Assessing the Impact of the LinkAge hub in Whitehall and St.George, Bristol:

Briefing Report

Richard Kimberlee and Robin Means

May 2013
Contents:

Contents Page 2
Key Points Page 3
What is this report about? Page 6
Background Page 7
Impact Assessment Page 8
The LinkAge Tool Page 9
The Background Page 11
The Results Page 11
Causal Explanation Page 17
Social Return On Investment Page 18
Moving Forward Page 22

References Page 24
Appendix 1: Abbreviations Page 27
Appendix 2: Follow-up Tool Page 28
Key Points:

Since the government’s Comprehensive Spending Review policy makers have increasingly anticipated that third sector Social Purpose Organization’s (e.g. LinkAge) mission should be to develop and promote innovative services to address local needs.

Through hubs LinkAge have sought to empower older people to fulfil their ambitions to enable them to influence local developments or to support them to design and set up new groups and activities that meet the interests and aspirations of local older people. This report looks at the social and economic impact of one hub: Whitehall and St. George, Bristol.

The LinkAge approach meets with current agendas established by the Marmot Review (2010) *Fair Society, Healthy Lives*, which reinforced the importance of handing over responsibility and control for promoting healthier lives to local communities and it also chimes well with current policies on adult social care with its emphasis upon active citizens and capable communities.

An impact tool using validated items was developed following extensive field work with LinkAge beneficiaries and stakeholders. This included 3 focus groups with 19 LinkAge beneficiaries, 2 further focus groups with 11 stakeholders involving: volunteers, befrienders and local advisory members. And, an additional 15 one-to-one structured interviews with key stakeholders identified by LinkAge, Bristol.

The impact tool used validated items to assess impact of beneficiary engagement on: their experience of social isolation (the Friendship Scale), well-being (Office for National Statistics *Happiness Index*), physical activity (International Physical Activity Questionnaire) and health (Self report on medications).

155 beneficiaries at the hub have attended a LinkAge activity more than once. 41 (26%) had completed a baseline questionnaire and 30 (19%) a follow up six months later. Our assessment of impact is based on the latter.

The LinkAge hub primarily supports women (90%, n=37) and 10% (n=4) have a self-defined BME identity. 10% (n=4) say they are disabled of which half (n=2) receive some kind of benefits. Significantly, the majority of hub beneficiaries live alone (75%, n=17) and in accommodation owned by themselves (71%, n=17). All beneficiaries are over fifty and the majority are in the sixties or seventies (71% n=15).

In terms of people in the hub, a third (33%, n=10) of the beneficiaries are already defining themselves as socially connected when they commence their LinkAge activities. But a half (50%, n=15) are declaring themselves to be very ‘socially isolated’ at baseline. This is extraordinarily high and suggests that the outreach work around the hub is bringing in beneficiaries that feel very isolated in their local communities. A key aim of the LinkAge approach.

Data obtained from using the LinkAge tool showed that the mean Friendship Scale scores moved from an average of 14.53 on the scale indicating ‘isolated or with a low level of social support’ at baseline to 22.5 ‘very or highly socially connected’ at follow up. There was a statistically significant increase in socially connectedness scores from baseline (M=14.3, SD=7.21) to follow up (M=22.8, SD=3.69), t=-6.602, p=<0.000 (two tailed). The mean increase in Friendship Scale scores was 8.3 with
a 95% confidence interval ranging from -10.82 to -5.70. The eta square statistic of 0.6 indicates a large effect size.

Looking at Office for National Statistics (ONS) Well-being indicators LinkAge beneficiaries reported that they are experiencing improved well-being on all four national indicators of the ONS ‘Happiness Index’ that is now being used by governments to guide national and European policy. On three of the four indicators beneficiaries showed statistically significant changes (p= <0.001) with large eta effect scores.

There is also clear evidence for an increase in beneficiary’ physical activity. An impact identified by established beneficiaries but not by stakeholders. The number of days of activity a LinkAge beneficiary spends in moderate exercise from baseline (M=3.3, SD=2.83) to follow up (M=4.93, SD=2.30) has increased. This is a statistically significant (t=-2.874, p= <0.008, two tailed) improvement. The mean increase in days spent doing moderate exercise was 1.63 with a 95% confidence interval (-2.796 to -471). The eta square statistic of 0.22 indicates a large effect size. So beneficiaries are more active on 1.6 days week after engagement with the hub.

This is important because our deadweight assessment in the social return on investment (SROI) analysis suggests that these beneficiary improvements at the LinkAge hub is counter to physical activity rates and trends in the St George housing partnership area and across Bristol as whole; i.e. their increase in physical activity is opposite to a general decrease in physical activity rates in their local community and across Bristol. And we are making comparisons here with the adult population as whole on this indicator.

Based on project costings, added value and assumptions around deadweight, displacement and attribution we calculate that for every £1 invested in the Whitehall and St. George Hub there is a SROI of £1.20. This is a considerable return and in our view it is probably an underestimation of the potential return in the medium term.

Why is this? The hub is only in its first year of existence. A considerable amount of time was spent bedding down activities and developing beneficiary confidence in the activities and the approach. So a lot of volunteer and community development worker time was spent in ‘starting up’ rather than in delivery. As we write new beneficiaries continue to join the hub and new activities are planned. Thus, simply through increased throughput the return on investment, ceteris paribus would increase until a ceiling in membership is reached.

Also, the impact of hub engagement on beneficiary health is probably underestimated in our calculations. To get an accurate assessment of health impact we would need permission to examine beneficiary medical records and follow beneficiaries over a longer period. Clearly there was insufficient resource to do this in a small scale analysis. In the absence of this data we have therefore followed SROI practice and been parsimonious in our calculations around values stemming from health improvement. Again it is our view that these improvements would probably be greater than we have allowed for in this analysis.

Finally, our SROI analysis shows that a lot of added value comes from the staff and the volunteers who run and support the Hub. This ingredient should be recognised and planned for in future roll out of any LinkAge hub across the city. We suggest that local contextual effects in extracting value
from local volunteers is a key factor in determining effective change and value for money in improving local people’s health and well-being. On the whole beneficiaries tend to attribute improved well-being to their community development worker and local volunteer rather than the LinkAge approach *per se*.

