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Covid-19 Loneliness Fund

A process evaluation

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Key findings and recommendations

- Some research participants were found to experience increased feelings of loneliness during the Covid-19 pandemic. Those at greatest risk were women, younger adults, ethnic minorities and people from mixed ethnic backgrounds and adults living with a disability.
- Service user loneliness has been exacerbated, rather than created, by the Covid-19 Pandemic. This was attributed to the varied existing situation of the service users, which included carers, single parents, refugees, young people, older people, and those leaving the armed services.
- The funded programmes were experienced in a positive way and were perceived as being user-driven, allowing control and flexibility. The positive experience was also evidenced when looking at how participants reported feeling after they accessed funded activities, compared to before. Findings indicated that there had been a significant improvement over time in service users' reported levels of loneliness. The proportion of service users reporting that they often feel lonely, lack companionship, feel isolated from others, or feel left out, fell during the course of the programme.
- The positive changes over time cannot be treated as an impact of the intervention per se due to a lack of a comparison group. However, findings suggest that attending funded activity did not make service-users feel more lonely than they would otherwise.
- Face-to-face service delivery remained the preferred option for vulnerable service users. However, the necessity of digital delivery during the lockdown did facilitate some benefits. For befriending services in particular, remote delivery enabled organisations to reach a greater number of service users with the resources they had. Whereas face-to-face delivery and meetings required travel time, remote working enabled some organisations to focus more on service delivery.
- The use of volunteers provided through corporate social responsibility initiatives was further pursued, not only because training could be delivered online but volunteers were working from home which provided both them and service users with more flexibility. Delivering activities was made more difficult by the limited time organisations had to set the activities up, and the original requirement that they had to spend the money and therefore end services by (Christmas 2020). Additional barriers included the fact that some service users were digitally excluded, and staffing issues.
- Recommendations for greater success include: allowing more time for project set up and considering closely when funding is originally planned to end; facilitating additional consultation with funded organisations on what is required regarding any evaluation activities; and ensuring service users are able to use the digital devices supplied and, if they are not, to provide assistance.

Executive summary

Introduction

- This report presents the results of a process evaluation of the Covid-19 Loneliness Fund, commissioned from NatCen by the Department for Digital, Culture, Media & Sport (DCMS).
- The aim of the Fund was to support the delivery of services aimed at addressing loneliness and to help organisations adapt services during Covid-19 restrictions. In addition, the Fund aimed to collect evidence on Covid 19 and Loneliness. This included looking into the impacts that measures such as self-isolation and social distancing are having on loneliness, particularly amongst vulnerable groups, as well as identifying ways that charities can adapt to manage social distancing requirements while still supporting social connection.
- Nine organisations were awarded Fund money. These were Alzheimer's Society, British Red Cross, Carers UK, EFL Trust (English Football League Trust), Home-Start UK, Mind, RNIB (Royal National Institute of Blind People), Sense, and SSAFA (Soldiers, Sailors, Airmen and Families Association).

Methodology

- This report details the outcomes of the process evaluation, which applied a multi-method approach consisting of three elements: workstream one, a literature review and documentary analysis; workstream two, the analysis of monitoring data; workstream three, six qualitative case studies involving service interviews and focus groups with programme managers, project leads, staff, and volunteers.
- The six case study organisations were Alzheimer's Society, British Red Cross, Carers UK, Home-Start UK, RNIB, and SSAFA. Due to the relative size and scale it was not possible to include Carers UK and Home-Start UK fully, so local partners were included. Manchester Carers Centre was selected as a local network partner for Carers UK, and Home-Start Medway was selected for Home-Start UK Findings.
- The meta-evaluation for the entire Covid-19 Charities Funding package will look to develop Theories of Change and undertake further quantitative and qualitative research to explore impact. The interim report for this wider evaluation will be available in Autumn 2021 with the final report available in January 2022.

Evidence on the impact of Covid-19 pandemic on loneliness and wellbeing

- In total 33 papers were included in the review. Many of the papers presented data collected in the initial acute first phase of the pandemic from March to May 2020. Some also compared data with pre-pandemic levels or mapped the rise and fall of loneliness during the first few months of the pandemic, while others focussed on interventions.
- A sizable minority of adults in the literature were found to have experienced loneliness during the Covid-19 pandemic, with those who felt lonely at the beginning of the Covid-19 pandemic feeling more lonely during it.
- According to the literature, groups at higher risk of loneliness included younger people, women, those who are single or divorced/separated, the unemployed, those who live alone, those shielding, people living with dementia, carers, and those who are digitally excluded.

- In the literature, befriending was the most prevalent service aimed at mitigating loneliness during the Covid-19 pandemic, followed by services aimed to address digital exclusion.

Grant holder monitoring data

- Funded activities coded as ‘other’ were the most prevalent (37.9%) type of support delivered. This included a range of different services, such as activity and guidance packs delivered to EFL Trust users by post, peer-to-peer support organised by Home-Start and the British Red Cross, and one-to-one mentoring delivered by SSAFA. After ‘other’, the most common activity was phone befriending (28.1%), followed by technical support, for example help with accessing laptops (22.8%), online befriending (5.4%), and face-to-face befriending (2.9%).
- Among service users where demographic characteristics were known, the majority of service users were women (60%), heterosexual (89%), from white ethnic backgrounds (75%), and nearly two thirds (64%) had a long-term disability. The distribution by age was concentrated towards the younger end of the age distribution and the very old (aged 75 or over), with fewer people in the dataset aged between 45 and 74.
- On feelings of loneliness, monitoring data analysis found that service users felt less lonely at the mid (17%) and final timepoints (16%) compared to baseline (23%). This trend was the same regarding feelings of lack of companionship, feeling left out, and feeling isolated from others.
- On feelings around wellbeing, monitoring data analysis found that those with feelings of low life satisfaction fell from 29% to between 23-25% between timepoints, whereas those with feelings of medium and high life satisfaction remained similar. This trend also applied to feelings around how worthwhile service users found life (negative perceptions falling from 24% to 19%), happiness (low happiness falling from 31% to 27%), and high levels of anxiety fell from 35% to 30% (although this was consistently the most common reported level of anxiety).

The experience of programme staff and volunteers: focus groups

- Participants who worked with service users (e.g. project manager, project staff, volunteers) felt that service user loneliness was exacerbated, rather than caused, by the Covid-19 pandemic. It was perceived that service users had experienced a sharp drop in support at the start of the Covid-19 pandemic, with restrictions having affected service users differently e.g. young people and school closures. Distance from family was also perceived to be a key factor contributing to service user loneliness.
- Mixed feelings were expressed by participants regarding face-to-face versus remote service delivery. Whereas remote delivery did enable more flexibility and efficiency, it was felt that the quality of services was not comparable to those delivered face-to-face, due to lack of social cues, access to service users’ environment e.g. home, and the additional sociability.
- Participants expressed that delivering services was made easier by the urgency for change required and remote working allowing services to be delivered based on availability rather than proximity. In addition, recruitment of service-users to new services was facilitated by investing in a recruitment drive before the Fund money had been received, advertising on social media, and making use of pre-existing contact lists from their other services which had been paused.
- The key barrier to delivering the funded activities mentioned by participants was timing. In particular, the lack of time for set up at the start of the project and the

original stipulation that Fund money had to be spent by the end of 2020, which was perceived as a time when service users were at their most vulnerable.

- Digital exclusion was cited as another barrier by participants, with some service users not being reached as a result. This was mitigated by many organisations which provided digital devices to service users, although providing instructions on how to use them remotely could be difficult.
- Staffing challenges mentioned by participants included volunteer and staff wellbeing (as they were also affected by the Covid-19 pandemic), recruiting enough volunteers to keep up with demand, and volunteer management.

The experience of service users

- Service users felt that Covid-19 restrictions exacerbated their feelings of loneliness. This included the impact that the pandemic had on routines, such as meeting friends, thus causing boredom, frustration, and discomfort. Other causes of loneliness cited by service users included bereavement, moving to a different area right before or during the Covid-19 pandemic, and fear of or uneasiness with technology.
- Service users reported being reluctant to speak to friends and family about their experiences or problems, resulting in an increased sense of isolation and loneliness. For those service users caring for others, some saw their caring responsibilities increase during the Covid-19 pandemic, partly due to shielding and difficulties adapting to restrictions.
- Service users reported very little access to services or support at the start of the Covid-19 pandemic, with no service or support specifically designed to mitigate loneliness and social isolation. What support there was came from family members, friends, GP practices, religious organisations, local councils, charities, and volunteering groups.
- Service users were recruited for activities by organisations in various ways. For example, some were in contact with volunteers or even acting as volunteers with the organisation themselves before the Covid-19 pandemic. However, others were unsure how the organisations found them and assumed this happened thanks to friends, relatives, carers, GPs, or housing associations.
- According to service users, activities delivered remotely included telephone and online befriending, wellbeing meetings, advising services, talking groups, companion and befriending calls, and various online activities such as classes, group meetings, singing sessions, and quizzes. Other services included doorstep visits, buying groceries, providing meals, and delivering electronic devices (smartphones, tablets and pedometers).
- Service users reported that the funded activities gave them hope, made them feel less isolated, and connected them with friends and family.
- Less positive experiences reported by services users around supplied digital equipment included that it did not work or was missing instructions. In addition, services delivered over the phone could sometimes feel rushed or too short.
- Access to services was made easier by excellent communication from organisations, the scheduling and flexibility of services, the social distancing and safety measures taken by organisations, and the accessibility of remote services for those more familiar with digital devices.
- Barriers to accessing services included technical issues with telephone and online services, timing and scheduling of service (also cited as a facilitator by some) and taking part in group calls was difficult for some who were not used to them.

Concluding remarks and recommendations

- As it became clear that restrictions would be implemented over a longer period, the Fund was seen very positively by both the organisations receiving the fund and the users of the services. The urgency underlying required changes to deliver services during the Covid-19 pandemic in conjunction with the Fund had a positive influence on organisations and services. Although telephone and digital delivery provided many benefits, face-to-face remained the gold standard for service delivery to vulnerable service users.
- The findings from service users of this evaluation mirrored previous published evidence found around loneliness in the literature review. Women reported higher levels of loneliness compared with men. Age and ethnicity were also associated with risk of loneliness with younger adults, ethnic minorities and people from mixed ethnic backgrounds being at increased risk of loneliness. Living with a disability was also associated with higher levels of loneliness during the Covid-19 pandemic.
- Although a significant improvement over time in service users' reported levels of loneliness was observed, experiences of loneliness remain high relative to the rate reported in other studies for the general population, which shows the heightened vulnerability of the users of the services funded.
- Recommendations for improvement include allowing more time for projects to be set up, although it is recognised that at the time the Fund was set up the length of the Covid-19 pandemic was highly unpredictable. Furthermore, when awarding short-term emergency funding, the timing of when that funding ends should be closely considered. For example, in this case the funding period was originally planned to end around Christmas, when service users were perceived to be at their most vulnerable, and thus organisations initially planned to withdraw services then. However, additional funding towards the end of the funded period was secured by seven out of nine of the organisations. Additional consultation on the evaluative element attached to funding was recommended by organisations. In future, organisations should consider the usability of digital devices when supplied, if this is not already built into their service.
- Overall, a sizable number of people who participated in the programme showed improvement in their levels of loneliness and wellbeing. While these changes can't be directly attributed to the programme due the methodological limitations, it seems likely that the programme contributed to this improvement. The Fund was also found to have made a difference in helping the beneficiary organisations to adapt their services to the new circumstances produced by the Covid-19 pandemic.

1 Introduction

This report presents the results of the evaluation of the Covid-19 Loneliness Fund which NatCen Social Research has undertaken, commissioned by the Department for Digital, Culture, Media & Sport (DCMS). The purpose of the Fund was to support charities to deliver targeted relief for people at high risk of loneliness during the Covid-19 pandemic. A further aim was to help these organisations adapt their services to the new circumstances and the public health requirements resulting from the Covid-19 pandemic. The Fund aimed to collect evidence of the consequences for individuals of public health measures such as self-isolation and social distancing in terms of loneliness.

The Fund was open to applications from large national charities which could demonstrate their ability to reach people whose needs for social connection are not fully met by smaller charities, and to serve the needs of vulnerable groups particularly at risk of loneliness. The Fund aimed to enable beneficiary charities to continue, adapt and expand existing programmes, and to provide frontline services. Nine organisations were awarded the grants in June 2020 (see section 3.2). The funded programmes started in June 2020 and continued until the end of December 2020, with seven out of nine organisations awarded with continuation funding.

The process evaluation goals included: an assessment of how the funded programmes were delivered and managed; the range and reach of the activities; the experience of service users with loneliness; and what factors have worsened or improved the experience of service users with loneliness. NatCen used a three-stage process evaluation to explore and understand programme inputs, activities and outputs, and to capture the range and diversity of experiences among grantees and their service users.

