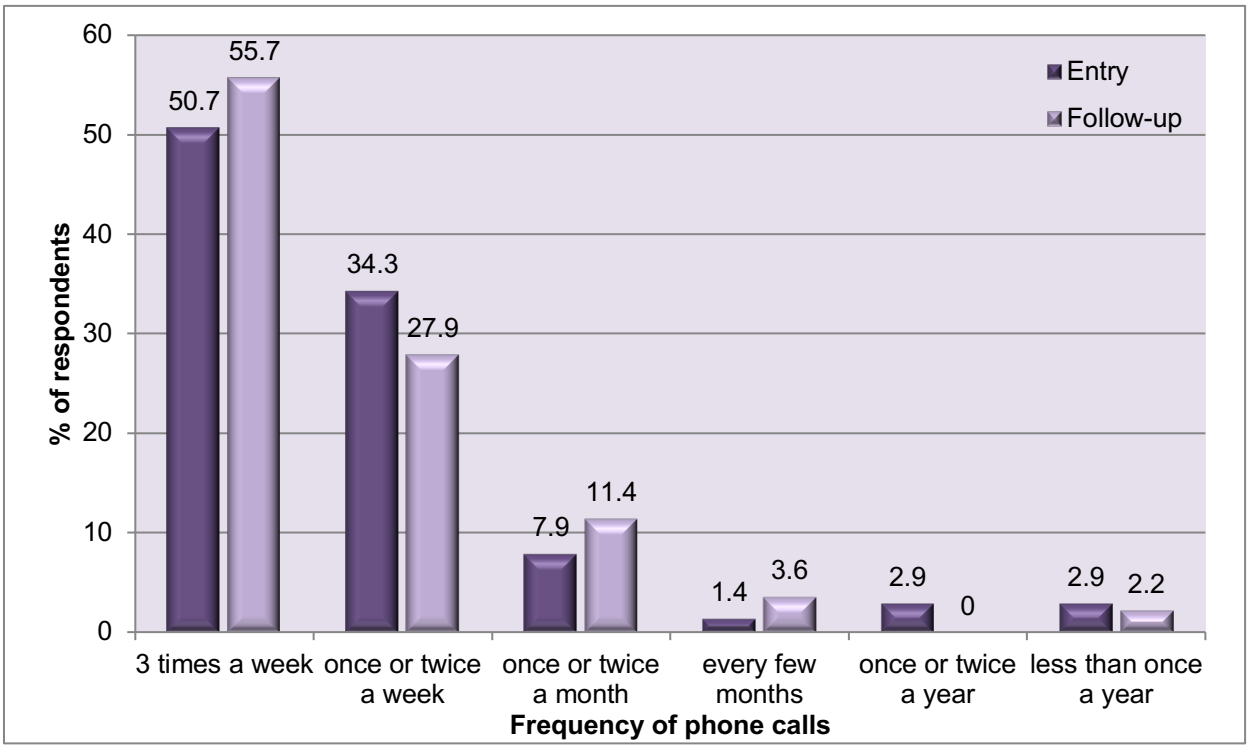

Figure 4 – Frequency of phone calls with children, family and friends

The outcomes for this question were mixed; however, fewer participants stated at follow-up they only spoke by phone with family and friends once or twice a year or less frequently than at entry and more participants spoke with family and friends three times a week or more. It can be suggested that this is a positive trend.

Email or write

One hundred and thirty four (n=134) participants completed this question at entry and follow-up (see Table 6 and Figure 5). Outcomes were mixed with an increase in those emailing once or twice a week but this was offset by an increase in those emailing less than once a year.

Table 6 - Frequency of emails/letters to children, family and friends

Frequency of emailing	No. participants entry	% participants entry	No. participants f.u.	% participants f.u.	% Change
3 times a week	38	28.4	37	27.6	-0.8
once or twice a week	20	14.9	26	19.4	+4.5
once or twice a month	20	14.9	15	11.2	-3.7
every few months	10	7.5	4	3.0	-4.5
once or twice a year	14	10.4	15	11.2	+0.8
< once a year	32	23.9	37	27.6	+3.7
Total	134	100	134	100	