Replication of this research in another Hub could help to provide decision makers with broader evidence of the effectiveness of the LinkAge approach to cost-effectively address the well-being needs of older people. It will help us to see whether this research was simply a one-off result because of the context of the Hub and the dedicated staff it engaged in service delivery.
What is this report about?

This is a briefing report. Briefing reports are typically used to keep those who make decisions appraised of an issue they wish to focus on. They are often used to appraise an organization of a particular project or piece of work. LinkAge, Bristol commissioned this report to support them in evaluating the impact of their work in the Whitehall and St George area. This document briefly outlines the local hub organization in this area, the methods adopted to measure impact, the results of the analysis and the social return on investment of the work of this hub.

What is LinkAge?

LinkAge has existed in Bristol since 2007. The LinkAge programme aims to promote and enhance the lives of older people (55+ years old) through the facilitation and the development of a range of activities. Their approach includes fostering social awareness and encouraging older people to share their skills with volunteers, young people and others within their community. LinkAge aims to inspire older people and others to share their time and experiences with other older people who for one reason or another have become isolated.

The vehicle for driving the programme are ‘beneficiary’ led Hubs. By beneficiary we mean a service user who has attended a LinkAge meeting or activity more than once. Hubs are supported by a paid Community Development Worker (CDW) who develops activities, primarily through encouraging and promoting beneficiary engagement. This often involves outreach work. Through hubs LinkAge seek to empower older people to fulfil their ambitions to enable them to influence local developments or to support them to design and set up new groups or activities that meet the interests and/or aspirations of local older people. Since its inception LinkAge has developed four active hubs and has a long term aim of developing more hubs across Bristol. One for each of Bristol’s fourteen Neighbourhood Partnership Areas.

Evaluation of impact is key to fostering LinkAge’s development and it previously commissioned an evaluation from the Evaluation Society. Their report highlighted significant achievements and concluded that most stakeholders were very positive about the programme (Edgington and Baker, 2010, p4). This report, also, highlighted the importance of developing their brand identity and documenting their success and failures to support their development and document their journey (Edgington and Baker, 2010, p6).

LinkAge in Bristol is supported by a range of partners including Bristol City Council, St. Monica Trust, the Guinness Trust and the Anchor Society. Since the government’s last Comprehensive Spending Review policy makers have increasingly anticipated that third sector Social Purpose Organization’s (SPOs) mission should be to develop and promote new innovative services to address need. They have been encouraged to foster what is sometimes called ‘the Big Society’ (Norman, 2010) where people can benefit from active involvement with their local community. It is anticipated that bespoke services like those developed by LinkAge hubs could be a cost effective way of addressing need (Cameron, 2011). Innovation is key to ‘the Big Society’ model and LinkAge is seen as offering this potential (Edgington and Baker, 2010, p32). Their approach meets with current agendas established by the Marmot Review (2010) Fair Society, Healthy Lives, which reinforced the
importance of handing over responsibility and control for promoting healthier lives to local communities and it also chimes well with present policies on adult social care with its emphasis upon active citizens and capable communities (Department of Health, 2010) but in doing so it is important that SPOs demonstrate impact and value. In the South West, the South West Forum, the regional voice for the voluntary and community sector, is directly urging SPOs to: Prove Our Value (South West Forum, 2011, Accessed 1st July 2011).

Thus, proving value and demonstrating impact is pertinent to promoting and developing the LinkAge approach. This consultancy research built on the interesting qualitative evaluation work undertaken by the Evaluation Trust and extends it to tackle the challenge of establishing value and impact. In fact the Marmot review (2010) stressed that the sustainability of innovation requires the development of an evidence base on effectiveness since this is a pre requisite to continued funding support. There is growing evidence that the right preventive interventions at the right time can yield not only benefits to older people but also financial benefits. The challenge is to demonstrate whether or not short-term investments can lead to a better quality of life and prevent the need for more costly interventions later in life.

Background

This briefing report summarises consultancy research undertaken to assess the impact of one LinkAge hub. The Whitehall and St.George hub was chosen because this hub was just commencing its activities in September 2011 when this work was commissioned. Over the first twelve months of the Whitehall and St.George hub’s existence LinkAge has contributed to and developed a range of activities for beneficiaries to enjoy. These include:

- Walking Group
- Coffee morning
- LinkAge Lunch Club
- LinkAge film club
- Tai Chi classes
- Computer courses for beginners
- Line dancing
- Gentle exercise classes

In order to track impact over time we advised to Whitehall and St.George to develop a database and introduce a registration scheme so it could more clearly track the range of activities it was facilitating and who was using them. A registration form collecting basic demographic and referral information was devised and beneficiaries were invited to complete the form. However, access to a LinkAge event was not dependent on completing this form. The registration form is available for use in all LinkAge hubs across the city. It will assist LinkAge to develop beneficiary profile information to use in reports and to present to future commissioners.
Impact assessment

Over time LinkAge and the LinkAge co-ordinator had witnessed and received feedback on the benefits gained from involvement with LinkAge activities. Basic service user questionnaires had collected anecdotal evidence that LinkAge events had:

- Facilitated friendship
- Improved well-being

This consultancy research aimed to assess whether this remained the picture after more in depth scrutiny and whether other latent effects which could be identified. It also sought to assess the financial value of social impact. With a limited budget available to the consultancy there were insufficient resources to do this in any depth. Randomised controlled trials (RCTs) with full cost benefit analysis were impossible. Nevertheless a rigorous plan was adopted to develop a tool using validated items to assess impact.

To understand the extent of impact on the lives of beneficiaries qualitative methods are often used to capture people’s theories of change (Cabinet Office, 2011). This was one of the approaches adopted in this consultancy since we wanted to understand what beneficiaries felt had changed by getting involved with LinkAge? Through focus groups and in depth interviews the views of beneficiaries and stakeholders were assessed. Three focus groups with 19 beneficiaries already active on LinkAge activities from Whitehall and St. George Hub and other LinkAge hubs in Bristol were undertaken in October 2011. This report refers to these people as established beneficiaries. Two further focus groups with 11 stakeholders involving volunteers, befrienders and local advisory members were undertaken. And, an additional 15 one-to-one structured interviews with stakeholders was carried out and these included members of the Anchor Society, Guinness Trust, Bristol City Council Adult Social Care Services, Bristol PCT and community members.