For the first stage (workstream one), NatCen carried out a documentary analysis and a literature review to feed into a classification matrix that underpinned the two further workstreams. This also ensured that we fully understood the inputs, activities and outputs of each of the grantees. The next stages included secondary data analysis (workstream two) as well as case study work (interviews with service providers and users) and qualitative research on Covid-19 and loneliness (workstream three). The structure of the rest of the report is outlined below:

- Chapter 3 - We first present findings from workstream one. This workstream included a brief literature review on the impact of Covid-19 on loneliness and wellbeing in the UK, and a documentary analysis which supported the development of a classification matrix, detailing the different structures and processes of the grantee projects. The documentary analysis, together with the literature review, also provided the basis for the selection of the case study sites.
- Chapter 4 - We then discuss the results of the secondary data analysis of the programme monitoring data provided by the grant holders. This chapter describes the demographic characteristics of the service users, the primary and secondary activities of the grant holders, and the changes in the service users' perception of loneliness and wellbeing throughout the duration of the funded programmes.
- Chapter 5 - We then move to the outcomes of the qualitative stream of the process evaluation which included four focus groups with staff and volunteers of the organisations selected for the six case studies, and 36 individual telephone interviews with service users of the same organisations. This section explores the perceptions and experiences of staff, volunteers and service users of the funded programmes, as well as the experiences of loneliness of the service users and the barriers and facilitators to accessing services that they encountered.

- Chapter 6 and 7 - We discuss the findings of the fieldwork (chapter six) before presenting our conclusions (chapter seven).
- Appendices - The report is completed with four appendices where we have included: the topic guides used to conduct the focus groups and the individual interviews (Appendix A); the information sheets provided to the interview and focus group participants (Appendix B); the aftercare leaflet provided to all service users who took part in individual interviews (Appendix C); and a briefing note on monitoring data by grant holder along with monitoring data tables (Appendix D).

2 Methodology

2.1 Workstream one: literature review and document analysis

Workstream one consisted of two research activities: a documentary analysis and a literature review. These were conducted alongside each other and informed the approach to workstreams two and three.

2.1.1 Documentary analysis

A documentary analysis was undertaken including all nine funded organisations. Following a project initiation meeting with each organisation, invitations to tender documents, project initiation documents, proposals, meeting minutes, qualitative returns, details on proposed ‘footfall’, and any returned cost information were requested for review. The number of documents provided by each organisation varied between three and ten, with 45 documents supplied in total.

A content analysis was conducted to code and generate themes to understand the input, activities, outputs, and outcomes of each organisation’s project. Data from the documents were extracted into a matrix by the following themes: partner organisation(s), location, new or existing programme, population type, recruitment strategy, number of service users targeted, staffing structure (including volunteers), activities, timeline of activities, how the activities meet the aims of the fund, how the activities meet the needs of service users, outputs, outcomes, and sustainability.

2.1.2 Literature review

To enable the assessment of emerging and final findings of this evaluation against the wider emerging literature around Covid-19 and loneliness, a literature review was conducted at two time points: November 2020 and February 2021. This resulted in 25 papers in total being selected for review. All key findings from the selected papers below were extracted thematically and are presented in section 3.1.

The initial search in November 2020 applied key pragmatic and condensed search terms (e.g., “Covid-19” AND “Loneliness”) to Google Scholar to identify relevant literature from between 2019-2020. This identified 40 papers of interest, which underwent title and abstract screening to identify study type, country of coverage, and whether data was collected after the start of the Covid-19 pandemic. Papers were subsequently categorised as ‘yes’, ‘no’, and ‘maybe’. A second researcher reviewed all papers marked as ‘maybe’, resulting in a shortlist of 17 papers for review. In addition, two papers from the Office for National Statistics (ONS) were included to provide up to date information on loneliness prevalence.

A follow up literature search in March 2021 applied the same key search terms as those previously, as well as additional terms relevant to activity typologies identified in the documentary analysis (e.g., “covid-19” AND “loneliness” AND “befriending”). To ensure the search did not capture papers already identified in the initial search, a date filter was applied starting from November 2020. This generated 64 papers, which then underwent the same screening, categorisation, and second review process discussed above, resulting in a shortlist of eight papers taken forward for the March 2021 update to the literature review.

2.2 Workstream two: analysis of monitoring data (quantitative)

All grant holders were required to collect monitoring data on their service users, including demographic information, the services they received (also referred to as activities), their experiences of loneliness, as well as their wellbeing. A common dataset of variables was requested from each grant holder covering these areas, which has allowed for analysis to be conducted across these programmes of support. A data specification detailing the variables to be included in the common dataset was provided to each grant holder in an excel spreadsheet to ensure comparability between programmes. As far as possible, this data has been combined for this report to provide a summary of findings across the diverse services delivered. However, not all grant holders were able to collect and share this data, and of the nine programmes only seven are included in the main dataset reported on below (SSAFA, EFL Trust, BRC, Alzheimer's Society, Home-Start, and RNIB). There are also some circumstances where a particular variable is missing for one or more grant holders, and we have highlighted wherever this is the case.

Findings around the changes in levels of loneliness and wellbeing reported in this section cannot be used to infer causality. There is no counterfactual data available for people who were not in receipt of the intervention, so the impact of the funded activities cannot be distinguished from changes which may have taken place in the absence of the additional support. This means that, while this dataset can be used to identify what changes have taken place among people in our dataset, these changes cannot be linked causally to the intervention.

Table 2:1 below shows the total number of cases in the dataset provided by each grant holder. Some grant holders provided significantly more data than others, and because it was not possible to weight this dataset to adjust for this, when analysed together this data will not be representative of all service users supported by these grant holders. Another caveat in interpreting this data is that it was collected in a number of ways, with some taken from existing administrative data and other grant holders collecting it through surveys. Survey data collection was also conducted in different modes, with some using online surveys and others having their staff collect data through interviews. This may introduce a level of measurement difference into these findings due to the effects of social desirability on responses where an interviewer was present. For example, people may have been less likely to acknowledge or admit to feelings of loneliness in situations where an interviewer was present compared to people completing an online survey.

Table 2:1 Grant holder loneliness and wellbeing data

Provider	**Baseline**	**FU1**	**FU2**
RNIB	146	73	N/A
Home-Start	709	134	609
Carers' Trust	419	103	N/A
EFL Trust	1,322	1,030	714
Alzheimer's Society	1,068	724	607
British Red Cross	107	54	N/A
Sense	455	N/A	N/A
SSAFA	195	53	N/A
Total	4,421	2,171	1,930

2.3 Workstream three: focus groups and service user interviews (qualitative)

Workstream three included case studies of six organisations: Alzheimer's Society, British Red Cross, Home-Start, Carers Trust, RNIB, and SSAFA. As Carers Trust and Home-Start are networked / federated organisations, one local service was selected for case study: Home-Start Medway and Manchester Carers Centre. These were chosen to provide a range of activities, service user groups, as well as include networked organisations. Local networked organisations were chosen based on the clarity of their application, the type of activities they delivered, and geographic area they covered. Data for the case studies was collected by service user interviews and focus groups with programme managers, project leads, operational staff, and volunteers. Two different topic guides were developed for the focus groups: one for programme managers and project leads, and one for staff and volunteers. One topic guide was developed for all service user interviews. The topic guides are presented in Appendix A.

2.3.1 Service user interviews

Service users were recruited through their respective organisations. Programme managers contacted service users to ask if they would like to take part in an interview, then gained consent for their details to be passed to NatCen via secure data transfer. The NatCen research team subsequently contacted potential participants by telephone and / or email to arrange an interview with an experienced researcher.

All participants were sent a study information leaflet (please see Appendix B), tailored by each organisation, explaining the evaluation in more detail, the process of consent, and data protection standards. In addition, all participants were sent an aftercare leaflet (please see Appendix C) tailored by each organisation, which signposted them to relevant services should they have needed them. NatCen also has a disclosure procedure in place as standard practice, whereby researchers could alert relevant parties if their interviewee or others were at risk of immediate harm.

Organisations were asked to provide the contact details of 30 service users, with the aim of recruiting eight participants from each organisation. This was to ensure anonymity, provide a larger pool of service users to recruit from due to expected take up, and prevent organisations selecting their most positive cases. However, this was not always possible, partly due to the vulnerability and time constraints on many of the service users (those living with dementia, young carers, single parents, and older people). However, possibly due to the staged consent process, whereby organisations contacted service users directly prior to sharing their contact details, the take up was high (75% of contacts provided agreed to be interviewed).

Service users interviewed included single parents, people living with disabilities, those who are digitally excluded, refugees/asylum seekers/vulnerable migrants, as well as young and parent carers. Not all participants disclosed their ethnicity, but of those who did eight came from ethnic minority backgrounds and 12 identified as White British. As presented below in Table 2:2, there were more female than male participants. Service users interviewed were a range of ages, although one did not disclose their age, with the 45-54 age group being harder to reach (Table 2:3).

Table 2:2 Participants by gender

Gender	Number

Table 2:2 Participants by gender

Female	22
Male	14

Table 2:3 Participants by age band

Age band	Number
18-24	4
25-34	5
35-44	5
45-54	2
55-64	6
65-74	5
75+	8

2.3.2 Focus groups

Programme managers were asked to provide contact details for project leads, operational staff, and volunteers. Participants were contacted by programme managers and were asked if they would like to take part in a focus group and, if so, consent for their details to be passed to NatCen via secure data transfer. The NatCen research team then contacted potential participants, requesting their availability over two days, before sending invitations to participants based on availability and role. All participants were sent a study information leaflet explaining the evaluation in more detail, the process of consent, and data protection standards.

Programme managers were asked to provide contact details of multiple participants under each role; however, the number was not prescriptive due to the varied structure and size between organisations. As with the service user interviews above, multiple contacts were requested to ensure anonymity, as well as provide a larger pool of participants to recruit from due to expected response rates. In total, 72 contact details were provided and one participant from each organisation was recruited for each focus group (n=16). As might be expected with participants in such demanding roles, three participants across all focus groups had to withdraw due to last minute commitments. However, follow up interviews were arranged and conducted in order to capture their views.

2.3.3 Data collection and analysis

All service users were invited to take part in an interview by telephone or Microsoft Teams, whereas all focus groups were conducted via Microsoft Teams. Interviews and focus groups were audio recorded through an encrypted computer programme (Amolto) to support analysis.

The Framework approach to qualitative data analysis was applied, facilitating robust qualitative data management and analysis by case and theme within an overall matrix.[1] Using this Framework approach, we developed thematic matrices through familiarisation with the data and identification of emerging issues. Each thematic matrix represented one key theme (e.g., barriers and facilitators to programme implementation), and the column headings in each matrix related to key sub-topics. We then summarised the data from each case (i.e., from one service user) into the relevant cell.

2.3.4 Interpretation

The aim of qualitative research is to access the breadth and diversity of participants' experiences and views. Participants' responses are not exhaustive in that only some potential participants take part. We made sure to obtain views from a range of participants, and all the views expressed were reported, but may not be representative of what all potential participants would have said since the sample was purposive (as opposed to representative).

We are reporting what participants told us, whether or not their perspectives contradict existing aims, activities, and policies of the respective case study organisations. Such contradictions or misunderstandings can themselves be a useful source of learning regarding how policies and practices translate into experiences of relevant stakeholders.

2.4 Ethics

Ethics permission was received from NatCen Research Ethics Committee (REC) for each workstream where primary data collection (i.e., surveys and interviews with staff and / or service users) was to be carried out. Our REC procedure is designed to ensure that all research undertaken by NatCen Social Research is ethically sound and meets the ethical standards of government and other funders. The REC reviewed each of our separate applications to ensure that we collected fully informed consent, considered diversity and accessibility requirements, that our approach to recruitment was not coercive and that the requests for information were proportionate and necessary to address research objectives.

2.5 Limitations

Limitations regarding service user qualitative interviews include:

- The proportion of participants were not evenly distributed across organisations, with a range of two to twelve, partly due to some organisations being able to provide more contacts than others.
- Interviews were offered in English via phone and the internet, which may have resulted in some hard to reach participant groups being excluded.
- Although the interviews were conducted with experienced researchers, the sensitivity of the topic i.e. loneliness may have resulted in participants not being as forthcoming compared to other topics.

The following limitations applied to the monitoring data:

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[1] Ritchie, J., Lewis, J., Nicholls, C.M. and Ormston, R. eds., 2013. Qualitative research practice: A guide for social science students and researchers. Sage.

- There was no counterfactual data available for people who did not receive support through the programme, so it was not possible to identify the impact (if any) of the intervention.
- There may be measurement differences in the data, because it was collected through a variety of different modes (both self-completion and with assistance from staff).
- There were differing levels of response from different grant holders and data has not been weighted to account for this, so will not be representative of all service users who received support from these grant holders.
- Finally, Mind and Sense service users are not included in the dataset.