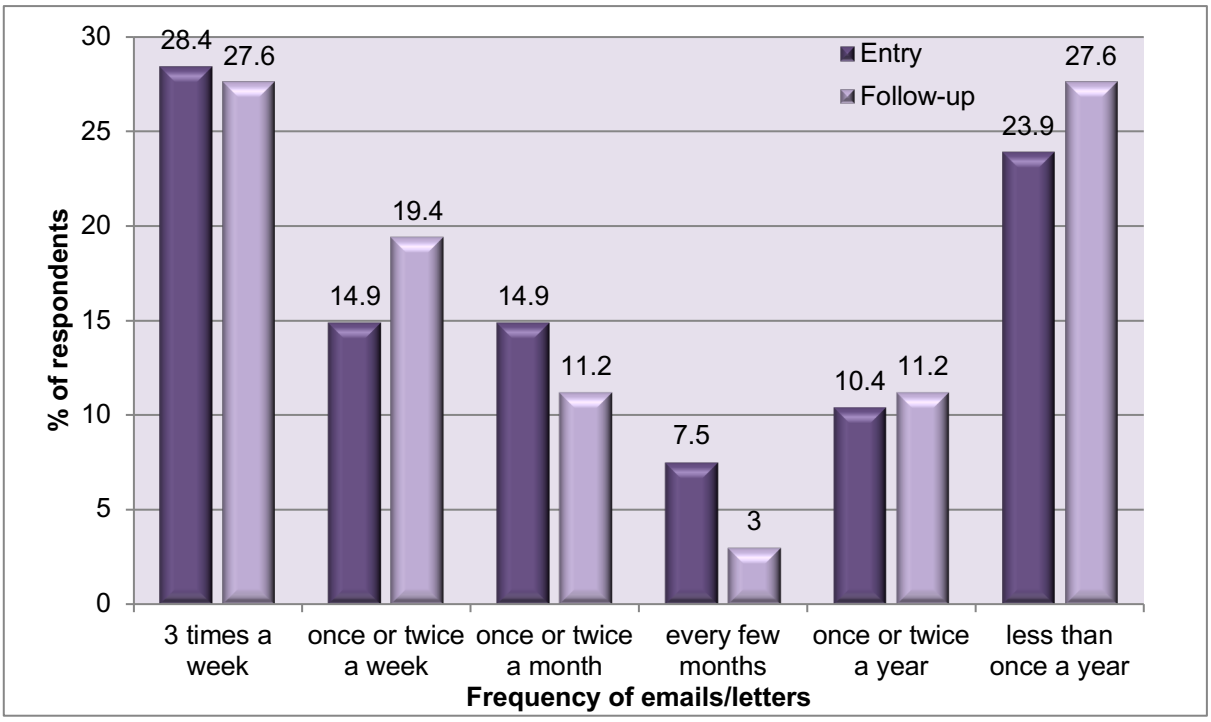

Figure 5 - Frequency of emails/letters to children, family and friends

Text message

One hundred and twenty-seven (n=127) participants completed this question at entry and follow-up (see Table 7 and Figure 6). There was very little difference between participants' frequency of texting at entry to Brightlife and follow-up.

Table 7 - Frequency of text messages to children, family and friends

Frequency of texting	No. participants entry	% participants entry	No. participants f.u.	% participants f.u.	% Change
3 times a week	37	29.1	35	27.5	-1.6
once or twice a week	20	15.7	20	15.7	0
once or twice a month	10	7.9	9	7.1	-0.8
every few months	5	3.9	5	3.9	0
once or twice a year	7	5.5	8	6.3	+0.8
< once a year	48	37.8	50	39.4	+1.6
Total	127	100	127	100	

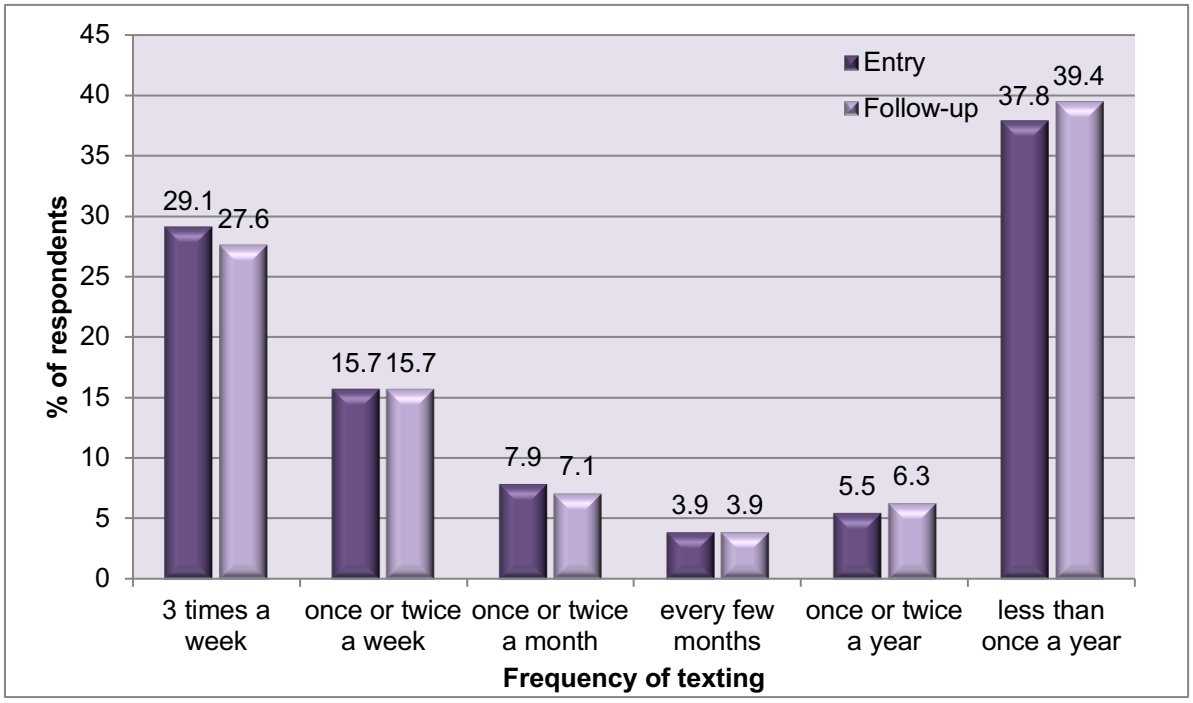

Figure 6 - Frequency of text messages to children, family and friends

4.2 Thinking about people in your local area, how often do you speak to anyone who isn't a family member?

Please include local friends[1], neighbours, acquaintances, people who come in to help you, people you see if you go out, and so on?