An Impact Map was devised to analyse established beneficiary and stakeholder theories of change. What was very clear was that stakeholders and beneficiaries were universal in their belief that the biggest impact of LinkAge activities was that it helped to promote friendship and reduce loneliness. And as a result their well-being was enhanced. However, beneficiaries also reported that there were also concomitant improvements in their physical health, something stakeholders were less likely to identify or reflect upon. The quote below is illustrative of common beneficiary views:

> When he first started coming here six months ago he would just sit there in his wheelchair (a mobility scooter). Wouldn’t do much or say much. He just sat there. Then one day everyone was doing something in the hall and I looked round and he got off his chair, stood up and started painting. Now he spends less and less times in his chair and even though he still comes with it he is now walking around and helping out like everybody else. (Established beneficiary 1)
The LinkAge tool

This initial research with established beneficiaries and stakeholders identified three potential broad impact areas which were:

- Facilitated friendship
- Improved well-being
- Improved physical health

The second stage of the research involved developing a tool to assess the level of impact in each of these three areas experienced by new beneficiaries of activities developed by the Whitehall and St George hub. When assessing impact in this way it is important to use validated items to measure impact wherever possible. This is principally because, they have been rigorously tested to ensure they actually assess impact and because there are population standards to which comparisons can be made. However, the choice of appropriate items for the tool had to meet important expediency challenges. Firstly the tool needed to be as brief as possible. It was to be delivered in activity settings either pre or post an activity when available time might be limited. Secondly, it needed to be as user friendly as possible because they were to be administered by the CDW and not by a researcher. As evaluation of public health interventions becomes routine, tools are increasingly being used to assess impact in this kind of way. Given that many elderly people are frail, it is important that such tools are as parsimonious as possible to minimise response resistance since this frequently correlates with questionnaire length (Dillman, 1978; Yammarino et al., 1991). Our work in developing national wellbeing indicators around health and wellbeing for the third sector (South West Forum, 2011) has shown that tools need to be as simple and user friendly as possible in order to foster the necessary culture of change required for SPOs to embrace evaluation techniques as a matter of routine. Anything too onerous would be asking too much of local staff.

i) Facilitated Friendship

The initial qualitative research had clearly shown that friendship and socialising is seen as a key impact of LinkAge’s work. The Friendship Scale is a short, user-friendly scale and hence met the requirements. Its psychometric properties suggest that it has excellent internal structures as assessed by structural equation modelling (CFI = 0.99, RMSEA = 0.02); that it possesses reliability (Cronbach a = 0.83) and discrimination when assessed against two other short social relationship scales (Hawthorne, 2006). So we anticipated that this item would help LinkAge to assess the extent they had addressed social isolation. Although many older people retain strong social networks, social isolation is a major issue for a significant minority and can be particularly deleterious. It is known that people who are socially isolated suffer worse health status and have a higher consumption of health care resources (Ellaway et al., 1999). And given that in later life many older people are seen as facing a network of loneliness, social isolation and neglect (Baltes and Smith, 1999) and in later life this can be related to difficulties with mild cognitive impairment, performance of daily living activities, declining health status and partner loss (van Oostrom et al., 1995). Many of the activities of LinkAge’ hubs could potentially be addressing these key health concerns about isolated older people.
ii) Improved Wellbeing

To assess impact on improved wellbeing we decided to use the newly developed Office for National Statistics (ONS): Wellbeing indicators. They are popularly referred to as ‘the Happiness Index’ (Sedgi, 2012); because they are officially seen as a means of measuring well-being and were designed to complement traditional economic indicators of national well-being such as the Gross Domestic Product (GDP). The indicators are a culmination of survey work with over 200,000 people in the UK and the four questions below are being used by civil servants to assess the impact of government policies on the wellbeing of the population (Dolan, et al 2011):

- Overall, how satisfied are you with your life nowadays? (Evaluation measure)
- Overall, how happy did you feel yesterday? (Experience measure)
- Overall, how anxious did you feel yesterday? (Experience measure)
- Overall, to what extent do you feel the things you do in your life are worthwhile? (Eudemonic measures)

The key benefit of using these items is that our local data can be compared to national scores and comparisons can be drawn.

ii) Improved Physical Health

To measure impact on physical health beneficiaries were asked to respond to two questions. The first asked beneficiaries to outline the number of days a week they undertook moderate exercise (e.g. brisk walking) for 30 minutes or more. This item is taken from the International Physical Activity Questionnaire (IPAQ). The IPAQ was developed for surveillance activities and to guide policy development in relation to health-enhancing physical activity. The questionnaire was developed between 1997 and 1998, by an International Consensus Group and was intended as an instrument for cross-national monitoring of physical activity and inactivity; and to assess changes across time in national settings. It has reasonable measurement properties for monitoring population levels of physical activity among 18- 65 year old adults in diverse settings (Craig et al, 2003). We have used the short form of the IPAQ before including with people aged over 65 (Jones and Kimberlee, 2012). But for LinkAge’s purpose we decided to use just one item that is well designed to pick out moderate levels of exercise because the focus group work suggested that there were very low levels of physical activity amongst established beneficiaries at the commencement of engagement. We believed that any increased physical activity across time could be effectively captured through this one item. Secondly, beneficiaries were also asked to inform us whether or not they had any changes in medication since they had engaged with LinkAge activities.
New beneficiaries gave permission for the tool to be completed soon after starting their LinkAge activity and in most cases for tool completion to be repeated about six months later. The CDW and two different researchers assisted in this process. Accessing beneficiaries was challenging because there were insufficient time resources available to sit down with beneficiaries to complete the tool. In order to effectively capture beneficiary responses the interviewer would need to spend between 10 - 30 minutes going through the items and getting their responses. This needed to be done on a one to one basis. This proved more challenging for the follow up questionnaires as beneficiaries would often have a lot to talk about with regards to their experiences and their life. It was initially planned that the CDW would deliver this element of the project, but as the Social Return On Investment (SROI) shows the CDW had only limited time resources to deliver on the evaluative element of the project as the CDW was already adding value supporting the project beyond the days agreed in terms of employment commitment. Instead two volunteer graduates were used to undertake the baseline and follow-up interviews with additional follow-up interviews being delivered by the researcher.