3 Background

3.1 Literature review: the impact of the Covid-19 pandemic on loneliness and wellbeing in the UK

The evidence from the literature presented in this section does not provide definitive conclusions on whether loneliness has increased during the Covid-19 pandemic. Many of the papers presented data collected in the initial acute first phase of the pandemic from March to May 2020, in some cases attempting to draw comparisons with pre-pandemic loneliness, or in others mapping a rise and fall in loneliness within the first two to three months of the pandemic. More recent ONS data presented below may provide a more reliable picture after the first full year of the pandemic and successive lockdowns. Underlying the headline prevalence figures is a wide variation in experiences between those who were already lonely or isolated and those who were not. There is some evidence of greater or increased loneliness during the Covid-19 pandemic in specific groups, such as young people, women, unemployed people, those who live alone or are isolated (divorced, single, shielding), people living with dementia and those who are digitally excluded.

3.1.1 Extent of loneliness during the Covid-19 pandemic in the UK

Prevalence estimates of loneliness from several studies are presented here. Differences in the methods used mean that the figures are not directly comparable: some studies have used volunteer samples rather than representative probability-based samples; different measures of loneliness have been used, as set out in Table 3:1 at the end of this section; other estimates are subject to large margins of error because of small sub-sample sizes.

Before the Covid-19 pandemic, the *Community Life Survey (CLS)* showed around 6% of adults (16+) were always or often lonely (DCMS, 2020). Official data indicated that "*lockdown loneliness*" (wellbeing "*affected through feeling lonely in the past seven days"*) may have been affecting **14.3%** of the Great Britain adult population during April 2020 (Office for National Statistics (ONS), 2020a). This compared with "*chronic loneliness"* (feeling lonely 'often or always') for which the prevalence at the same time point was **5.0%**.

Later figures from the November 2020 national lockdown period indicated that **8%** of adults in Great Britain felt lonely 'often or always', while the proportion of those feeling lonely was higher among young adults (16-29 years) at 15%, than among the general population (ONS, 2020b, Table 13: Loneliness). Regional differences in loneliness and wellbeing among adults emerged during the first two weeks of the November 2020 lockdown, although small sample sizes in some of the areas mean that this finding should be treated with caution (ONS, 2020b). Loneliness increased among the adult population in Great Britain, from **5.0%** in April 2020 to 7.2% according to ONS survey findings for the period October 2020 to February 2021; loneliness rates were higher in areas with higher concentrations of younger people (aged 16 to 24), higher in areas with higher unemployment rates, and lower in countryside areas than in urban or industrial areas (ONS, 2021).

Several UK studies pointed to a sizeable minority reporting loneliness during the Covid-19 pandemic. Analysis from the nationally representative *Understanding Society Covid-19 Study* showed that **35.86%** of respondents ‘sometimes’ (28.63%) or ‘often’ (7.22%) felt lonely (Li and Wang, 2020), while a smaller scale study conducted between 23 March and 24 April 2020, assessed the prevalence of loneliness among UK adults at **27%** (Groarke et al., 2020). A large online survey with a volunteer sample (*UCL Covid-19 Social Study*) found the prevalence of being ‘often’ or ‘always’ lonely to be **18.5%** (data collected 21 March through 10 May 2020) (What Works Centre for Wellbeing, 2020).

3.1.2 Effects of the Covid-19 pandemic on loneliness (including change to loneliness) in the UK

In addition to the ONS figures cited above which suggest an increase from 5.0% to 7.2% in chronic loneliness among adults in Great Britain across the first year of the Covid-19 pandemic (ONS, 2021), other surveys and studies have attempted to determine whether there has been a change in the prevalence of loneliness.

Analysis of wave 1 (pre-pandemic) and wave 2 (during the pandemic) of the *Community Life Survey* (and *Community Life Covid-19 Re-Contact Survey*) suggested that overall there was little net change in the rate of loneliness (**8%** said they felt lonely ‘often or always’ at both time points); however at the individual level there was variation with some people feeling lonely more often at wave 2, while others felt lonely less often (DCMS, 2020).

A study drawing on the *UCL Covid-19 Social Study* data from March to May 2020 found that **32.5%** of people felt lonely ‘sometimes’ and **18.3%** felt lonely ‘often’ during that period, compared with pre-pandemic loneliness levels found by the *UK Household Longitudinal Study (UKHLS)* data collected 2017-2019, which were 28.6% ‘sometimes’ and 8.5% ‘often’ (Bu et al., 2020a).

Those who were loneliest at the outbreak of the Covid-19 pandemic (14% of the population) became lonelier; in comparison, those who were least lonely before the Covid-19 lockdown became less lonely during the first six weeks of the national lockdown (What Works Centre for Wellbeing, 2020). A UK cross-cohort analysis found that risk factors for loneliness were very similar before and during the pandemic with “*young adults, women, people with lower education or income, the economically inactive, people living alone and urban residents at higher risk”* (Bu et al, 2020a, p32).

Looking at change to loneliness during the first months of the Covid-19 pandemic in the UK, a study grouped participants into four levels of loneliness and found that self-reported loneliness increased among those with the highest loneliness at the start of lockdown, dropping back and stabilising in weeks six and seven, while those with the lowest initial levels of loneliness reported this decreasing in the first five weeks and then *“rebounding*” in week six. (Bu et al., 2020b).

3.1.3 Effects of the Covid-19 pandemic on loneliness (including change to loneliness) in Europe and USA

A nationally representative April 2020 survey of US adults found that **13.8%** reported feeling lonely ‘always’ or ‘often’, compared with 11% in a separate 2018 study, while there was a sharper increase in serious psychological distress (13.6% relative to 3.9%) (McGinty et al., 2020).

A study of US adults found no significant changes to mean levels of loneliness across three time points from late January to late April 2020. However, older adults (aged 65 or more) reported less loneliness compared with younger age groups (aged 18 to 39), and those reporting higher levels of loneliness at baseline (people living alone and those with at least one chronic health condition) did not report increased loneliness during the lockdown (Luchetti et al., 2020).

By contrast, a survey of young US adults aged 22–29 found that loneliness did increase a small amount between January 2020 (before the Covid-19 pandemic) and April/May 2020 (Lee et al., 2020), with greater increases in loneliness among women compared with men. People who felt they had less social support reported higher levels of loneliness at both points in time, however those with higher social support in January reported a bigger increase in loneliness during that period (Lee et al., 2020).

Older adults (aged 65+) in the Netherlands reported an increase in social and emotional loneliness[2] in May 2020 after social distancing measures were introduced, compared with autumn 2019, but there was stability in people's mental health and physical distancing did not lead to feelings of social isolation (van Tilburg et al., 2020).

Online searches for 'loneliness' topics increased significantly in Europe (then fell back after a few weeks) but not in the USA, comparing searches before and after the spring 2020 lockdown periods with searches in the same two periods in 2019 (Brodeur et al., 2020). Searches for boredom topics increased sharply in both the US and Europe and searches for boredom, sadness and worry did not abate during that period (Brodeur et al., 2020).

3.1.4 Loneliness as a risk factor for psychological distress and mental health issues

In Britain, both "chronically lonely" and "lockdown lonely" adults "were more likely than average to report: feeling stressed or anxious; spending too much time alone; feeling bored; making their mental health worse; strain on their personal relationships; having no-one to talk to about their worries" (ONS, 2020a, p. 9 of 22). There was a statistically significant[3] difference between the chronically lonely and the lockdown lonely in self-reported worsening mental health in the past seven days (62.5% and 45.8% respectively).

Several studies in the UK and international literature have demonstrated a link between loneliness and Common Mental Disorders (CMDs), such as depression and anxiety, during the pandemic (Chandola et al., 2020; Krendl and Perry, 2020; Shrira et al., 2020 cited in Manca et al., 2020). This is particularly noticeable in older people, especially older women, or those who felt older than their demographic age (e.g., Krendl and Perry, 2020; Robb et al., 2020; Manca et al., 2020; Shrira et al., 2020 cited in Manca et al., 2020), young adults (e.g., Lee et al., 2020), children and adolescents (e.g., Loades et al., 2020).

Several studies found that younger age groups were at higher risk of loneliness than their older peers, with one concluding from multivariate analysis that age is the stronger predictive variable (Bu et al., 2020a; Groarke et al., 2020; Li and Wang, 2020; ONS, 2020a; Robb et al., 2020). Of studies which included sex as part of their analysis, four

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[2] Social loneliness denotes loneliness from reduced or unengaging wider social networks and connections, while emotional loneliness results from lack of intimate companionship or close emotional ties (Weiss, 1973, cited in van Tilburg et al., 2020).

[3] Survey estimates are subject to a margin of error. It is likely that the proportion of chronically lonely and lockdown lonely people who reported that their mental health had been affected in the past seven days was between 52.8% and 72.3% (chronically lonely) and between 40.9% and 50.7% (lockdown lonely).

studies found that women were at greater risk of loneliness during the Covid-19 pandemic (Bu et al., 2020a; Bu et al., 2020b; Li and Wang, 2020; Robb et al., 2020), whereas one study found no significant difference between men and women (Groarke et al., 2020). Partnership status was also found to have an effect, with those not in a relationship being at greater risk of loneliness than those who were in a relationship, and those who were separated or divorced were at twice as much risk as those who were single (Groarke et al., 2020). Other groups associated with being at higher risk of loneliness include those living alone (Bu et al., 2020a); being unemployed and / or having low household income (Bu et al., 2020a; Li and Wang, 2020); those shielding and therefore in need of social support (Li and Wang 2020; Local Government Association & Association of Directors of Public Health (LGA & ADPH), 2020); people living with dementia and their carers (Giebel et al., 2020); cancer patients (Garutti et al., 2020); and those who are digitally excluded (LGA & ADPH, 2020).

3.1.5 Protective factors and mitigations – what works well

Befriending was the most prevalent intervention cited in the literature aimed at reducing loneliness. One randomised control trial found a reduction in loneliness after four weeks (Kahlon et al., 2021), whereas another study found that befrienders themselves benefitted by learning new skills such as active listening (Joosten-Hagye et al., 2020).

A number of facilitators for remote befriending services were reported, with one paper splitting facilitators into three elements: participants were able to talk freely and form relationships with peers; groups connected participants who had common or shared experiences; and there was some form of guidance or pastoral input, even if very light (Boulton et al., 2020). One nursing home-based study reported that volunteers found it useful having had prior in-person contact, agreeing a preferred mode of contact e.g., video or telephone, and flexibility about timing as facilitators (Fearn et al., 2021). In the same study, barriers perceived by the volunteers included: older adults' concerns about possible costs of the calls, unwillingness to take up time of nursing home staff to set up calls, loss of visual cues if befriending through phone calls, connection problems, health conditions such as deafness or memory loss, and loss of physical touch such as a hug or gentle touch on the hand (Fearn et al., 2021).

In the UK, combatting digital exclusion and social isolation through intergenerational support was mentioned by the LGA / ADPH, with the recommendation that younger relatives could help older family members to get online (LGA & ADPH, 2020). Responses at the local level such as "*virtual pubs, choirs and concerts*" (LGA & ADPH, 2020, p.3) have helped to keep people connected. An Italian-based study recommended that medical staff should play a greater role in the emotional support usually provided by family, as well as recommending that care plans for cancer patients should include digital support provision to facilitate phone and video calls with family and enabling remote medical consultations (Garutti et al., 2020). Older adults in a small US study of those sheltering in place reported keeping in touch with family and friends by making more use of social media; however, this did not mitigate being lonely for them (Krendl and Perry, 2020).