One hundred and thirty-seven (n=137) participants completed this question at entry and follow-up (see Table 8 and Figure 7). The outcomes were non-conclusive with a lower percentage of participants selecting every/almost every day and once/twice a week, but a similar percentage of participants selected three or more times a week.

Table 8 – Frequency of speaking with non-family members

Frequency of speaking	No. participants entry	% participants entry	No. participants f.u.	% participants f.u.	% Change
Every/almost every day	77	56.2	72	52.6	-3.6
3 or more times a week	30	21.9	40	29.2	+7.3
Once/twice a week	23	16.8	18	13.1	-3.7
Few times a month	6	4.4	4	2.9	-1.5
Once a month	1	0.7	1	0.7	0
Every few months	0	0	1	0.7	+0.7
once/twice a year	0	0	1	0.7	+0.7
< once per year	0	0	0	0	0
Totals	137	100	137	100	

[1] This question presents potential "double counting" as the previous question about meeting with people also asks about friends.

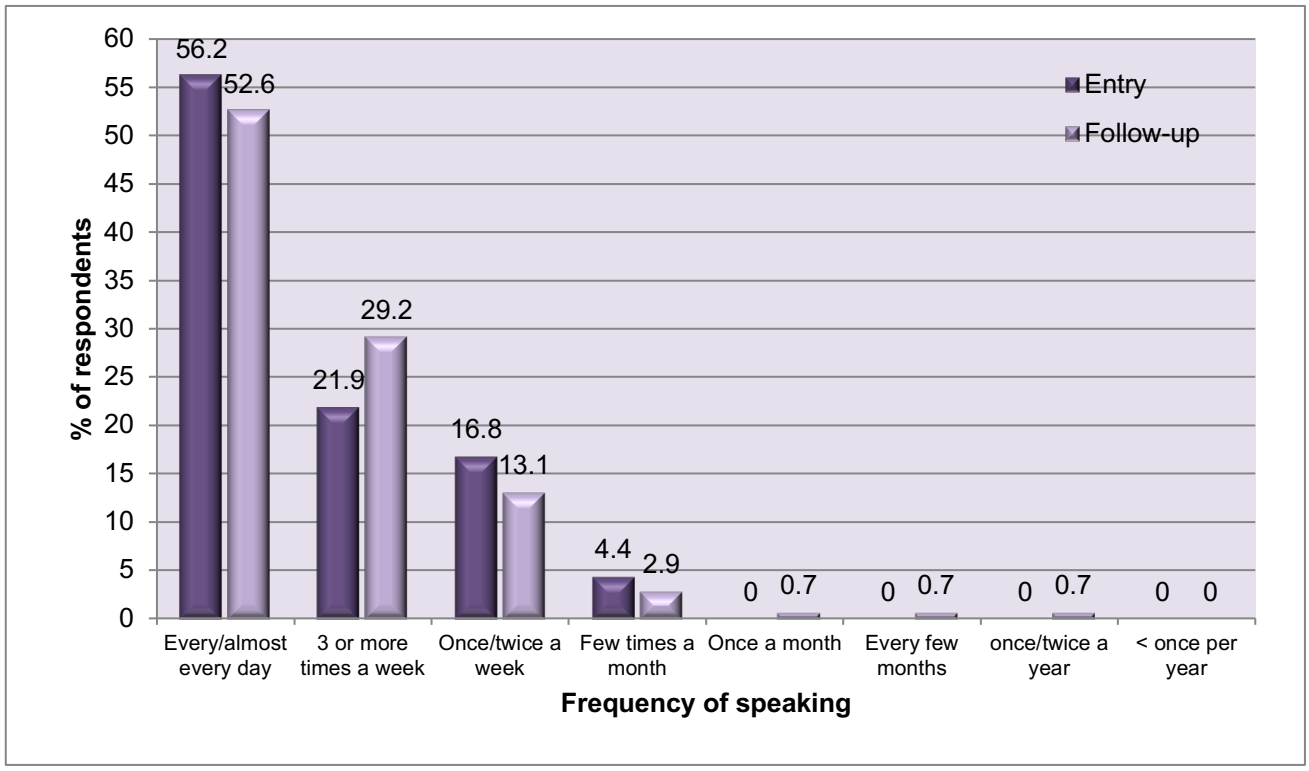

Figure 7 - Frequency of speaking with non-family members

4.3 Are you a member of any clubs, organisations or societies?

One hundred and thirty-four (n=134) participants completed this question at entry and follow-up (see Table 9 and Figure 8). The average number of clubs people belonged rose between entry and follow-up (this was a statistically significant outcome). A 6.8% increase was seen in membership of four clubs and a 1.5% increase of three clubs.