The beneficiaries

Who are the beneficiaries? Local attendance data at this hub suggest that since the project’s inception in September 2011, 155 beneficiaries have attended a LinkAge activity more than once. At the time of analysis the researchers and the CDW had obtained registration details on 42 (27%) people from the Hub. Of which 41 (26%) had completed a baseline questionnaire and 30 (19%) a follow up. What we know from the registration data is that the hub primarily supports women (90%, n=37) and 10% (n=4) have a self-defined BME identity. 10% (n=4) say they are disabled of which half (n=2) receive some kind of benefits. The majority of hub beneficiaries live alone (75%, n=17) and in accommodation owned by themselves (71%, n=17). All beneficiaries are over 50 and the majority are in the sixties or seventies (71% n=15).

Figure 1: Age ranges of Whitehall and St George Hub

Most of the beneficiaries say they heard about the project through word of mouth with a few suggesting that they were referred by their GP or health professional.
The results

As already indicated, we know from the focus group and interviews with established beneficiaries and stakeholders there are three definite benefits that could accrue to new beneficiaries.

- Improved friendship
- Improved well-being
- Improved physical health

Improved friendship

Given that the majority of established beneficiaries in the first phase of the research reported that the major issue they face is isolation and feelings of loneliness our tool set out to measure their feelings both at the start of their experience of the hub and six months after they joined. The Friendship Scale scores beneficiaries on their perception of isolation. Scores range from 0 to 24. The higher an individual score the greater the degree of social connectedness, and the lower the score the greater their social isolation. In addition to the summated scale scores, Friendship Scale scores divide the population into 5 levels, where each represents a different level of social connection-isolation. The associated levels are:

- 0-11: Very socially isolated
- 12-15: Isolated or with a low level of social support
- 16-18: Some social isolation or some social support
- 19-21: Socially connected; and
- 22-24: Very or highly socially connected.

Table 1: Summated average scores on the Friendship Scale for new beneficiaries

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Follow up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>14.53</td>
<td>22.8</td>
</tr>
<tr>
<td>Mode</td>
<td>8</td>
<td>24</td>
</tr>
<tr>
<td>Range</td>
<td>21</td>
<td>15</td>
</tr>
</tbody>
</table>

The table above clearly shows that the mean Friendship Scale scores moved from an average of 14.53 on the scale indicating ‘isolated or with a low level of social support’ at baseline to ‘very or highly socially connected’ at follow up. The modal score (i.e. the score obtained by most people) increased from 8 to 24. However the range of scores condenses across time, at baseline there are a broad range of scores across the five levels but this range narrows at follow up.
Table 2: Baseline and Follow up Friendship scores

<table>
<thead>
<tr>
<th>Degree of isolation</th>
<th>Friendship Scale Score</th>
<th>% of Population Aged 60+*</th>
<th>Number of beneficiaries with this score at Baseline (n=30)</th>
<th>Number of beneficiaries with this score at Follow up (n=30)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very socially isolated</td>
<td>0 - 11</td>
<td>4.8%</td>
<td>50% (n=15)</td>
<td>0% (n=0)</td>
</tr>
<tr>
<td>Isolated or with a low level of social support</td>
<td>12 - 15</td>
<td>10%</td>
<td>10% (n=3)</td>
<td>3% (n=1)</td>
</tr>
<tr>
<td>Some social isolation or some social support</td>
<td>16 - 18</td>
<td>6%</td>
<td>6% (N=2)</td>
<td>6% (n=2)</td>
</tr>
<tr>
<td>Socially connected</td>
<td>19 - 21</td>
<td>87.3%</td>
<td>26% (N=2)</td>
<td>26% (n=8)</td>
</tr>
<tr>
<td>Very or highly socially connected</td>
<td>22+</td>
<td>26%</td>
<td>26% (n=8)</td>
<td>63% (n=19)</td>
</tr>
</tbody>
</table>


Table 2 tells us quite a few things. In terms of people joining the hub a third (33%, n=10) of the beneficiaries are already defining themselves as socially connected when they commence LinkAge activities. They have busy active lives and do not feel isolated. In attending the LinkAge hub at Whitehall and St. George they have found activities they enjoy but it is just one component in their weekly routine of activities and lifestyle that they enjoy at this stage in their life.

‘I come along for the walks, when I feel like it, but I am tired today because I had my grandchildren to look after at the weekend and coming here gives me something to do during the week when I am not looking after them.’ (New beneficiary 12)

But a half (50%, n=15) are declaring themselves to be very ‘socially isolated’ at baseline. This is extraordinary high and suggests that the outreach work around the hub is bringing in beneficiaries that feel very isolated and that they benefit from the connectedness that the Hub offers. By the end of follow up the number of people who feel that they are connected increases from 33% (n=10) to 89% (n=27). This is a significant improvement. A paired samples t-test was conducted to evaluate the impact of the LinkAge intervention on beneficiary’ Friendship Scale scores. There was a statistically significant increase in socially connectedness scores from baseline (M=14.3, SD=7.21) to follow up (M=22.8, SD=3.69), t=-6.602, p<0.000 (two tailed). The mean increase in Friendship Scale scores was 8.3 with a 95% confidence interval ranging from -10.82 to -5.70. The eta square statistic of 0.6 indicates a large effect size.
Our interviews with current beneficiaries yielded almost universal agreement that the main reason why they attend the hub is to access friendship and end their sense of isolation.

*It’s about getting out and meeting up and chatting. If I didn’t come here most days I wouldn’t see a soul. My children live a long way away and have their own families now so they can’t be around me. They call but I need to see real people and spend time with them.* (New beneficiary 22)

*We have a good chat over a cup of coffee, there is always someone coming in and everyone here are always very welcoming* (New beneficiary 5)

**Improved well-being**

It has always been our experience that improvements made through a holistic service approach in one area (e.g. mental health/loneliness) can provide wider health benefits for beneficiaries in other areas (e.g. wellbeing, changed diets, enhanced social capital scores etc.) (Jones and Kimberlee, 2011). Interviews with established beneficiaries and stakeholders suggested that the interventions primary aim of addressing isolation and loneliness was also impacting on the well-being of participants. Table 3 shows strong improvement on ONS well-being scores.