Table 3:1 Loneliness measures used in studies

Measures	**Scale / Responses**	**Source - if using a standard or published measure**	**Studies using the measures**
"Chronic loneliness": 'How often do you feel lonely?'	'often or always', 'some of the time', 'occasionally', 'hardly ever', 'never'	Measure asked in the ONS *Opinions and Lifestyle Survey.*	Office for National Statistics (2020a)
"Lockdown loneliness": 'In the past seven days, how has your well-being been affected?' Asked of respondents who said their well-being had been affected in the past seven days and they were 'very' or 'somewhat worried' about the effect of coronavirus on their life.	'Feeling lonely – Y/N'		
'In the last 4 weeks, how often did you feel lonely?'	'hardly ever or never', 'some of the time,' and 'often'.	*English Longitudinal Study on Ageing (ELSA)*	Li & Wang (2020); Chandola et al. (2020) (did not mention the source)
'How often do you feel lonely?'	'always', 'often', 'sometimes', 'rarely', 'never'		McGinty et al., (2020)
Emotional loneliness: 'I experience a general sense of emptiness', 'I miss having people around me', 'I often feel rejected'. Social loneliness: 'There are plenty of people I can rely on when I have problems', 'There are many people I can trust completely', 'There are enough people I feel close to'.	'no', 'more or less', 'yes'	The de Jong Gierveld short scales for emotional and social loneliness	van Tilburg et al. (2020); Kahlon et al. (2021)
Past month loneliness measured on three-item scale: 'how often do you feel that you lack companionship', 'how often do you feel left out', 'how often do you feel isolated from others'	'Hardly ever', 'some of the time', or 'often'?	Hughes et al., (2004) *A short scale for measuring loneliness in large surveys*, cited in Lee et al. (2020).	Lee et al. (2020)
'How often do you feel that you lack companionship?' 'How often do you feel left out?' 'How often do you feel isolated from others?' Also 'How often do you feel lonely?'	3-point scale from 'hardly ever/never' to 'often' Same 3-point scale for response.	UCLA 3-item loneliness scale Direct measure of loneliness Together these four questions make up the Government's recommended harmonised measure of loneliness[4]	*Covid-19 Social Survey* cited by What Works Centre for Wellbeing (2020); DCMS (2020) Krendl and Perry (2020); Bu et al. (2020a); Bu et al. (2020b); Kahlon et al. (2021).
"During the period of reduced social contact, have you experienced loneliness (felt isolated, with no companions)'	'Never, 'rarely, 'sometimes', 'often'.	Imperial College Sleep Quality questionnaire and Centre for Epidemiologic Studies of Depression Scale, for work-free periods)	Robb et al. (2020)

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[4] The Government's recommended harmonised measure for loneliness in those aged 16 and over is made up of four questions (indirect and direct measures of loneliness): the UCLA three-item scale (indirect questions); and the direct question 'How often do you feel lonely?'. Retrieved on April 16, 2021 from https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/methodologies/measuringlonelinessguidanceforuseofthenationalindicatorsonsurveys and https://gss.civilservice.gov.uk/wp-content/uploads/2020/05/Loneliness-addition-harmonisation-guidance-1.pdf.

3.2 Activities supported by the Covid-19 Loneliness Fund

This section presents the structure, processes and activities delivered by each organisation that have been supported by the Fund. The findings are based on the document analysis and discussions with organisations throughout the project.

3.2.1 Alzheimer's Society

The Alzheimer's Society directly supports people with dementia, as well as their carers and families, to manage the condition effectively and live well with the support of their community. Three sets of activities were developed and delivered nationally to support people with dementia and their carers, which have continued as part of the extension of the Fund. Welfare calls took place over the phone and aimed to support the wellbeing of people with dementia by providing advice, information and signposting. Companion calls for people with dementia and their carers were provided by Alzheimer's Society volunteers. These provided an opportunity for an informal chat, which aimed to reduce loneliness and provide support to those who may have been isolated from usual sources of support during the Covid-19 pandemic. Finally, weekly 'singing for the brain' group sessions were provided over video and telephone for people with dementia. These sessions were based around music therapy and singing, focussing on vocal exercises that help improve brain activity and wellbeing.

3.2.2 British Red Cross

The British Red Cross directly supports people through personal crisis and aims to build resilient communities. In the UK, they are helping people living with challenges ranging from poor health and poverty to emergency response and insecure immigration status. The Fund has enabled the British Red Cross to adapt and scale up services, which aim to continue delivery and support for unmet needs during the Covid-19 pandemic. The programme was implemented in nine different locations across England and their Vulnerability Index[5] was used to identify additional 'cold areas' with greatest unmet need. Within these areas, support has been provided through working with existing British Red Cross services. Although the programmes aim to reach a range of people at risk of loneliness, support has focussed on young people (16-24), BAME communities[6], refugees, digitally excluded individuals and people with health problems.

The Fund has enabled the British Red Cross to train digital mentors who support those who may be at risk of loneliness to get online. Online learning sessions have also been delivered, which aimed to connect groups of people digitally and prevent loneliness. Those identified as lonely or at risk of loneliness received either telephone or face-to-face practical and emotional support. Support for refugees has focussed on the distribution of digital equipment and data packs which allow people to make calls outside the UK and access the internet. Programmes have placed focus on translation of resources to allow BAME individuals who speak little or no English to access support.

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[5] Please see here: https://britishredcrosssociety.github.io/covid-19-vulnerability/

[6] The term 'BAME' has been used to reflect the language used by the British Red Cross. However, guidance published by the UK Government advises different language is now to be used. Please see here for more information: https://www.ethnicity-facts-figures.service.gov.uk/style-guide/writing-about-ethnicity

3.2.3 Carers Trust

Carers Trust is the largest charity supporting unpaid carers in the UK. They work nationally to raise awareness of the challenge that carers face, campaign for better support and provide services and grants through a network of independent partners. Although the programme has been managed by the Grants and Programmes Team at the Carers Trust, the Fund has been disseminated between the trust's England Network Partners which are local carers organisations. It has allowed them to increase their capacity to deliver existing services as well as offer additional services. Focus was placed on improving and adapting existing support services to make them suitable for delivery during the Covid-19 pandemic, offering better support to Carers who have experienced increased isolation and loneliness. For example, young carers, older carers, and those caring for people in the shielding group were some of the groups targeted for support. Carers Trust UK have provided onward grants to local charities in their network to offer group activities enabling these carers who are most at risk of loneliness to connect with others from home. A second stream of work focussed on adapting carers support services. This has included setting up and managing online carer support, expanding telephone and befriending services and increasing online and offline marketing materials. Priority was given to activities which targeted carers living in rural and high-density urban areas, where they can experience high levels of loneliness due to their location and access to services.

Manchester Carers Centre was chosen as a case study for this evaluation, which provided a 'Call a Carer' service and creative writing activities. The 'Call a Carer' service offered emotional support, befriending at a difficult time, and aimed to help carers deal with a range of emotions as well as to access practical help. The 'Creative Writing' course available both online and offline offered carers a viable opportunity to access regular respite, safely from their own home, and in a manner that suited them best.

3.2.4 EFL Trust

The EFL Trust is the charitable arm of the English football league. It operates through a network of Community Club Organisations (CCOs) to deliver projects that focus on improving health and wellbeing, raising aspirations, and building stronger, more cohesive communities. The CCOs run activities at a local level and are based in football clubs, supporting those within a 10-mile radius of the club. The Fund has allowed an extension and digital adaptation of their 'Extra Time Hubs', which aim to improve the connectedness and lifestyle habits of older people. The selection of local clubs for the programme was influenced by public health data and loneliness risk factors, with the aim to reach older people over 70 who have experienced increased loneliness during the Covid-19 pandemic. Telephone befriending services were provided by local clubs, which aimed to provide reassurance, companionship, practical advice and signposting to older people. In addition, some face-to-face conversations and keeping fit sessions were delivered by staff and volunteers from a distance 'at the garden gate'. The EFL Trust has also provided online networking and activities including coffee mornings, quizzes and virtual tours. In order to reach those who are not online, support was also provided by post, such as the distribution of activity and guidance packs.

3.2.5 Home-Start

Home-Start is a family support organisation which is run through a network of local Home-Starts. Support is tailored to each family's need, which is provided to parents in their homes and communities on both a one-to-one and group basis. The Fund was distributed to local Home-Starts through an application process and onward grants were made across England. Home-Start has identified that new mothers are at particular risk of isolation and loneliness during the Covid-19 pandemic. The Fund has allowed targeted and proactive support for this group to take place. In particular, young mothers, mothers with mental health vulnerabilities, mothers with no support networks and expectant or new mothers were targeted. Home-Start aimed to reach these groups by working with health visitors, hostels, midwives, refuges, GPs, Covid-19 response hubs and local charities. The support has included telephone and online calls to provide critical emotional support for family mental health, as well as helping families stay connected with each other through group chats, video calls and online meet ups. In addition, local Home-Starts have mobilised crisis responses with local partners, distributing emergency aid such as food, nappies and medicines. They have also provided data and technology to ensure mothers have the means to stay connected.

Home-Start Medway was chosen as a case study for this evaluation, which has been providing Family Support Workers to single parents. An initial contact with a Family Support Worker identifies the service user’s individual needs and signposts them to specialist services, followed by a further two contacts for up to four weeks. These are delivered via telephone or face-to-face, depending on government guidelines. Support is reviewed after four weeks and, if agreed with service users, a trained volunteer telephone befriender calls once a week alongside ongoing weekly support with the Family Support Worker.

3.2.6 Mind

Mind is a mental health charity which provides advice and support for those experiencing a mental health problem, as well as campaigning to improve services, raise awareness and promote understanding of mental health. Support is delivered through a network of ‘local Minds’ based in the community. The Fund was used to distribute at least 18 large (<£50k) or small (<£30k) grants through an Isolation and Loneliness Grant Fund to a network of 100 local Mind organisations. These grants have been used to continue, adapt or expand an existing service or deliver one of Mind’s evidence-based products. Feelings of loneliness are more common in people with mental health problems and the support has been targeted at sub-groups who are particularly impacted by loneliness. This has included women, older adults, children and young people, people living with disabilities, the digitally excluded and single parents. Services have varied between areas, but have focussed on listening, befriending and wellbeing support. Examples of evidence-based products include Active Monitoring, an early intervention for people with low to moderate mental health needs, which aims to improve wellbeing; and My Generation, an eight-week programme for older people, which aims to build resilience and reduce isolation and loneliness. Work has taken place to adapt services for remote delivery during the Covid-19 pandemic.

3.2.7 RNIB

RNIB is a national charity directly supporting blind and partially sighted people. The priorities of the charity are to offer information, support and advice to those who are blind or partially sighted and create the conditions in society for them to thrive. Being blind or partially sighted can often lead to loneliness and this issue has been exacerbated during the Covid-19 crisis. The Fund allowed RNIB to continue and expand existing strands of work, such as telephone support groups. In addition, it allowed new actions such as phone calls reaching out to blind and partially sighted people and the piloting of face-to-face interventions to tackle loneliness. Activities have supported both new and existing service users, with recruitment supported by a marketing campaign to publicise the services available. The telephone support groups were adapted and expanded by introducing new facilitated group sessions, supporting the establishment of self-sustaining online groups for older people with digital skills, while establishing new geographic groups in ‘cold spots’. There has also been a focus on increasing the number of young people involved in online groups. Activities have aimed to reduce isolation and increase connections that blind and partially sighted people have to others, as well as increase confidence and independence.

3.2.8 Sense

Sense is a national disability charity directly supporting people with complex disabilities and those who are deafblind. The Fund was used to expand and scale up their Connect 4 Service, which helps disabled people form social connections. Sense’s service users often have specialist communication and access requirements, which can be expensive and leave them at risk of digital exclusion. The project focussed on reaching children, adults and families with complex disabilities, including specific support for young carers and siblings of children with complex disabilities. The charity worked alongside local authorities, corporate partners and disability networks to refer individuals to the project. The funding was used to bring back specialist workers from furlough and work with volunteers who have specific speech and language or social work skills. Virtual activities for children and families were delivered via zoom, including activities for pre-school groups, parent and carer groups and one-to-one support. Specialist sensory equipment and technology was also loaned. In addition, the project delivered a virtual buddying scheme for young people and adults and the provision of arts, sports and wellbeing resources online.

3.2.9 SSAFA

SSAFA aims to relieve need, suffering and distress among the Armed Forces, veterans and their families in order to support their independence and dignity. They do this through holistic support in local communities, tailored support services and health / social care services. The Fund has enabled SSAFA to provide services that aim to create social connections for lonely veterans and their families, while establishing virtual alternatives to their face-to-face services. Those who took part in services were either existing beneficiaries, those who self-referred (e.g., through the organisation helpline) or those referred through other organisations. Social media was also used to publicise support available. A visiting service was developed to maintain in-person contact with vulnerable veterans who may be shielding or self-isolating. The SSAFA helpline was also expanded to provide regular or pro-active calls to lonely veterans and a new online community was developed. This consisted of virtual breakfast and lunch clubs, quizzes and group activities. There was also an expansion of the weekly one-to-one mentoring service, which is aimed at the acutely lonely who are facing extreme challenges adapting to civilian life. Across all activities, those at particular risk of loneliness were targeted, including older people, those in poor health, younger family members, women, and those caring for disabled children.

4 Grant holder monitoring data

This chapter presents findings from monitoring data collected by grant holders about the experiences of their service users during the course of delivering their funding activities. It includes their experiences of loneliness and wellbeing, at a baseline and two follow up timepoints (follow up 1 and follow up 2), their demographic characteristics, and the activities (or services) which were delivered for those people.

Chapter four is split into the following sections: a brief summary of the dataset and how it was collected (section 4.1); a description of the services provided to service users (section 4.2); the findings on how lonely service users were (and what their wellbeing was like) at the baseline and follow up timepoints (section 4.3); and finally the demographic characteristics of service users and how their levels of loneliness and wellbeing varied by their demographics (section 4.4).

Key Findings

- Grant holders provided service users with a range of services.
- The most common individual activities were phone befriending (delivered to 28% of service users) and technical support (23%), although 38% received some ‘other’ form of support.
- This ‘other’ group includes activity and guidance packs delivered to EFL Trust users by post, peer-to-peer support organised by Home-Start and the British Red Cross, and one-to-one mentoring delivered by SSAFA.
- Less common activities were online befriending (5%) and face-to-face befriending (3%).