Table 9 – Membership of clubs, organisations and societies

No of clubs	No. of participants entry	% of participants entry	No. of participants follow-up	% of participants follow-up	% Difference
0	31	23.1	23	17.2	-5.9
1	43	32.1	43	32.1	0
2	37	27.6	34	25.4	-2.2
3	17	12.7	19	14.2	+1.5
4	3	2.2	12	9.0	+6.8
5	2	1.5	2	1.5	0
6	1	0.7	1	0.7	0
Total	134	100	134	100	

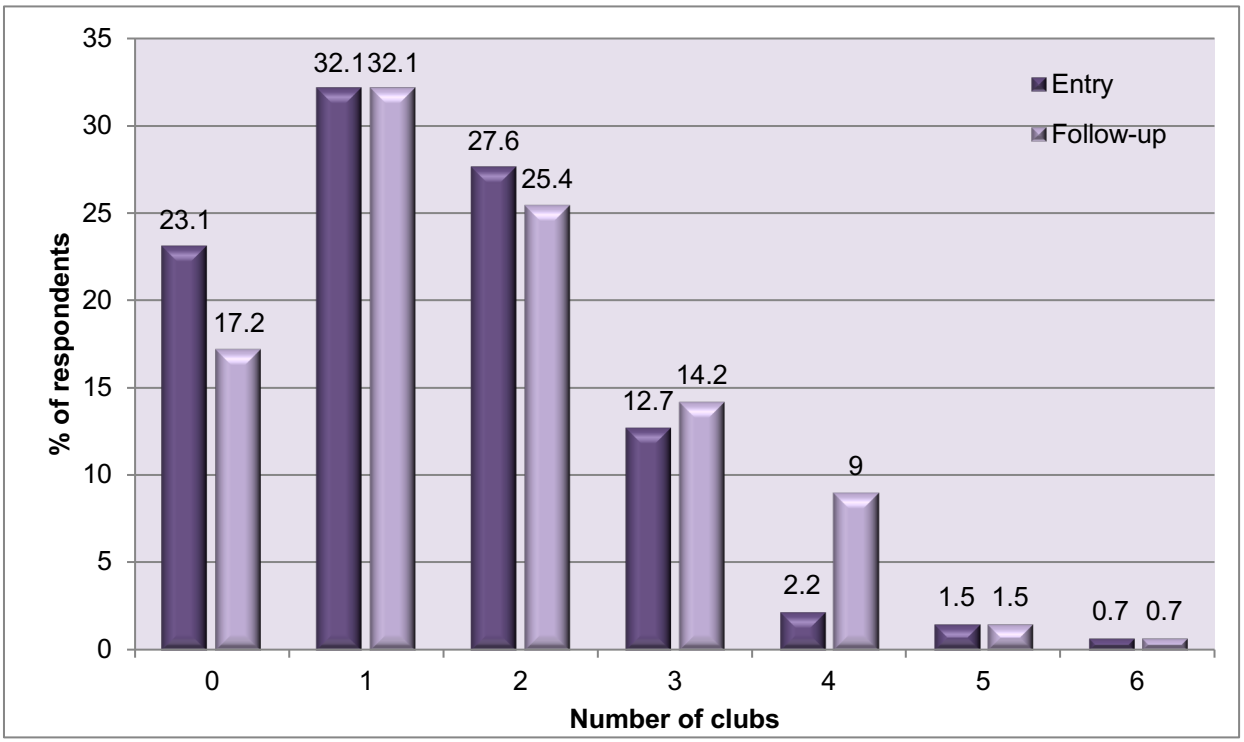

Figure 8 - Membership of clubs, organisations and societies

The CMF does not facilitate identifying whether the clubs of which participants are members are Brightlife clubs, other clubs or a mixture of both; however, the outcome suggests people have become more socially active since engaging with Brightlife. It should be noted this may reflect the reductions in loneliness indicated by the UCLA and de Jong loneliness scales.

4.4 In the last 12 months have you given any unpaid help in any of the ways shown below?

(Participants have 12 types of unpaid role from which to select their answer and may select more than one response).

One hundred and thirty-four (n=134) participants provided the number of voluntary roles they had undertaken both at entry and follow-up (see Table 10 and Figure 9). There was an increase in the average number of voluntary roles between entry and follow-up.

Table 10 – Participation in unpaid roles

No unpaid roles	No. participants entry	% participants entry	No. participants f.u.	% participants f.u.	% Change
0	56	41.8	49	36.6	-5.2
1	29	21.6	29	21.6	0
2	21	15.7	25	18.7	+3.0
3	12	9.0	14	10.4	+1.4
4	8	6.0	12	9.0	+3.0
5	1	0.7	4	3.0	+2.3
6	5	3.7	0	0	-3.7
7	1	0.7	0	0	-0.7
8	0	0	0	0	0
9	1	0.7	1	0.7	0
10	0	0	0	0	0
11	0	0	0	0	0
12	0	0	0	0	0
Total	134	100	134	100	