<table>
<thead>
<tr>
<th>Overall, how satisfied are you with your life nowadays?</th>
<th>Baseline</th>
<th>Follow up</th>
<th>ONS (2012) National scores for all adults*</th>
<th>ONS (2012) National indicators for people aged 65-69*</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.67 (Range 0-10)</td>
<td>8.0      (Range 4-10)</td>
<td>7.4</td>
<td>7.8</td>
<td></td>
</tr>
<tr>
<td>Overall, how happy did you feel yesterday?</td>
<td>5.63 (Range 0-10)</td>
<td>8.13 (Range 4-10)</td>
<td>7.3</td>
<td>7.7</td>
</tr>
<tr>
<td>Overall, how anxious did you feel yesterday?</td>
<td>2.03 (Range 0-8)</td>
<td>1.6 (Range 0-8)</td>
<td>3.2</td>
<td>2.9</td>
</tr>
<tr>
<td>Overall, to what extent do you feel the things you do in your life are worthwhile?</td>
<td>5.7 (Range 0-10)</td>
<td>8.33 (Range 4-10)</td>
<td>7.6</td>
<td>7.8</td>
</tr>
</tbody>
</table>

*Population norms obtained from ONS (2012). This age range was chosen because the majority of the Hub’s beneficiaries are aged 60-69. The range scores of 0-10 also confirm that there are people accessing the services who are already experiencing a sense of well-being.*
Please note on these items new beneficiaries are asked to score their well-being so that 0 = 'not at all' and 10 is 'completely'. Looking at the data beneficiaries are reporting that they are experiencing improved well-being on all four national indicators of the so called ‘Happiness Index’ that will be used to guide national policy in the future. The baseline scores show that overall the beneficiaries scored lower than the national adult average on these indicators at the start of their engagement with the LinkAge hub; and later they were scoring higher than the national adult scores and also for people aged 65-96. On the whole older and young people tend to report higher levels of well-being. There is a ‘U shape’ relationship between the ‘life satisfaction’ ‘worthwhile’ and ‘happiness yesterday’ questions and age. This means that younger and older adults in the UK report higher levels to these questions on average than people in their middle years. Highest levels were for those aged 16 to 19 and aged 65 to 79 (ONS, 2012). Also people in the South West and South East of England report higher scores on these than anywhere else in the UK (ONS, 2012).

Table 4: t-test and eta scores on responses to the ONS Well-being Index (n=30)

<table>
<thead>
<tr>
<th></th>
<th>Mean difference</th>
<th>t-test value</th>
<th>Eta score and effect</th>
<th>Significance and value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall, how satisfied are you with your life nowadays?</td>
<td>2.33</td>
<td>-3.892</td>
<td>0.34</td>
<td>Large effect</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Significant p= &lt;0.001</td>
</tr>
<tr>
<td>Overall, how happy did you feel yesterday?</td>
<td>2.37</td>
<td>-3.922</td>
<td>0.346</td>
<td>Large effect</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Significant p= &lt;0.000</td>
</tr>
<tr>
<td>Overall, how anxious did you feel yesterday?</td>
<td>0.43</td>
<td>-0.729</td>
<td>0.017</td>
<td>Small effect</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Not significant p= &lt;0.472</td>
</tr>
<tr>
<td>Overall, to what extent do you feel the things you do in your life are worthwhile?</td>
<td>2.63</td>
<td>-3.938</td>
<td>0.348</td>
<td>Large effect</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Significant p= &lt;0.000</td>
</tr>
</tbody>
</table>

This is a significant change in reported well-being. The new beneficiaries were significantly likely to feel more satisfied with their lives, happier and have an improved sense that their lives are worthwhile six months after joining the LinkAge hub. However although they feel less anxious the change on this item is not statistically significant.
The range scores in Table 3 of 0-10 also reconfirms that there are people accessing the LinkAge activities who are already experiencing a good sense of well-being. Just looking at the ONS indicator of Life Satisfaction, 23% (n=7) of beneficiaries had above national average scores at baseline and showed no change on this scale at follow up.

**Improved physical health**

Established beneficiaries, rather than stakeholders, highlighted during focus groups and interviews that after their engagement with their LinkAge hub they had noticed an improvement in health. This was measured by two items in the tool. An open question on medication usage and an IPAQ item on level of physical activity. For the latter new beneficiaries were asked: *Last week on how many days a week did you do moderate exercise (e.g. brisk walking) for 30 minutes or more?*

Table 5: Baseline and follow up days of moderate exercise

<table>
<thead>
<tr>
<th></th>
<th>No days of physical activities</th>
<th>7 days of physical activity</th>
<th>Mean day score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>26.7% (n=8)</td>
<td>26.7% (n=8)</td>
<td>3.3</td>
</tr>
<tr>
<td>Follow up</td>
<td>3.3% (n=1)</td>
<td>40% (n=12)</td>
<td>4.93</td>
</tr>
</tbody>
</table>

Again this table suggests that there has been improvement in the amount of moderate physical activity taken up by new beneficiaries. In fact the improvement is statistically significant showing an increase in the number of days of activity a beneficiary spends in moderate exercise from baseline (M=3.3, SD=2.83) to follow up (M=4.93, SD=2.30), t= -2.874, p<0.008 (two tailed). The mean increase in days spent was 1.63 with a 95% confidence interval ranging from -2.796 to -471. The eta square statistic of 0.22 indicates a large effect size. This should be expected given that the hub has been particularly keen to promote physical exercise by providing opportunities to engage with such activities as: Tai Chi, gentle exercise, line dancing and walking. But the increases have been made by 53% (n=16) of new beneficiaries only. 30% (n=9) show no increase and 16% (n=5) show a decrease in physical exercise. Those who show a decrease were in the older age bracket of 70 to 89 years of age.