Loneliness and wellbeing:
Service users were asked about their loneliness and wellbeing at up to three timepoints, a baseline and up to two follow ups.
Loneliness:

- At baseline, among those asked how often they felt lonely, 27% said they ‘often’ felt lonely, which had fallen to 16% by the follow up 2.
- Thirty percent said they often lacked companionship at the baseline, falling to 20% at follow up 2.
- When asked how often you feel left out, 28% said they often felt left out at the baseline, falling to 15% by follow up 2.
- Finally, 37% often felt isolated from others at the baseline, which fell to 24% at follow up 2.

Wellbeing:

- At baseline, 29% of people reported low levels of life satisfaction, which fell to 25% at the follow up 2.
- Nearly a quarter (24%) fell into the ‘low’ band for how worthwhile they felt the things they did in their lives were, which fell to 19% at follow up 2.
- Thirty-one percent of people reported low happiness at the baseline timepoint, which fell to 27% at follow up 2.
- Thirty-five percent of people reported a high level of anxiety, which fell to 30% at follow up 2.

- When only those people with data at both baseline and follow up 2 were analysed, these differences were statistically significant (see Table 4:9 and Table 4:11).

Demographics:

- Among the people in this sample, women were more likely to report that they often had feelings of loneliness across all four measures, and to report lower levels of wellbeing.
- Loneliness was highest in the middle of the age distribution, before falling off among those aged 55+, and the least lonely groups were those aged 65-74 and 75 or over.
- When looking at patterns in wellbeing by age, the main difference is between older and younger age groups, with those aged younger than 55 more likely to report lower wellbeing.
- Finally, people with disabilities were also more likely to report they often had feelings of loneliness and to report lower levels of wellbeing.

4.1 Grant holder activities

4.1.1 Primary activities

Grant holders delivered a diverse range of services to people, as outlined in more detail in section 3.2. Table 4:1 on the next page shows the 'primary' activity each service user in the monitoring data received, grouped into five broad areas. These are befriending (delivered either face-to-face, by phone, or online), technical support, and 'other'.

The 'other' category is the most common (including 38% of service users) because it includes a wide variety of different forms of support, which did not fit into the other areas. This includes activity and guidance packs delivered to EFL Trust users by post, peer-to-peer support organised by Home-Start and the British Red Cross, and one-to-one mentoring delivered by SSAFA.

Phone befriending, the next common primary activity at 28%, also includes a diverse range of services. For example, Alzheimer's Society delivered companion calls to its service users, which have been included under the phone befriending label.

The next most common group, technical support, primarily includes the provision of equipment such as phones or tablets, or of data packages and was the main service for 23% of our dataset.

Online and face-to-face befriending were less common, delivered to relatively few service users as their primary activity (5% for online befriending and 3% for face-to-face befriending).

Table 4:1 Primary activity

	%
Phone befriending	28.1
Technical support (e.g., using IT equipment)	22.8
Online befriending	5.4
Face-to-face befriending	2.9
Other	37.9
Not answered	2.5
Not supplied by grant holder	0.5
Base	***6,808***

4.1.2 Additional activities

Not all grant holders provided data on additional activities, resulting in SSAFA and Sense service users being exempt from Table 4:2. Among those grant holders that did record this data, nearly 80% of service users were not provided additional activities beyond the primary activity. Most commonly delivered as an additional activity was online befriending, received by 12% of service users. This was followed by phone befriending (11%), face-to-face befriending (7%) and technical support (6%). A further 12% of service users were also provided some form of other additional services.[7]

Table 4:2 Additional activities

	%
Phone befriending	11
Face-to-face befriending	7
Online befriending	12
Technical support (e.g., using IT equipment)	6
Other	12
No additional activities recorded	77
Base	***5,990***

4.2 Loneliness and wellbeing

Four measures of loneliness were collected by grant holders, intended to capture different elements of the experience of loneliness. These are self-reported measures asked of service users and were collected either through self-completion or through interviews by frontline staff or volunteers. The measures are outlined in Table 4:3 on the next page.

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[7] Note that these sum to more than 100% because people could receive multiple additional types of support.

Table 4:3 Measures of loneliness

Measures	Items	Response categories
Three-item UCLA Loneliness scale[8]	1. How often do you feel that you lack companionship?	Hardly ever or never, Some of the time, Often
	2. How often do you feel left out?	Hardly ever or never, Some of the time, Often
	3. How often do you feel isolated from others?	Hardly ever or never, Some of the time, Often
Direct measure of loneliness	How often do you feel lonely?	Often / always, Some of the time, Occasionally, Hardly ever, Never (In the reporting these are combined into 1) often/always, 2) some of the time/occasionally, and 3) hardly ever/never)

The individual UCLA loneliness questions measure different elements of the experience of loneliness. Across the three questions, responses can then be scored to give a single measure. To score the UCLA loneliness scale, the average is taken of each respondent's score across the three questions (Hardly / never=1, Often=3: High score = lonely, Low score = not lonely). There is no standard score at which someone can be said to be lonely, however, the average score across the sample may be compared across different groups or over time.

When trying to estimate the overall level of loneliness in a sample, ONS recommend using the 'how often do you feel lonely?' question.[9] It can be used as a stand-alone measure of loneliness, or in combination with the UCLA loneliness scale questions. The disadvantage with this question is that a direct question about loneliness may lead to it being under reported in particular groups, in particular among men. Most explanations of why women may be more willing to admit to feelings of loneliness centre around social influences. One study tested this by presenting people with a case study of a lonely person and varied only whether this person was male or female. This study found people were more negative about men who were lonely than women, which supports the position that underreporting of loneliness by men may be due to more negative social consequences for men.[10] Due to this underreporting it can be useful to combine it with the UCLA score. For example, if the direct loneliness question suggests older men are less likely to be lonely than women in the same age group, but the UCLA loneliness scale is higher for men, that may suggest some underreporting of loneliness by men.

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[8] UCLA refers to University of California Los Angeles (UCLA) three-item loneliness scale.

[9] Office for National Statistics (2018). Measuring loneliness: guidance for use of the national indicators on surveys. [Accessed at https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/methodologies/measuringlonelinessguidanceforuseofthenationalindicatorsonsurveys]

[10] Borys, S., Perlman, D. (1985). Gender differences in loneliness. *Personality and Social Psychology Bulletin,* 11(1), 63-74.

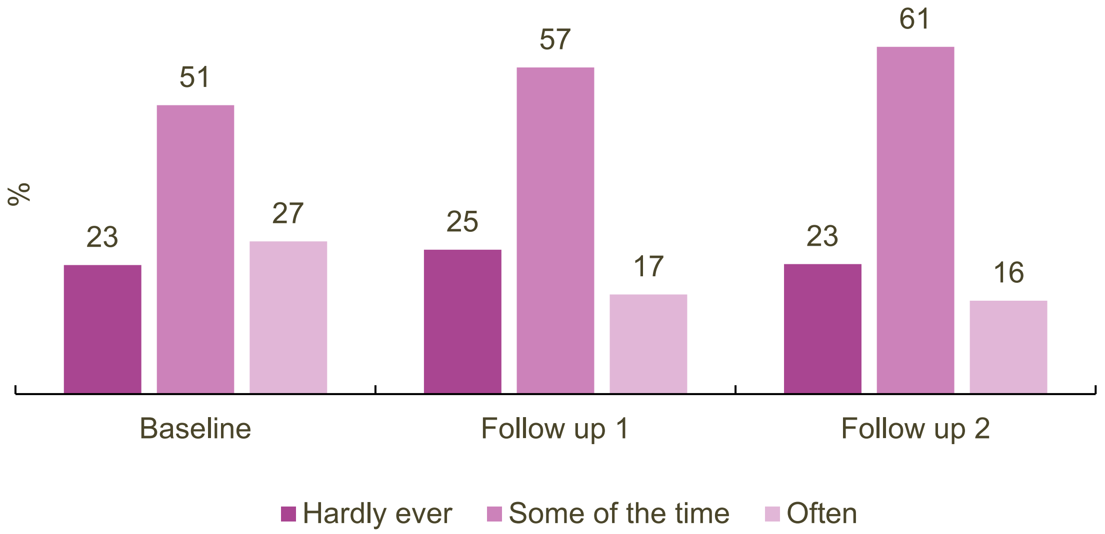
4.2.1 Loneliness – at baseline and follow up

How often do you feel lonely?

Figure 4:1 presents service users' self-reported loneliness at each of the three timepoints. At the baseline and follow up 1, the data covers all seven grant holders, but only three at the final timepoint (the EFL Trust, Home-Start and the Alzheimer's Society).

The chart shows that at the first timepoint, when asked directly about feeling lonely, 27% of service users in the dataset said they often felt lonely, about half that they felt lonely some of the time, and 23% said that they hardly ever felt lonely. At follow up 1 the proportion who felt lonely often had fallen to 17% and remained similar (16%) at the final timepoint.

Figure 4:1 How often do you feel lonely?



Base: includes all seven grant holders at baseline (3,561) and follow up 1 (2,126), but only three grant holders at follow up 2 (1,893).

How often do you lack companionship?[11]

Figure 4:2 shows a similar picture to figure 4:1, with 30% of service users reporting that they often lack companionship at the baseline, 42% that they sometimes lack companionship and 27% that this was rarely the case. The proportion feeling lonelier (those who often lack companionship), has also fallen in a similar way, dropping from 30% at the baseline to roughly one-fifth at the follow up timepoints.

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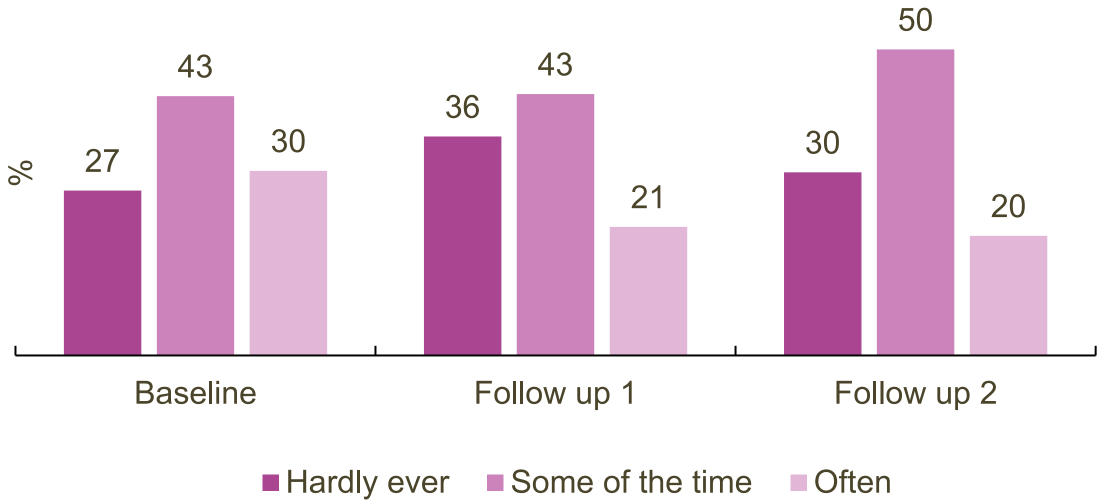
[11] It should be noted, the remaining loneliness measures (the UCLA measures) do not include Alzheimer's Society service users, as they were not asked these questions.

Figure 4:2 How often do you lack companionship?

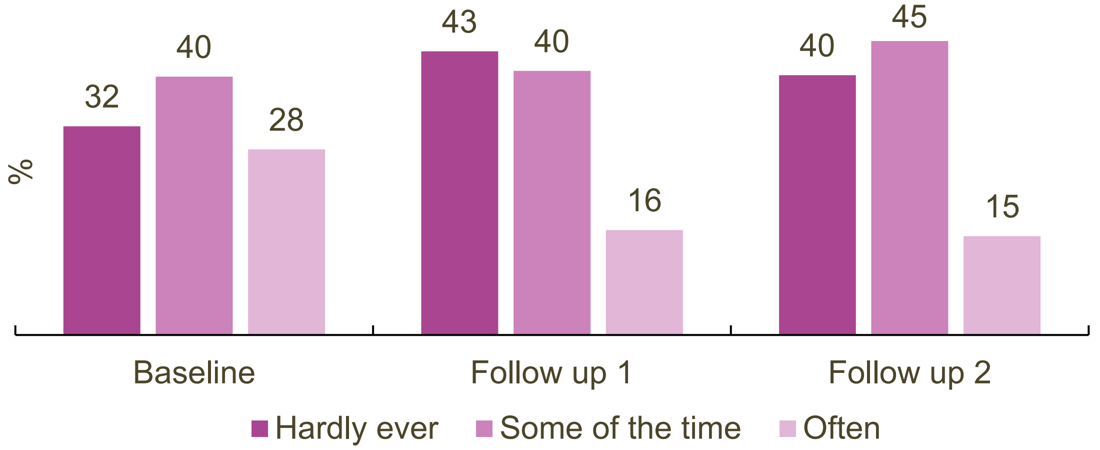


Base: includes six grant holders at baseline (2, 773) and follow up 1 (1, 421), but only two at follow up 2 (1, 293).