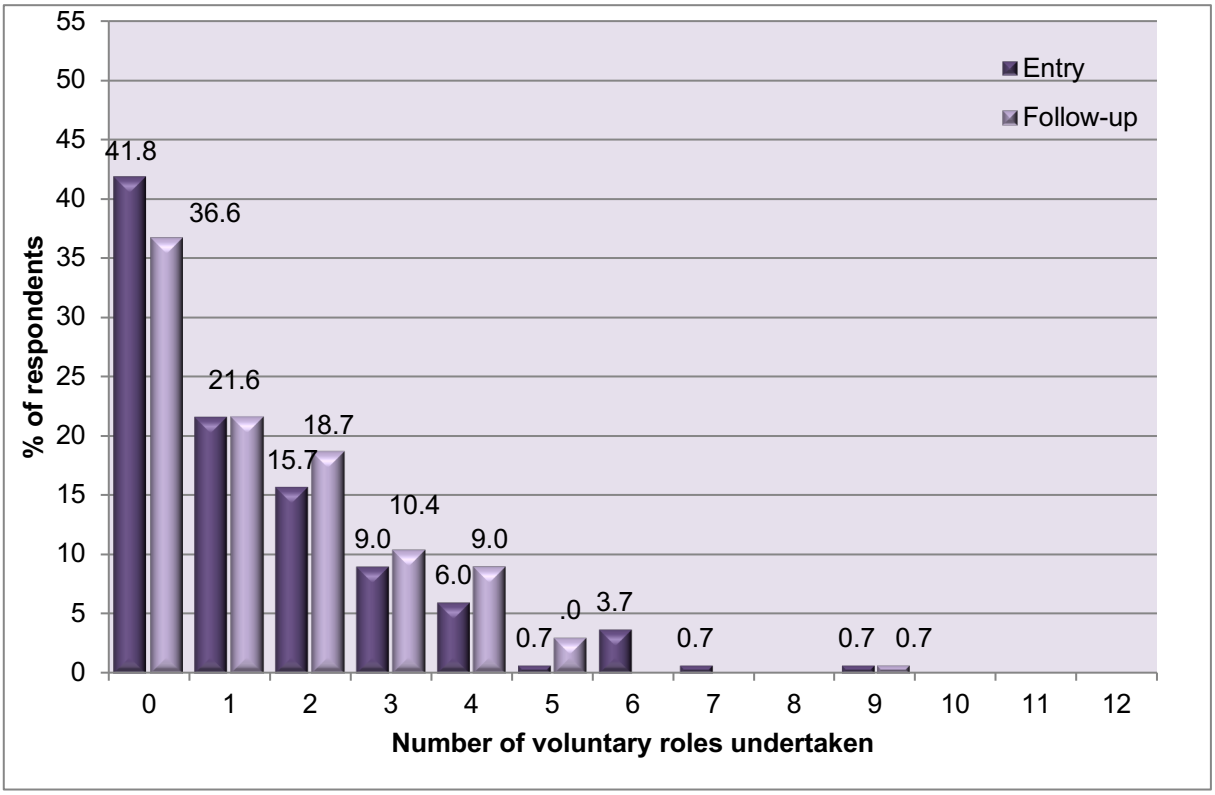

Figure 8 - Participation in unpaid roles

It is interesting to consider this outcome in the context of the next question (4.5)

4.5 Do you intend to volunteer in the future?

Participants were asked at entry to Brightlife and at follow-up whether they would be likely to undertake any voluntary work in the future. One hundred and thirty-seven (n=137) participants responded at entry and at follow-up (see Table 11 and Figure 10). At follow-up, there was a 3.7% increase in participants who would volunteer in the future.

Table 11 – Participants' intentions regarding voluntary work

Response	No participants entry	% participants entry	No participants follow-up	% participants follow-up	% Difference
Yes	41	29.9	46	33.6	+3.7
No	36	26.3	33	24.1	-2.2
Maybe	45	32.8	48	35.0	+2.2
Don't know	12	10.9	10	7.3	-3.6
Total	137	100	137	100	

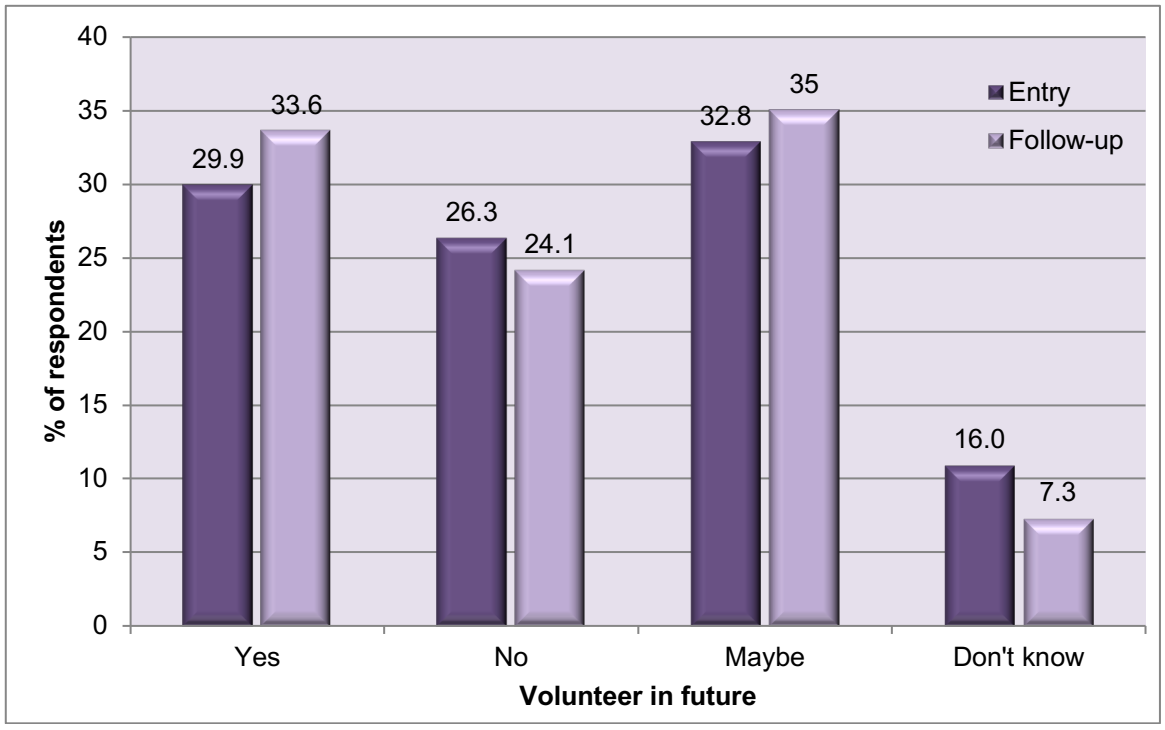

Figure 9- Participants' intentions regarding voluntary work

4.6 Points to consider

When evaluating the changes in the contacts participants have with family and friends it is useful to examine the overall picture. As an example, a greater percentage of participants both spoke with family and friends by phone three times a week or more and met face to face with them at follow-up compared to entry. This suggests a positive trend in the number of social interactions.