On medications taken, at the time of follow up 66.7% (n=20) beneficiaries report that they were currently taking some form of medication; however 26% (n=8) reported that they had stopped taking some form of medication since they started visiting LinkAge:
Table 6: List of medicines that they have stopped taking since you attending the Hub.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure tablets</td>
<td>3</td>
</tr>
<tr>
<td>Cholesterol tablets</td>
<td>1</td>
</tr>
<tr>
<td>Anti-depressants</td>
<td>1</td>
</tr>
<tr>
<td>Inhaler for asthma</td>
<td>1</td>
</tr>
<tr>
<td>Pain killers</td>
<td>1</td>
</tr>
<tr>
<td>Thyroxine</td>
<td>2</td>
</tr>
<tr>
<td>Tablets for a hernia</td>
<td>1</td>
</tr>
</tbody>
</table>

This sense of improved health was identified by both established and new many beneficiaries:

*This has really improved (walking group) my fitness. I love seeing the colours on the trees and looking at other people in the park. Its fun!* (New beneficiary 4)

*It has helped me to find someone to talk about my anxiety about drug dealing that goes on outside my house.* (New beneficiary 17)

**Causal explanation**

Clear benefits that have been identified in this research by both established and new beneficiaries. This evidence has been generated both through the completion of baseline and follow up questionnaire and in the focus group and interviews undertaken with beneficiaries and stakeholders. The data presented suggests improvement in connectivity, well-being and physical health. However, the crunch question is whether or not this has been due to the hub model developed and promoted through LinkAge? This is difficult to judge. It is clear there are significant improvements on these indicators but this may be due to a range of issues. Are improvements due to the passage of time? Given the scale of the increase and the validation provided through the triangulation of findings with stakeholder’ and new beneficiary views, this seems an inadequate explanation by itself.

Could it be due to the delivery team in the hub rather than model itself? Like all new community development projects there were teething challenges from the onset. But the Hub has grown and continues to broaden the range of activities available to beneficiaries. What did become clear during the new beneficiary interviews was that beneficiaries felt and broadly praised the CDW and the volunteer team that worked with them to deliver the activities as the reason for the success of the activities.

* ****(the CDW) is wonderful, she has got us walking and she is always around talking to people and she sorts out so many things for us all.* (New beneficiary 43)

* Without their help (the volunteers) I am not sure it would work we are here because they help us with the lunches and things they are so friendly and always welcoming especially to the new ones.* (New beneficiary 32)
It could be that this hub has simply got an excellent team to deliver the activities and inspire the beneficiaries. To test whether this is the case it would have been necessary to control for them in the design of the research but unfortunately there was limited resources for this and it is hard to have a comparative analysis when the emergence of an additional new hub at the same time would depend on a range of factors. Having a comparative new hub may have addressed this issue and can do so in the future.

So positive outcomes are clear but whether this is directly attributable to the LinkAge model has not been fully clarified. Part of the problem is that the beneficiaries do not necessarily perceive or understand the LinkAge brand. They do know and report that the activities they pursue are good, worth attending and that they have contributed to an enhancement of their well-being, but unfortunately they do not perceive this as a consequence of the LinkAge mission. Very few new beneficiaries knew what LinkAge was and even less understood the funding arrangements that underpinned the CDW’s role and the project city wide.

*I am not sure what a Hub is or what it is about to be honest. And I am not sure anyone else does. We don’t really talk about it...... There is a LinkAge badge on the door, but I think.... what is that about? (New Beneficiary 39)*

It is a perception also held by stakeholders including an advisory member.

*I suppose there may come a time when we are chasing the same elderly people but that hasn’t happened as yet. But there is some confusion. No one knows what LinkAge is. Are they Age UK? The council? What are they? (Stakeholder, Advisory 7)*

The social return on investment

LinkAge asked us to look at any potential financial benefits that may accrue from this hub. We recommended undertaking a SROI analysis on the financial costs and benefits of the hub in the first year of operation: September 2011 to August 2012. SROI approaches simply compare the monetary benefits of a program or intervention with the program costs (Phillips, 1991). SROI developed from traditional cost–benefit analysis in the late 1990’s (Emerson, 2000). The government have provided guidance for SPOs on how to undertake SROIs and recommended their usage for valuing the benefits that they deliver people and communities (Cabinet Office, 2009).

What is the value of doing an economic assessment of impact? Primarily it gives information on the value created. In providing numbers and qualitative value information a SROI can help in communicating information with stakeholders holding different objectives and preferences. It can also provide a means of helping investors more efficiently select investments that align with their
value objectives. The concept of social return also helps people understand that any grant or loan into an organisation or initiative can be thought of as an investment rather than as a subsidy and that it can create more value through its utilisation in an intervention or project.

Information on the costings involved in the LinkAge SROI can be found in Appendix 3. This is where the calculations and references for proxies can be found. It provides details on the cost of running the project together with an outline of the value created by additional activities and benefits accrued. In this section we outline our methodology around the SROI.

SROIs seek to valorise the benefits or impacts that have accrued as a result of their work. In this case study the biggest impact has been the development of connectedness. In the past we have used a befriending service charge as a proxy to cost the added value gained from socialising activities that help to end isolation (Shergold, Kimberlee and Musselwhite, 2012). It is clear from the evidence outlined above that many beneficiaries report improvements in connectedness. Table 2 shows that 46% (n=14) were already saying that they were either ‘socially connected’ or ‘very or highly socially connected’ at baseline. Given that there are 155 beneficiaries that have attended more than one activity at the hub the SROI can account for improvement in connectedness for 54% (n=71) of new beneficiaries. The importance of befriending services for elderly people cannot be underestimated. Research has shown that outcomes are positive and lead to cost saving benefits for the NHS through the early intervention and prevention of complicated health issues as well as through reducing dependency on its resources (Mulivihill, 2011). We have only anecdotal support for the latter but we can support the impact of the befriending culture at the hub. The accounts report suggests that on average beneficiaries attend 10 activities. Using the parsimonious assumption that this activity lasts for 1 hour we can calculate befriending costs for support received. This approach has been used before to calculate the befriending value of a Wheels-to-Meals scheme (SROI Network, 2012).

Through befriending and support it is clear that beneficiary well-being has also improved. Concomitant improvements in physical health have been documented. The latter outcome has been particularly noticed by established beneficiaries and these can be costed in the SROI by calculating the cost of medications stopped for the new beneficiaries. Additionally by costing in the cost of physical activity or gym attendance (Capacity Builders, 2010) we can valorise the outcome of improved fitness. In doing this we have looked at the costs of attending Methodist Church’s Lifestyles Fitness Centre on Clouds Hill Road, Bristol the nearest gym to new beneficiaries in Whitehall and St.George. We have done this on the basis of 43% (n=13) of new beneficiaries managed to achieve government recommended levels of physical activity: at least 150 minutes (2½ hours) of moderate intensity activity over a week.