How often do you feel left out?

At the baseline, Figure 4:3 shows that 28% of service users reported they often felt left out, 40% that they sometimes did, and 32% that they hardly ever felt left out. As in the other loneliness measures, the proportion of service users who often felt lonely fell at the later timepoints (from 28% to around 15%).

Figure 4:3 How often do you feel left out?

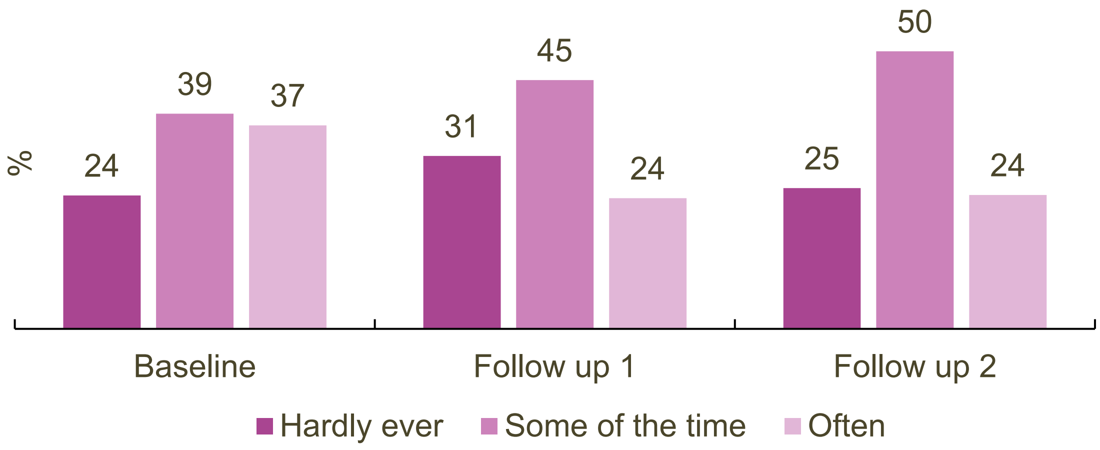


Base: includes six grant holders at baseline (2,726) and follow up 1 (1,399), but only two at follow up 2 (1,281).

How often do you feel isolated from others?

Figure 4:4 on the next page shows a higher level of loneliness than the other measures. At the baseline nearly one in four service users often felt isolated from others, a further 39% felt isolated some of the time, and a quarter (24%) hardly ever felt isolated from others. However, similar to the other measures, the proportion who felt isolated often fell at the follow up timepoints (to 24% at follow up 1 and 2).

Figure 4:4 How often do you feel isolated from others?



Base: includes six grant holders at baseline (2,859) and follow up 1 (1,412), but only two at follow up 2 (1,291).

4.2.2 Wellbeing – at baseline and follow up

Four measures were used to assess service users' wellbeing, which are outlined in Table 4:4 below. These measures include life satisfaction, happiness, anxiety and how worthwhile people feel the things they do are (the question text for each measure is shown in the table). The different measures are not meant to be compiled to give one score for wellbeing; each question is considered to measure a separate dimension of wellbeing and therefore not to be suitable for combination. On each of these areas people are asked to score themselves between zero and ten.

Table 4:4 Personal wellbeing questions

Life Satisfaction	Overall, how satisfied are you with your life nowadays?
Worthwhileness	Overall, to what extent do you feel that the things you do in your life are worthwhile?
Happiness	Overall, how happy did you feel yesterday?
Anxiety	Overall, how anxious did you feel yesterday?

People's responses about life satisfaction, the worthwhileness of life, and happiness rank scores of zero as low wellbeing and ten as high, while the anxiety scores are the reverse (with ten being a high level of anxiety). Each score of 0-10 has been grouped for reporting into four levels, based on a threshold for different levels of wellbeing. These categories are outlined in Table 4:5.

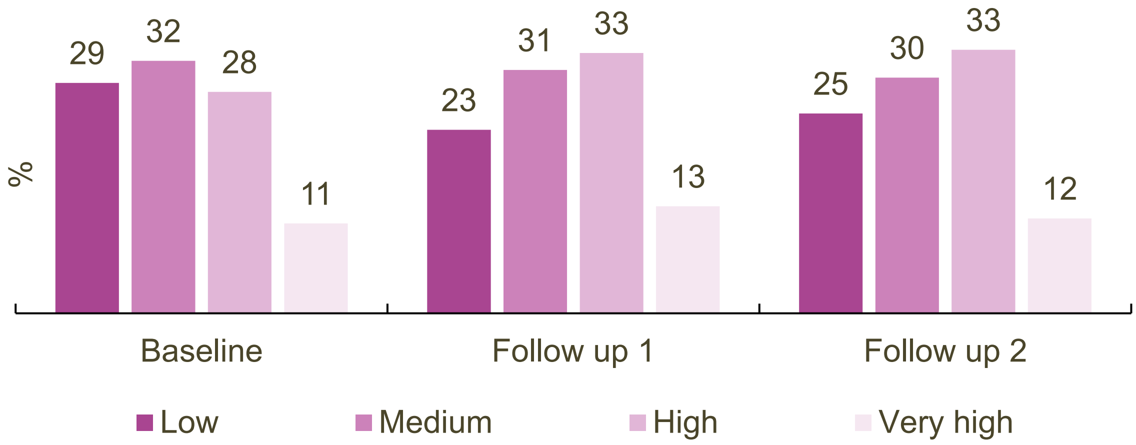
Table 4:5 Personal wellbeing thresholds

Life satisfaction, worthwhileness and happiness		Anxiety	
Score	Label	Score	Label
0 to 4	Low	0 to 1	Very low
5 to 6	Medium	2 to 3	Low
7 to 8	High	4 to 5	Medium
9 to 10	Very high	6 to 10	High

Life satisfaction

Figure 4:5 shows that at the baseline timepoint 29% of service users in the dataset reported low life satisfaction, 32% medium life satisfaction and 28% high life satisfaction, with the remaining 11% of service users having very high life satisfaction. These levels remained similar at the follow up timepoints, although the proportion with low life satisfaction fell to between 23-25%.

Figure 4:5 Overall, how satisfied are you with your life nowadays?

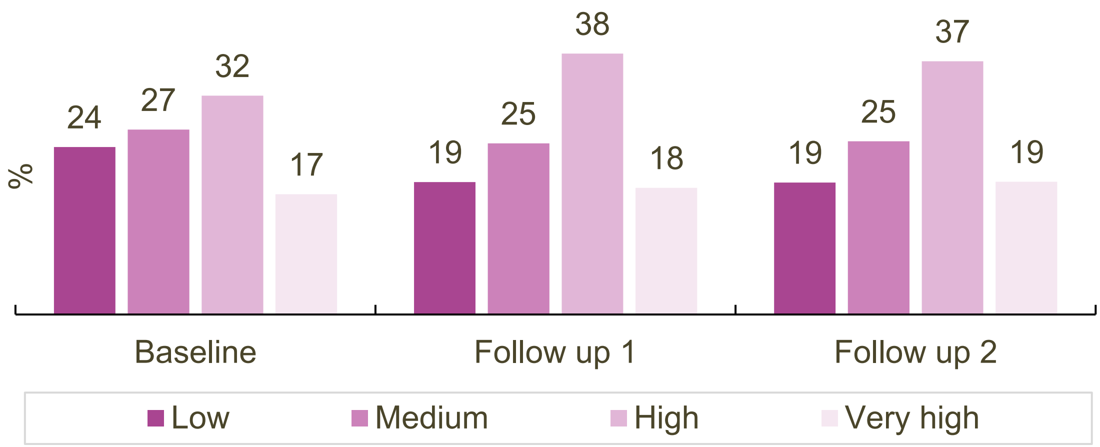


Base: Includes five grant holders at baseline (2,988) and follow up 1 (1, 922), but only three at follow up 2 (1, 907).

How worthwhile people find life

When asked how worthwhile they consider the things they do in their lives, 24% of responses fell within the ‘low’ band, suggesting that they feel their activities are not very worthwhile (Figure 4:6). Around 27% gave a response in the ‘medium’, 32% in the ‘high’, and 17% in the ‘very high’ band. At the follow up timepoints, the proportion with a low perception of how worthwhile their activities were fell from 24% to 19%.

Figure 4:6 Overall, to what extent do you feel that the things you do in your life are worthwhile?

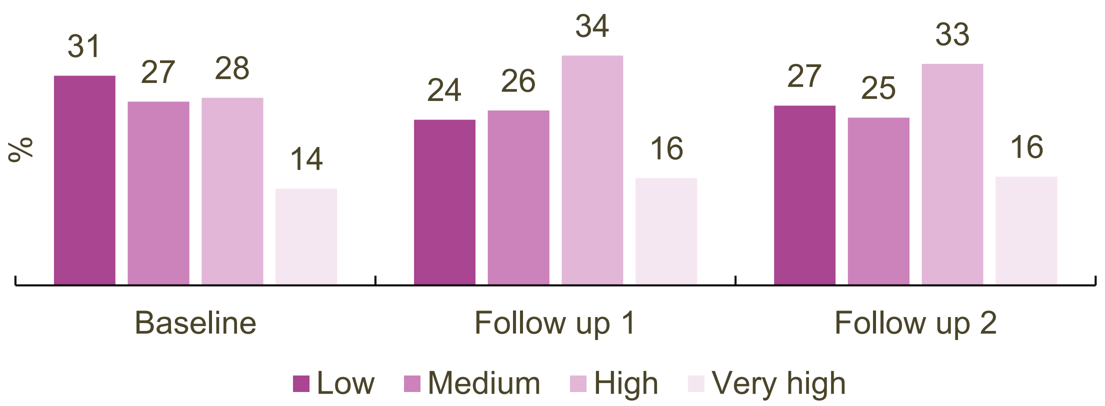


Base: Includes five grant holders at baseline (2, 973) and follow up 1 (1, 910), but only three at follow up 2 (1, 864).

Happiness

Nearly one-third (31%) of service users reported a low level of happiness at the baseline timepoint, 27% a medium level of happiness, 28% a high level, and 14% a very high level of happiness (Figure 4:7). By the time of the follow up timepoints, the proportion reporting a low level of happiness had fallen to 24% at follow up 1 and 27% at follow up 2.

Figure 4:7 Overall, how happy did you feel yesterday?

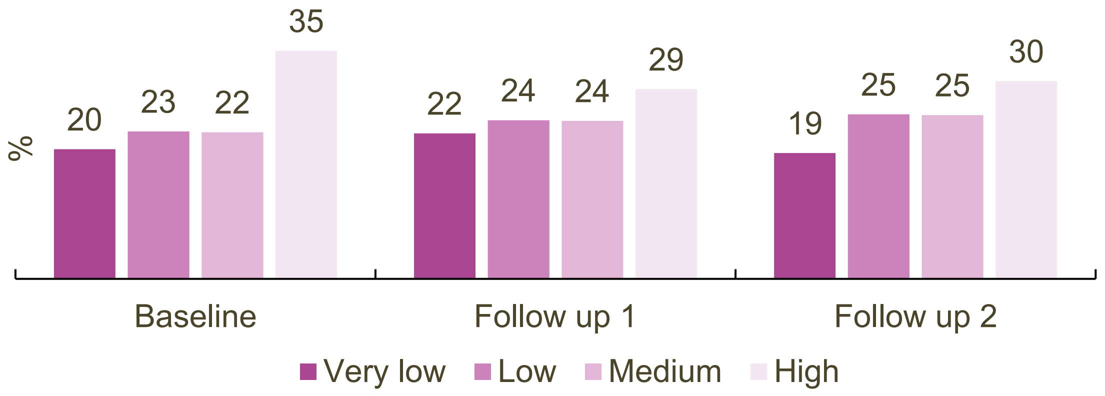


Base: Includes five grant holders at baseline (2,984) and follow up 1 (1,914), but only three at follow up 2 (1,870).

Anxiety

Finally, Figure 4:8 shows that at the baseline timepoint around one-fifth of service users had reported a very low level of anxiety, 23% a low level, 22% a medium level of anxiety and 35% a high level. This fell to 29% at follow up 1 and 30% at follow up 2, although high anxiety remained the most common response among service users.

Figure 4:8 Overall, how anxious did you feel yesterday?



Base: Includes six grant holders at baseline (3,112) and follow up 1 (1,980), but only three at follow up 2 (1,866).

4.2.3 Changes in loneliness and wellbeing between baseline and follow up timepoints

The sections above have presented findings on the distributions of loneliness and wellbeing across the three timepoints. However, the number of service users who responded at first and second timepoints fell and so the change over time for service users where we have multiple timepoints is analysed separately below.