Additionally, although the percentage of participants having face-to face meetings with non-family every day, or almost every day, fell at follow-up, this reduction may have been offset by the increase in interactions with family and friends.

It is also important to consider the context of the questions relating to emailing and texting, it may be that some of the Brightlife participants do not have access to the Internet, hence emailing is not an option for them. It may also be some participants may prefer face-to-face and verbal communication rather than using digital methods. Brightlife has commissioned several services that aim to engage participants with IT and offer access to the Internet; as these services may influence the use of digital communication it will be useful to specifically track the responses of those who participate in these activities.

The increase in participants who intend to volunteer in the future is positive. It can be anticipated commissioned service providers will include the engagement of volunteers in sustainability strategies, thus encouraging more participants to become volunteers post engagement in a Brightlife funded activity. If this is successful, a greater increase in participants intending to volunteer may be evidenced at follow-up. It will be useful to continue to monitor this factor moving forwards, especially as volunteering is one method of individuals staying connected with the community and other people.

5 Wellbeing

5.1 EQ5D – 3L outcomes – pre and post participation in Brightlife

Participants are asked to complete the EQ5D questionnaire (EuroQol Research Foundation 1990), which measures self-rated health, at entry to Brightlife and at follow up. This questionnaire comprises five domains which, as well as exploring the participants' health status, also offers an indication of how this affects daily life. Table 12 shows participants' EQ5D scores at entry and follow-up (n=111), as well as indicating any changes that may be attributable to participation in Brightlife activities.

Table 12 - Participants' scores on the EQ5D wellbeing score at entry and follow-up

Domain	Level	No participants entry	% participants entry	No participants f.u	% participants f.u	% Change
Mobility	No problems	62	55.9	65	58.6	+2.7
	Some problems	49	44.1	45	40.5	-3.6
	Extreme problems	0	0	1	0.9	+0.9
	Total	111	100	111	100	
Self-care	No problems	97	87.4	95	85.6	-1.8
	Some problems	13	11.7	15	13.5	+1.8
	Extreme problems	1	0.9	1	0.9	0
	Total	111	100	111	100	
Usual activities	No problems	70	63.1	70	63.1	0
	Some problems	37	33.3	38	34.2	+0.9
	Extreme problems	4	3.6	3	2.7	-0.9
	Total	111	100	111	100	
Pain/ discomfort	No problems	45	40.5	37	33.3	-7.2
	Some problems	55	49.5	62	55.9	+6.4
	Extreme problems	11	9.9	12	10.8	+0.9
	Total	111	100	111	100	
Anxiety/ depression	No problems	66	59.5	74	66.7	+7.2
	Some problems	40	36.0	32	28.8	-7.2
	Extreme problems	5	4.5	5	4.5	0
	Total	111	100	111	100	

Breaking this scale into its constituent domains provides an indication of where participants' scores have improved or declined. Table 12 highlights participants' mobility has improved since entry to Brightlife, while a greater percentage report some problem with pain at follow-up than at

entry. There have also been reductions in the percentage of participants reporting anxiety/depression.

The EQ5D also utilises a visual scale EQVAS, which is similar to a thermometer; this is completed by participants to indicate health status on the day of completion. The scale runs from zero – worst imaginable health state to 100 - best imaginable health state. One hundred and seven (n=107) participants who completed the 5 question scale also completed the EQVAS at entry and follow-up. Table 13 and Figure 10 show participants' entry and follow-up scores, split into 5 point intervals for presentation.

Table 13 – EQ5D VAS scale scores at entry and follow-up

Score	No participants - entry	% participants - entry	No participants – f.u.	% participants – f.u.	% change
30 - 35	4	3.7	1	0.9	-2.8
36 - 40	5	4.6	4	3.7	-0.9
41 - 45	2	1.8	0	0	0
46 - 50	10	9.3	12	11.2	+1.9
51 - 55	0	0	0	0	0
56 - 60	11	10.3	6	5.6	-4.7
61 - 65	1	0.9	3	2.8	+1.9
66 - 70	11	10.3	17	15.9	+5.6
71 - 75	11	10.3	4	3.7	-6.6
76 - 80	20	18.7	19	17.8	-0.9
81 - 85	6	5.6	5	4.6	-1.0
86 - 90	11	10.3	19	17.8	+7.3
91 - 95	9	8.4	11	10.3	+1.9
96 - 100	6	5.6	6	5.6	0
Total	107	100	107	100	