But by far the biggest added value that the project brings into the hub is the large amount of unpaid volunteer time provided by individuals to help support the hub’s activities. This is particularly important since the ward has the second lowest level of volunteer rates in Bristol according to the Quality of Life in Bristol survey (Bristol City Council 2011). We parsimoniously calculate that they have worked 2430 hours across the year. This is done on the assumption of an operational year of 45 weeks with closures for Christmas, Summer and Easter. It is recommended that the hours given by volunteers are often given a value equivalent to the average hourly rate for the type of work they are doing (SROI Network, 2012, 31). We have calculated their hourly rates by comparing them to equivalent roles using the Chartered Institute of Personnel and Development salary scales.
In keeping with the SROI approach it is important to consider deadweight, displacement and attribution. Deadweight is a measure of the amount of outcome that would have happened even if the activity had not taken place. It is often calculated as a percentage. Would the new beneficiaries have improved their social connectivity and or levels of physical exercise without help? To calculate deadweight, reference is often made to comparison groups or benchmarks. Ideally we would have undertaken a RCT, but resources were scarce. To some degree we have addressed this issue by excluding people who were already connected or in good health from the SROI valorisation process.

Looking at the increase in physical activity the improvement showed by beneficiaries here seems counter to the trend in physical activity across the city. The *Quality of Life in Bristol* survey (Bristol City Council, 2011, 4) which looked at trends between 2005 and 2011 revealed:

*Of concern is a rise in the proportion of people who are overweight and obese, and a fall in exercise levels, participation in active sport and creative activities.*

In fact residents in St George East and St George West Neighbourhood Partnership Area (NPA) have the second lowest moderate physical exercise rates in Bristol. This conclusion is based on data using the same indicator as used in our analysis. The survey showed that only 29% of adults in the NPA were undertaking 5 days of moderate exercise (e.g. brisk walking) for 30 minutes or more. At the Hub 70% (n=21) report they achieve this level of physical exercise.

In terms of connectedness there is no simple way of measuring this across the NPA or the city. The *Quality of Life in Bristol* survey doesn’t cover it. No direct questions are asked about loneliness and isolation. The survey did report that 90% of residents said they were happy and that 75% of respondents said they were satisfied with life. These figures have remained the same between 2005 and 2011 suggesting little change in perceived well-being. The city council have supported the Isolation to Inclusion project developed by the City’s Older People’s Partnership Board. It is clear from the data that new beneficiaries who live alone are more likely to score low on the Friendship Scale than those who live with a partner and/or family. It is quite conceivable that a few may have had help and support from elsewhere that may have yielded the same effect as that achieved through the hub. As a result, in the absence of a clear comparator it is important to try and use a ‘best estimate’ (Cabinet Office, 2009:56) to assess deadweight. Let us assume that one person could have improved all things being equal and apply a 3% deadweight reduction.

Displacement is another component of impact and is an assessment of how much of the outcome (the hub) displaced other outcomes. My interviews and focus groups with stakeholders and new beneficiaries revealed very limited evidence of displacement. Established beneficiaries in two other hubs provided some evidence of this around certain services but to the new beneficiaries in this new hub there was no evidence of displacement. New beneficiaries were enjoying these activities as a new event and it was not replacing a previous activity or service they had previously accessed. In a group of 155 there may be some services accessed in the hub that could have been accessed elsewhere before so we will assume a low displacement rate of 1%.
Attribution is an assessment of how much of the outcome was caused by the contribution of other organisations or people. To avoid over-claiming SROI uses attribution to assess how much other people or activities have attributed to the identified outcome. This analysis has shown that the new beneficiaries attribute the improved outcomes they have experienced not so much to the LinkAge brand but more to the people who deliver the activities in the hub. We have accepted that this brings a positive value to the hub and should be valorised accordingly. We have also taken out of the analysis new beneficiaries who were already connected, with high levels of well-being and physically active so they are not part of the valorisation process. It is conceivable that there are partners and friends outside of the hub who are helping and inspiring each new beneficiary. But almost half live alone. So we will assume a low attribution rate of 10% which in the absence of any other information seems ‘fair and reasonable’ (Buchan Development Partnership, 2010:17).

Based on these costings and assumptions around deadweight, displacement and attribution we calculate that for every £1 invested in the Whitehall and St. George Hub there is a social return on investment of £1.20. This is a considerable return and in our view it is probably an underestimation of the potential return in the medium term. The hub is only in its first year of existence. A considerable amount of time was spent bedding down activities and developing beneficiary confidence in the activities and the approach. So a lot of the time was spent in starting up activities rather than delivery. As we write new beneficiaries continue to join the hub and new activities are planned. Thus, simply through increased throughput the return on investment would increase until a ceiling in membership is reached. Secondly, the impact of hub engagement on beneficiary health is probably underestimated in our calculations. To get an accurate assessment of health impact we would need permission to examine beneficiary medical records and follow beneficiaries over a longer period. Clearly there was insufficient resource to do this in this small scale analysis. In the absence of this data we have therefore been parsimonious in our calculations around values stemming from health improvement. Again it is our view that these would be greater than we have allowed for in this analysis.
Moving forward

We are now living in an ageing society. People are living longer and the balance of their lives are changing. There are now more people aged over 60 than children under 16 and most people moving to retirement can now look forward to many more years of healthy life than ever before. Our society is also becoming more diverse and expectations of what public services can deliver remain high. Baby boomers are now edging into retirement and the search for effective ways of maintaining older people’s health and wellbeing has never been greater than it is now. Just under ten years ago the government was urged to encourage local authorities to help older people to stay healthy and active and to encourage their contribution to their local community (Audit Commission, 2004:2). This report called for a fundamental shift in the way people think about older people, from dependency and deficit towards independence and well-being. The LinkAge Hub approach is delivering interventions in for local communities to promote well-being and healthy aging matching the suggestions of the Audit Commission report.

Ten years on and the government’s Comprehensive Spending Review has seen policy makers increasingly anticipate that third sector Social Purpose Organization’s, like LinkAge should be encouraged to develop and promote innovative services to address local needs. Through Hubs, LinkAge have sought to empower older people to fulfil their ambitions to enable them to influence local developments or to support them to design and establish new groups and activities that meet their interests and their aspirations.