Table 4:6 shows the changes in loneliness measures between baseline and follow up 2. These have been grouped into binary measures in this section in order to run significance tests to establish whether there is a statistically significant change in the proportion of service users who chose the ‘often’ response.[12] These showed that consistently, across all the measures, the changes were statistically significant with the proportions of people who ‘often’ felt lonely falling by the time of follow up 2. For example, at the baseline 41% of service users often felt isolated from others, which fell to 24% at follow up 2. These proportions are slightly different from those in section 4.3.1, because people who were missing one of these timepoints were not included in this table.

Table 4:6 Changes in experiences of loneliness over time: Baseline to follow up two

Question	Timepoint	Some of the time to hardly ever %	Often %	Base	P
How often do you feel lonely?	Baseline	73	27	1,748	0.000
	Follow up 2	84	16		
How often do you lack companionship?	Baseline	68	32	1,293	0.000
	Follow up 2	80	20		
How often do you feel out?	Baseline	70	30	1,268	0.000
	Follow up 2	85	15		
How often do you feel isolated from others?	Baseline	59	41	1,290	0.000
	Follow up 2	76	24		

Base: Includes data from service users with data at both baseline and follow up time point 2. “How often do you feeling lonely” includes data from three grant holders, and the other two questions include data from two.

Table 4:7 on the next page shows the same overall picture, although in this case between baseline and follow up 1. Between these timepoints the proportion of service users who reported that they often felt lonely, across these different measures, fell. For example, the proportion who often felt they lacked companionship reduced from 25% to 20%.

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[12] An estimate considered to be statistically significant at a 5% level where there is P-value of 0.05 or less. This means that there is less than a 5% chance that the change we have found between the baseline and follow up timepoints has occurred by chance. Here the p-values are also less than 0.01, indicating there is less than a 1% of these differences arising by chance.

Table 4:7 Changes in experiences of loneliness over time: Baseline to follow up one

Question	Timepoint	Some of the time to hardly ever %	Often %	Base	P
How often do you feel lonely?	Baseline	79	21	1,861	0.000
	Follow up 1	84	16		
How often do you lack companionship?	Baseline	75	25	1,352	0.000
	Follow up 1	80	20		
How often do you feel left out?	Baseline	78	22	1,312	0.000
	Follow up 1	85	15		
How often do you feel isolated from others?	Baseline	69	31	1,390	0.000
	Follow up 1	77	23		

For wellbeing, Table 4:8 shows the changes in the different wellbeing measures between the baseline and follow up 2. Broadly, it shows that across all these measures the proportion of service users within the low wellbeing bracket has fallen, and these differences were statistically significant. In the first three measures (happiness, life satisfaction and how worthwhile life is) the response categories have been grouped to identify changes in the proportion of service users reporting low wellbeing. Looking at life satisfaction, the table shows the percentage of people reporting low life satisfaction has fallen from 32% to 24%, and this difference was statistically significant. For anxiety, the table indicates whether there was a change in the proportion of service users reporting high anxiety, which can be seen to have fallen significantly (from 36% to 30%).

Table 4:8 Changes in experiences of wellbeing over time: Baseline to follow up two

Question	Timepoint	Medium, high, or very high	Low	Base	P
How satisfied you are with life?	Baseline	68	32	1,758	0.000
	Follow up 2	76	24		
How worthwhile the things you do in life are?	Baseline	74	26	1,706	0.000
	Follow up 2	82	18		
How happy did you feel yesterday?	Baseline	66	34	1,721	0.000
	Follow up 2	75	25		
Anxiety		**Very low, low or medium**	**High**	**Base**	**P**
How anxious did you feel yesterday?	Baseline	64	36	1,711	0.000
	Follow up 2	70	30		

Table 4:9 on the next page shows the difference between wellbeing reported at the baseline and follow up 1. The trend here is the same, with the proportion of service users reporting low wellbeing falling at the follow up timepoint. However, the changes are smaller and not statistically significant in the case of how worthwhile service users felt life is.

Table 4:9 Changes in experiences of wellbeing over time: Baseline to follow up one

Question	**Timepoint**	**Medium, high, or very high**	**Low**	**Base**	**P**
How satisfied you are with life?	Baseline	76	24	1,732	0.003
	Follow up 1	79	21		
How worthwhile the things you do in life are?	Baseline	81	19	1,712	0.129
	Follow up 1	82	18		
How happy did you feel yesterday?	Baseline	74	26	1,723	0.003
	Follow up 1	77	23		
Anxiety		**Very low, low or medium**	**High**	**Base**	**P**
How anxious did you feel yesterday?	Baseline	67	33	1,781	0.001
	Follow up 1	71	29		

Base: Includes all service users with data at both baseline and follow up time point 1. The anxiety question was collected by six grant holders, and the others by five grant holders.

4.3 Demographic characteristics

Service users' demographic characteristics are summarised below in terms of their gender, sexual orientation, age, ethnicity and disability status. The rest of the section then explores the relationship between these characteristics and service users' reported levels of loneliness at the baseline time point. Where we describe differences between demographic groups, these are statistically significant unless otherwise stated.

- A majority (60%) of service users in our dataset were women, and 39% men, with 1% identifying as non-binary.
- The vast majority of service users were heterosexual (89%), although 6% preferred not to give their sexual orientation, 1% were gay or lesbian, and 2% bisexual. Another 2% gave an 'other' response, where they could describe their own sexual orientation.
- Three quarters (75%) of service users were from white ethnic backgrounds, 23% from ethnic minorities, and 2% from mixed ethnic backgrounds.
- Nearly two thirds (64%) of service users held a long-term disability, significantly above the general population, where it is around one-fifth.[13] In part this reflects the populations served by some of the grant holders, which focussed their attention towards groups with health problems and disabilities.
- The distribution by age was concentrated towards the younger end of the age distribution and the very old (aged 75 or over), with fewer service users in the dataset aged between 45 and 74 (see Figure 4.9 below). This age distribution reflects the focus of different grant holders, which targeted specific groups with their support.

Figure 4:9 Age bands

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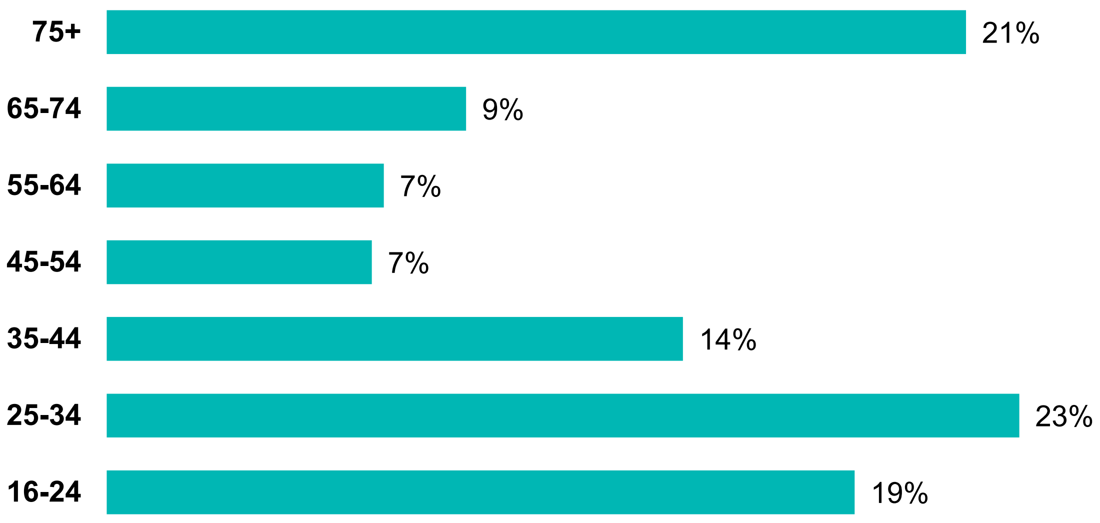
[13] Department for Work & Pensions (2020), Family Resources Survey: financial year 2018/19 2018/19. Accessed at: https://www.gov.uk/government/statistics/family-resources-survey-financial-year-201819

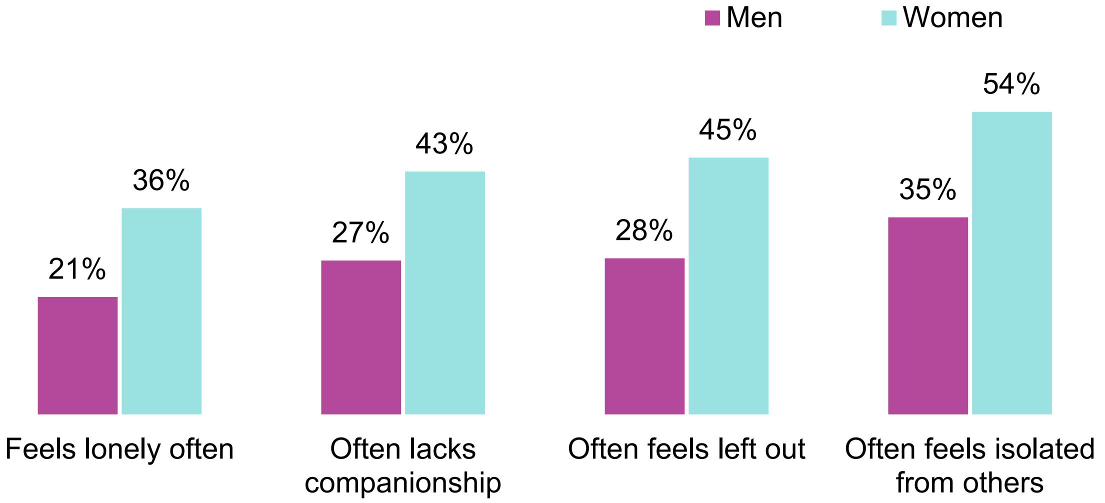


Base: includes six grant holders (3,964)

4.3.1 Gender

Figure 4:10 shows that in all measures of loneliness women were statistically significantly more likely to report feeling lonelier. The chart displays the proportions of men and women separately who often felt lonely, lacking in companionship, left out, and isolated from others. These consistently show a higher proportion of women feeling this way regularly, for example, 43% of women said they often lacked companionship, compared to 27% of men.

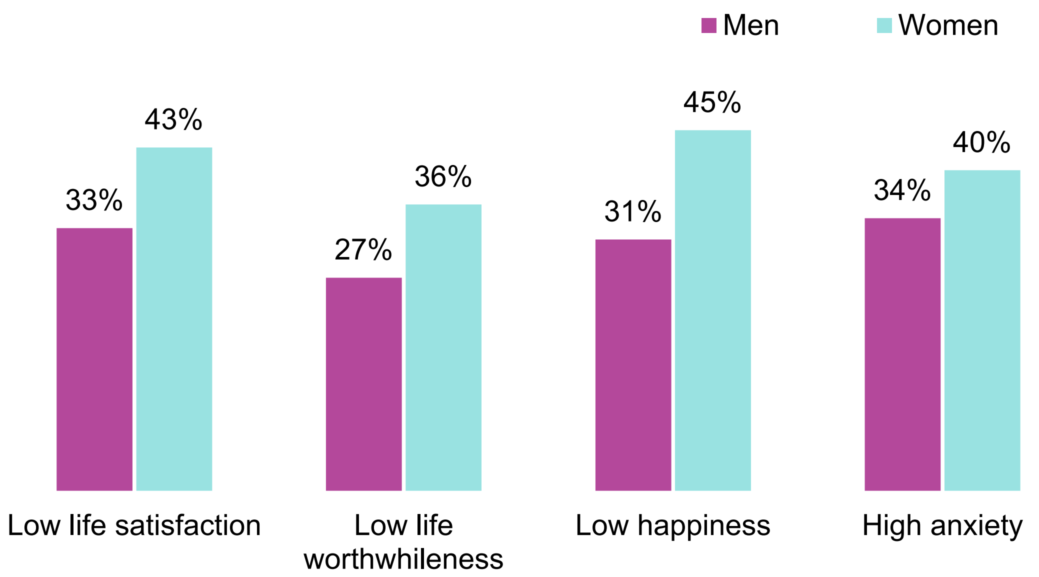
Figure 4:10 Experiences of loneliness by gender



Base: Data includes six grant holders. Often feels lonely (2,153), often lacks companionship (1,445), often feels left out (1,442), often feels isolated from others (1,553).

Similarly, when looking at wellbeing, women were consistently more likely to report high anxiety, low happiness and life satisfaction and to fall into the lower threshold for how worthwhile the things they do in life are (Figure 4:11) on the next page.