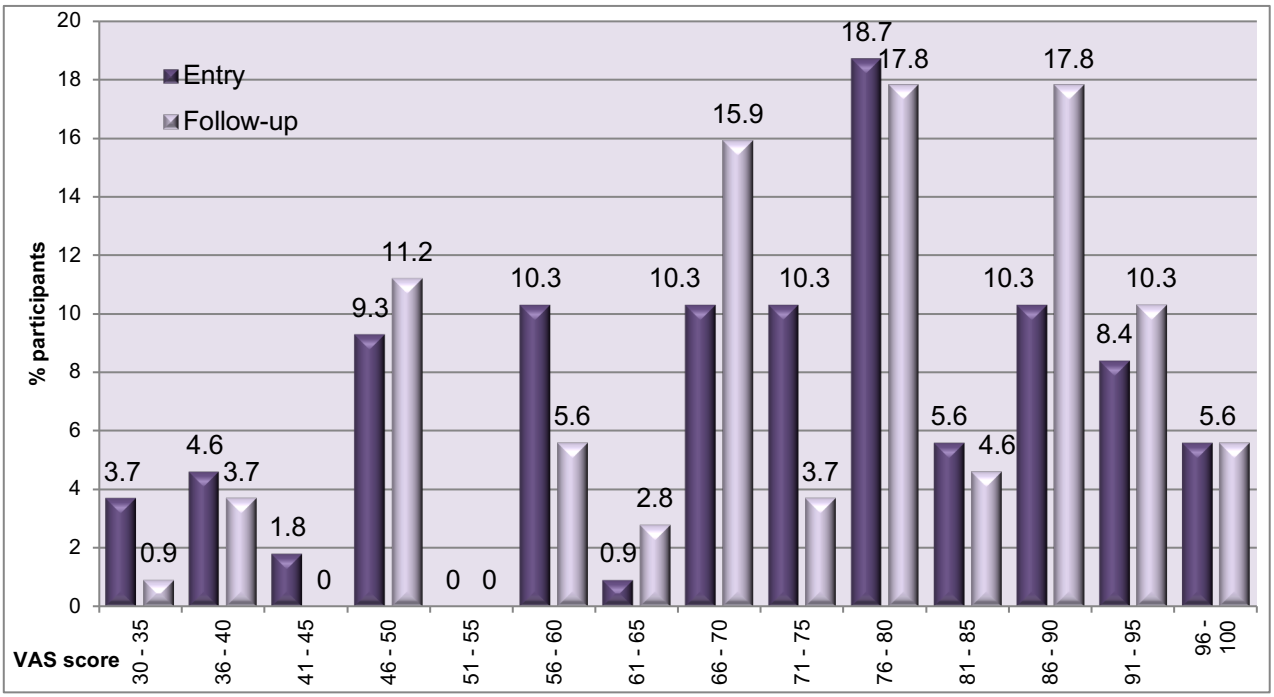

Figure 10 - EQ5D VAS scale scores at entry and follow-up

At entry to Brightlife 80.4% of participants scored 51 or more on the VAS this rose to 84.1% at follow-up.

5.2 Short Warwick and Edinburgh Mental Wellbeing Scale

One hundred and twenty-eight (n=128) participants completed the Short Warwick and Edinburgh Mental Wellbeing Scale (SWEMWBS) (NHS Health Scotland, University of Warwick and University of Edinburgh 2007) at entry and follow-up. There was a small increase in average scores between entry and follow-up; this suggests an improvement (not statistically significant) in mental wellbeing (see Table 14 and Figure 10).

Table 14 – SWEMWBS scores

SWEMWB score	No. participants entry	% participants entry	No. participants f.u	% participants f.u	% Change
7.00	0	0	0	0	0
9.51	0	0	1	0.8	+0.8
11.25	1	0.8	0	0	-0.8
12.40	0	0	0	0	0
13.33	1	0.8	1	0.8	0
14.08	0	0	1	0.8	+0.8
14.75	0	0	0	0	0
15.32	0	0	1	0.8	+0.8
15.84	1	0.8	0	0	-0.8
16.36	0	0	0	0	0
16.88	1	0.8	3	2.3	+1.5
17.43	5	3.9	2	1.6	-2.3
17.98	10	7.8	3	2.3	-5.5
18.59	6	4.7	6	4.7	0
19.25	11	8.6	12	9.4	+0.8
19.98	3	2.3	5	3.9	+1.6
20.73	8	6.3	10	7.8	+1.5
21.54	12	9.4	9	7.0	-2.4
22.35	10	7.8	7	5.5	-2.3
23.21	6	4.7	8	6.3	+1.6
24.11	15	11.7	15	11.7	0
25.03	6	4.7	11	8.6	+3.9
26.02	5	3.9	8	6.3	+2.4
27.03	5	3.9	5	3.9	0
28.13	5	3.9	3	2.3	-1.6
29.31	6	4.7	2	1.6	-3.1
30.70	3	2.3	3	2.3	0
32.55	2	1.6	2	1.6	0
35.00	6	4.7	10	7.8	+3.1
Total	128	100	128	100	

The SWEMWBS may also be interpreted by comparing participants' outcome with other populations; in this instance the general population of CWaC and of England. Champs (2013) state that, as measured on the SWEMWBS, the population average (all ages) in 2012/13 for the

North West of England was 27.66 and 27.86 for Cheshire West and Chester. Thus, Brightlife participants' level of mental wellbeing (23.08 at entry and 23.49 at follow-up) is lower than that of both those populations.

5.3 Points to consider

It should be considered that, given the demographic composition of the Brightlife cohort, 31.6% (n=131) are aged 80 or over, large improvements in physical health conditions may not be feasible and preventing further decline may be a positive outcome. A positive trend is evidenced in participants' mental wellbeing; at follow-up a greater percentage of participants reported having no problems with anxiety/depression as measured by EQ5D, although only a small difference was detected by the SWEMWBS.