The LinkAge approach fits the current agendas established by the Marmot Review (2010) *Fair Society, Healthy Lives*, which reinforced the importance of handing over responsibility and control for promoting healthier lives to local communities. It also chimes well with current policies on adult social care with its emphasis upon active citizens and capable communities. LinkAge’s Hub approach is *Localism* at its best. But it also echoes the recent Francis Report (2013) which called for *Choice and Control* – empowering people to make their own health choices and take responsibility for their own health and well-being. The LinkAge Hub intervention promotes this approach in fact it is the core of its philosophy.

In the Department of Health (2010b) report *Our Health and Well-being* evidence of threats to our well-being were highlighted to be: depression and anxiety, obesity and reduced levels of physical activity amongst the UK population. These are linked to major burdens of ill health in the form of cancer, heart disease, type-2 diabetes and mental ill health. This report has shown that stakeholders from established hubs report recognise that loneliness, a lack of exercise, anxiety and depression were key experiences of elderly people’s lives prior to LinkAge engagement. This research had an opportunity to assess whether new beneficiaries at a new hub could benefit from the LinkAge approach. Using validated items we have shown that beneficiaries report a significant reduction in loneliness, increased well-being, increased physical activity and a decrease in social isolation. In addition to social outcomes we also parsimoniously demonstrated clear economic benefits from participating in a LinkAge hub. Based on project costs, added value and assumptions around deadweight, displacement and attribution we calculated that for every £1 invested in the Whitehall and St. George Hub there is a SROI of £1.20. This is a considerable return and in our view it is probably an underestimation of the potential return in the medium term.
The evidence therefore suggests that the potential economic return is strong given that the findings reported here were based on findings from the hub’s first year of existence. It was noted that a considerable amount of time was spent bedding down activities and developing beneficiary confidence in the type and range of activities on offer and their approach. So a lot of the volunteer and community development worker time was spent in ‘starting up’ rather than in delivery. We were aware of new beneficiaries continuing to join the hub and that new additional activities are being planned to meet local need. Thus, simply through increased throughput the return on investment, *ceteris paribus* should continue to increase in the Hub until a ceiling in membership is reached.

But by how much will benefits increase? And was the Whitehall and St. George Hub a one off? Background stakeholder interviews with beneficiaries in other Hubs suggest not. However we need to explore this and therefore recommend looking at another Hub in the city where activities are already well established and impact can be monitored through the engagement of new beneficiaries to the Hub approach. This will enable us to answer these questions and also validate the findings reported here about the Whitehall and St George Hub.

We know and understand that the Health & Social Care Act 2012 and the Localism Act 2011 have been key pieces of legislation and policy that have transferred public health responsibilities back to local government, meaning the establishment of local Health and Wellbeing Boards, Clinical Commissioning Groups and Healthwatch. We understand that post-April 2013 will be a critical time for health and social care services in all sectors to demonstrate their value and evidence base their impact. Therefore replication of this research in another Hub could help to provide decision makers with broader evidence of the effectiveness of the LinkAge Hub approach to cost-effectively promoting the well-being needs of an ever growing section of the population who are currently posing an increasing drain on diminishing resources.
References


Accessed 23rd November 2011

Accessed 20th June 2012.


Accessed 1st November 2012


Accessed 1st July 2011


Office for National Statistics (2011) Most people rate their well-being at 7 or more out of 10 http://www.ons.gov.uk/ons/dcp29904_245867.pdf
Accessed 4th September 2012

Accessed 4th September 2012

Accessed 31st October 2012


Accessed 30th October 2012

South West Forum (2011) Proving Our Value
http://www.southwestforum.org.uk/provingourvalue
Accessed 1st July 2011


Appendix 1: Abbreviations

**COO**  Chief Operating Officer

**CDW**  Community Development Worker

**GDP**  Gross Domestic Product

**IHS**  Integrated Household Survey

**IPAO**  International Physical Activity Questionnaire

**NPA**  Neighbourhood Partnership Area

**ONS**  Office for National Statistics

**RCT**  Randomised controlled trial

**SPO**  Social Purpose Organizations

**SROI**  Social Return On Investment
Appendix 2: LinkAge Follow up tool

Reference number

We would like to ask you some questions on how you feel today. Just simply tick one box for each question. It helps us to plan and provide services. If you answer these questions it will help us to search for more funding. Thanks for your help.

1. During the past four weeks:

   Has it been easy to relate to others:
   - Always
   - Most of the time
   - About half the time
   - Occasionally
   - Not at all

   I felt isolated from other people:
   - Always
   - Most of the time
   - About half the time
   - Occasionally
   - Not at all

   I had someone to share my feelings with:
   - Always
   - Most of the time
   - About half the time
   - Occasionally
   - Not at all

   I found it easy to get in touch with others when I needed to:
   - Always
   - Most of the time
   - About half the time
   - Occasionally
   - Not at all

   When with other people, I felt separate from them:
   - Always
   - Most of the time
   - About half the time
   - Occasionally
   - Not at all

   I felt alone and friendless:
   - Always
   - Most of the time
   - About half the time
   - Occasionally
   - Not at all

2. Overall, how satisfied are you with your life nowadays? Where 0 is not satisfied at all and 10 is completely satisfied.

   0 1 2 3 4 5 6 7 8 9 10
Overall, how happy did you feel yesterday? Where 0 is not at all and 10 is completely.

[0-10 rating scale]

Overall, how anxious did you feel yesterday? Where 0 is not at all and 10 is completely.

[0-10 rating scale]

Overall, to what extent do you feel the things you do in your life are worthwhile?
Where 0 is not at all worthwhile and 10 is completely worthwhile.

[0-10 rating scale]

3, Overall, are you satisfied with your neighbourhood?

Yes  No  Don’t Know

4, Last week on how many days a week did you do moderate exercise (e.g. brisk walking) for 30 minutes or more:

[0-7 rating scale]

5, At present are you taking-using any medicines?

Yes, taking medicines  No medicines  Can’t say  Not answered

6, Please list any medicines you have stopped taking since you have been coming here.
6. What benefits have you got from this activity
Thank you. This will help us to improve our services.