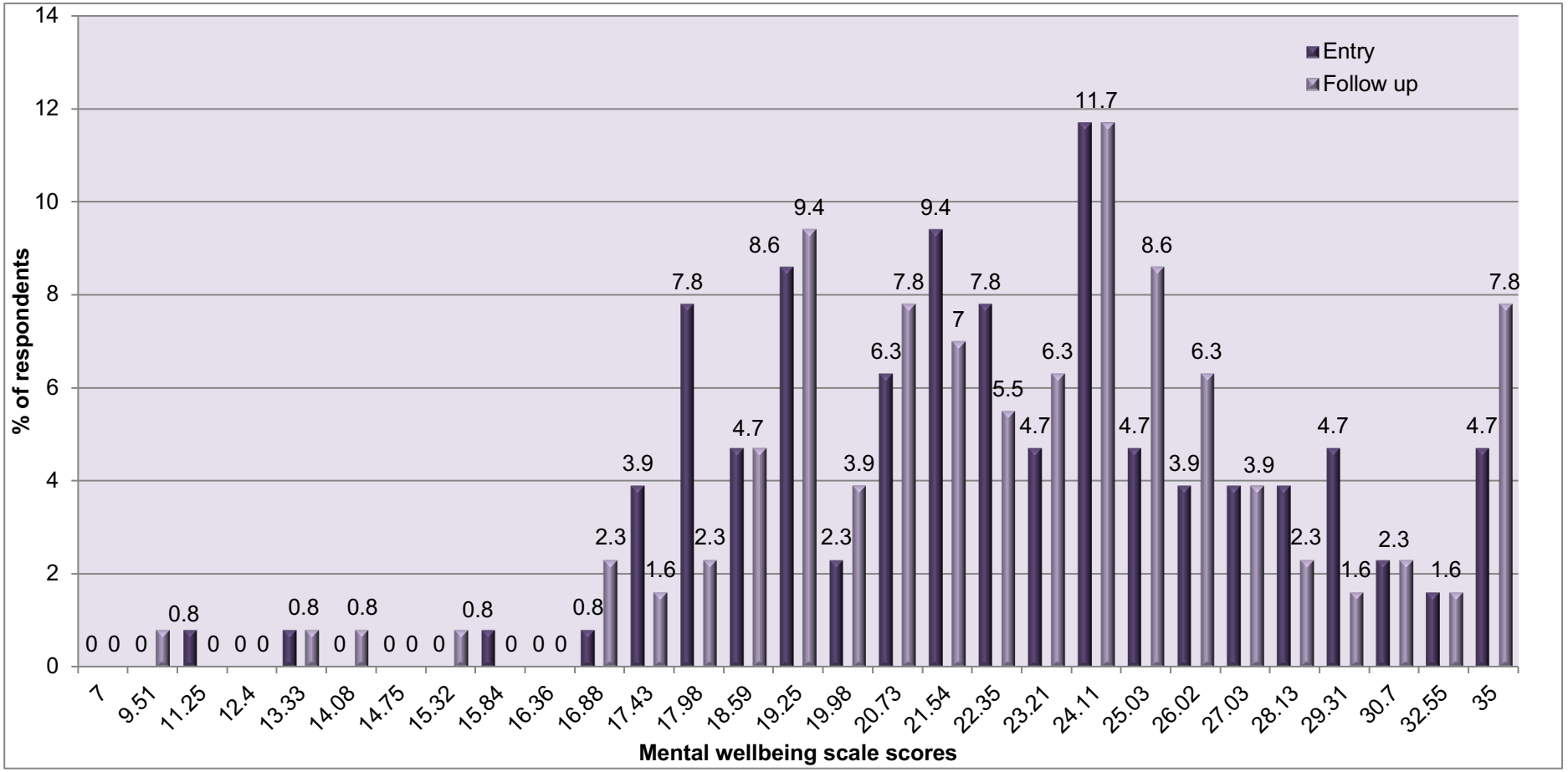

Figure 11 – SWEMWBS scores

6. Recommendations

The following recommendations for consideration by the Brightlife partnership are made:

- All commissioned service providers should screen potential participants to identify whether they fall within the Brightlife target population. The University evaluation is able to identify entry data by provider so it will be possible to ascertain the effectiveness of the screening methods.

- Liaison with commissioned service providers regarding the completion of the CMF should continue; moving forwards providers of Bright Ideas services should also be included in this liaison. Additionally, how to successfully engage commissioned service providers in data collection is valuable information and should be included in the material held on the Brightlife Repository.

- Brightlife evidences good engagement with people who have long term health conditions and with those who live alone; both groups are at risk of social isolation. It would be valuable to follow-up these recruitment successes with the aim of identifying the techniques used to engage with individuals from these groups. Again, this should yield useful information for inclusion in the Brightlife Repository.

- Completion of follow-up CMFs by Social Prescribers should be re-visited to facilitate the assessment of social prescribing during the lifetime of Brightlife, which is consistent with the ethos of “test and learn”.

- In a forthcoming work stream the University evaluation team intend to focus on volunteers and volunteering; this will facilitate identifying why older people have volunteered and what encouraged them to continue volunteering. This information can be utilised by commissioned service providers to develop sustainability strategies and will also be valuable information for inclusion in the Brightlife Repository.

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