Figure 4:11 Experiences of wellbeing by gender

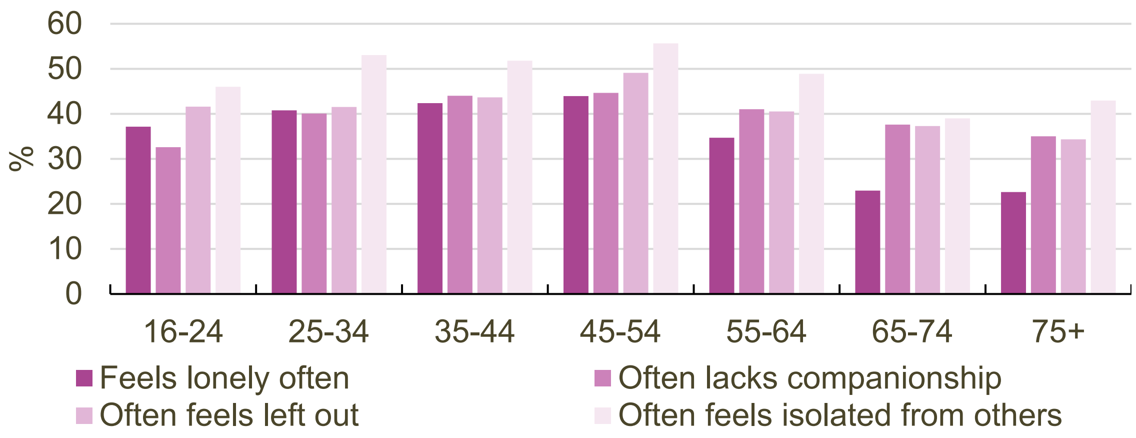


Base: Data included from five grant holders for low life satisfaction (1,579), low life worthwhileness (1,568), low happiness (1,577), and six grant holders for high anxiety (1,713).

4.3.2 Age

As shown in Figure 4:12, loneliness was highest in the middle of the age distribution, before falling off among those aged 55+, and the least lonely groups were those aged 65-74 and 75 or over. Looking at the self-reported measure of how often people feel lonely, those aged 45-54 were most likely to often feel lonely (44%), whereas in the two oldest age groups (both those aged 55-64 and 75+) only 23% of service users often felt lonely. Similarly, 56% of service users aged 45-54 often felt isolated from others, compared to 43% of those aged 75 or over. The younger age group fell somewhere between these extremes. Those aged 16-24 were actually the least likely of any age group to report lacking companionship, which was reported by 33% of 16-24 year olds (compared to 45% of 45-54 year olds). However, in other areas they were more likely to have reported feeling lonely. For example, when asked how often they felt left out, 42% of young service users said they often felt this way, compared to 49% of 45-54 year olds and 34% of those aged 75 or older.

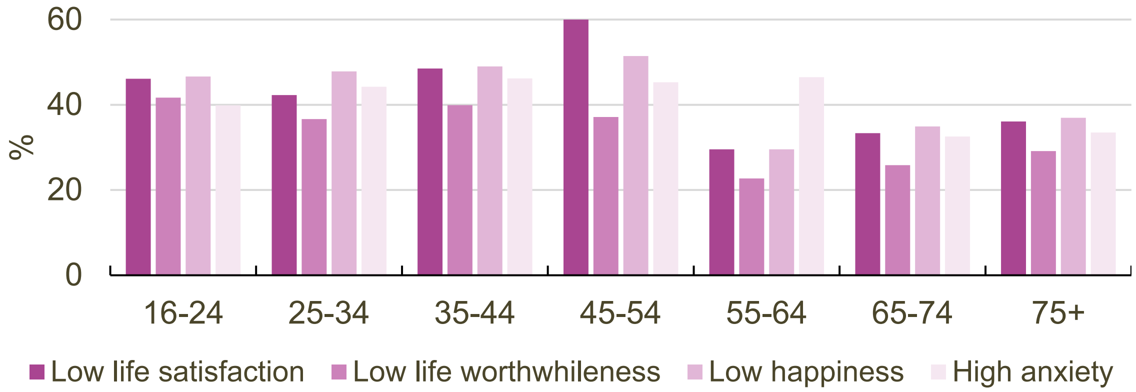
Figure 4:12 Loneliness by age bands



Base: Data includes six grant holders. Often feels lonely (2,133), often lacks companionship (1,440), often feels left out (1,437), often feels isolated from others (1,528).

When looking at patterns in wellbeing by age, the main difference is between older and younger age groups, with those aged younger than 55 more likely to report lower wellbeing. One area that did not fit this pattern was anxiety, where those aged 55-64 reported a similarly high level of anxiety to 35-44-year olds and 45-54-year olds. Once above 65 years old though, the proportion of service users reporting high anxiety fell again to around one third, compared to between 45% and 46% in age groups between 35 and 64 years old (Figure 4:13).

Figure 4:13 Wellbeing by age bands

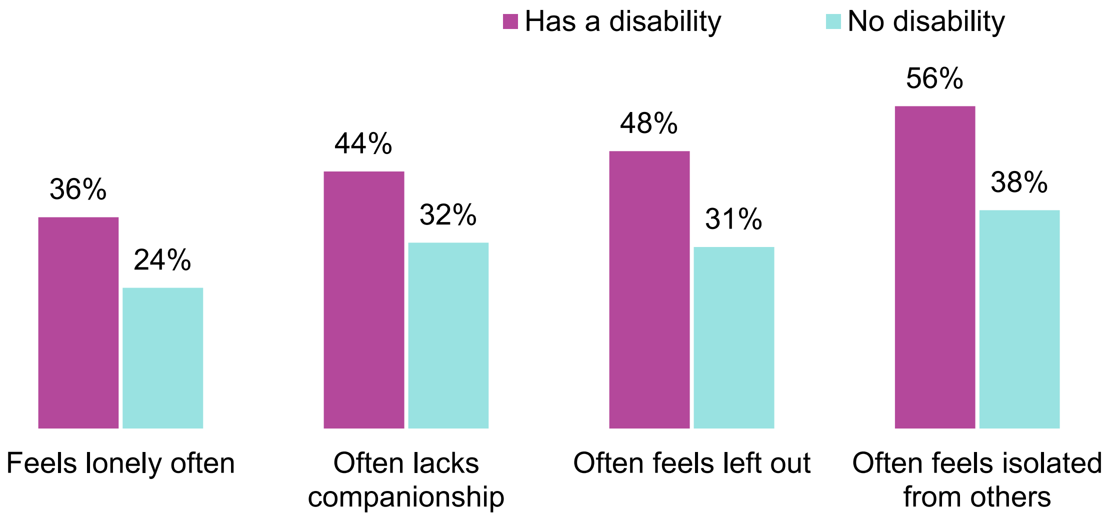


Base: Data included from five grant holders for low life satisfaction (1,564), low life worthwhileness (1,553), low happiness (1,561), and six grant holders for high anxiety (1,696).

4.3.3 Disability

The presence of a disability was consistently associated with higher levels of loneliness, as seen in Figure 4:14. This chart shows how the proportion who often feel lonely, lacking in companionship, left out, or isolated from others varies by the presence of a long-term disability. To take feeling isolated from others as an example, over half (56%) of service users with a disability often feel this way, compared to 38% of those with no disability.

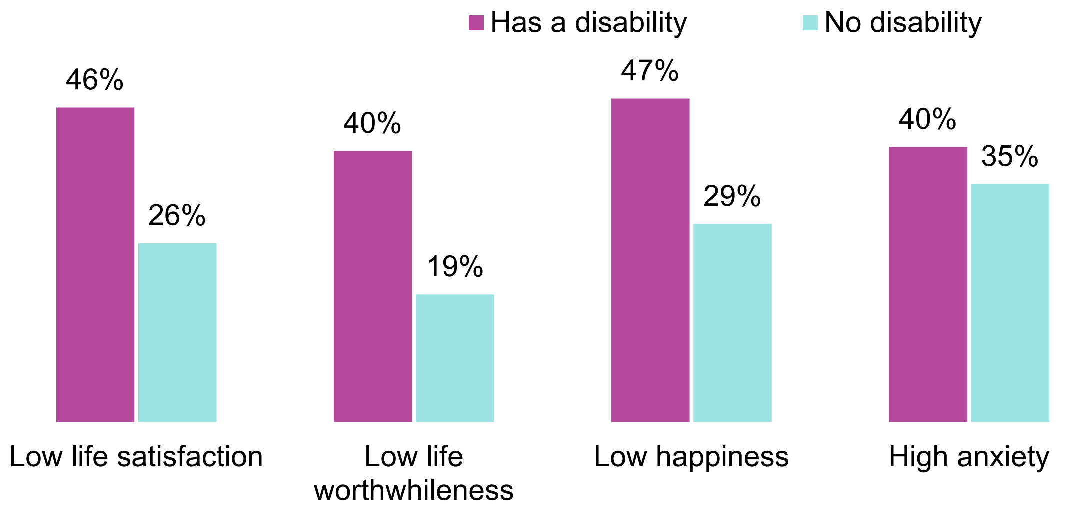
Figure 4:14 Loneliness by disability



Base: Data includes six grant holders. Often feels lonely (2,036), often lacks companionship (1,383), often feels left out (1,380), often feels isolated from others (1,471).

A similar pattern in wellbeing was found with service users who report having a disability reporting lower levels of wellbeing across all measures (Figure 4:15). For example, almost half of service users with a disability reported low life satisfaction, compared to 26% of those without a disability. The difference is similar in terms of happiness and how worthwhile people feel life to be. For anxiety the gap is smaller between service users with disabilities and those without, where 40% of service users with a disability reported high anxiety compared to 35% of those with no disability.

Figure 4:15 Wellbeing by disability



4.3.4 Sexual orientation

Due to a relatively high level of missing data around sexual orientation, the total number of people identifying as gay, lesbian, bisexual, or as self-described within the data was small. To analyse whether this group experienced any differences with regard to loneliness and wellbeing, these groups were combined to provide a larger sample size, although the large amount of missing data means that the base size for this group ranges from 56 to 95. As a result, even where there are differences seen compared to heterosexuals these are not statistically significant in most cases. For example, in the question about how often people lack companionship, 40% of service users who identified as heterosexual often felt they lacked companionship, compared to 33% of those in the lesbian, gay, bisexual or other group. However, this difference was not statistically significant, and we cannot draw reliable conclusions about the differences in these groups' experiences. The same issue was seen in the questions about wellbeing. There was one statistically significant difference among these questions, in anxiety, however, it is the 'Prefer not to say' group which is driving this difference. Among those who say that they would prefer not to give their sexual orientation, 53% had a high level of anxiety, compared to between 38-39% among those who stated their sexuality. For this reason, the charts for sexual orientation have not been presented, but the data tables are presented in Appendix D (Tables D13 and D12).

4.3.5 Ethnicity

The relationship between loneliness and ethnicity was also mixed. In most cases, a similar proportion of service users from white ethnic backgrounds fell into the 'often' category for the different loneliness measures as service users from ethnic minority backgrounds. Whereas people from mixed ethnic backgrounds in all these areas were more likely to have fallen into the 'often' category. However, the base size for the mixed ethnicity group was small (between 47 and 60), and in most cases there was not a statistically significant difference by ethnicity in how lonely service users were. The only area where there was a significant difference was in how often service users felt lonely overall, where service users of white ethnic backgrounds were the least likely to report feeling lonely often (31%), compared to 35% of service users from ethnic minority groups and 48% from mixed ethnic backgrounds.

The association of ethnicity with wellbeing was also inconsistent across the four areas measured, with a statistically significant difference present only in happiness. Nearly half (49%) of people from ethnic minority backgrounds fell into the low happiness band, compared to 45% of those from mixed ethnic backgrounds and 40% from white ethnic groups. However, in anxiety, life satisfaction and how worthwhile people felt their lives were, there were no statistically significant differences.

With most of these areas not showing statistically significant differences, again the charts for this section have not been presented. The data tables are available in Appendix D (Tables D14 and D15).

5 The experience of staff, volunteers and service users

5.1 Programme staff and volunteers

This section presents findings from the four focus groups with programme managers, project leads, operational staff and volunteers. Perceptions of staff and volunteers will be synthesised to provide a holistic picture, while highlighting if and where such perceptions differ between groups.

5.1.1 Perceptions of service user loneliness during the pandemic

This section will present focus group participants' perceptions on the experiences of service user loneliness, which are discussed in more detail from the service user perspective below (see section 5.2.1).

Focus group participants expressed that service user loneliness had been exacerbated, rather than created, by the Covid-19 Pandemic. This was attributed to the varied existing situation of their service users, which included carers, single parents, refugees, young people, older people, and those leaving the armed services.

> *"Covid's a storm and we're all going through it, but we're on very different boats." – Volunteer*

Operational staff and volunteers, who had been closer to service users, were able to provide more detail on how restrictions as a result of the Covid-19 pandemic affected service users differently. For instance, young peoples' social relationships had been affected by school closures, older people were asked to shield away from family, single parents had midwifery appointments cancelled, and refugees had been locked in hotels. In addition, often socially isolated carers were having to maintain heightened caution, due to the vulnerability to infection of those they cared for.

> *"The pandemic has definitely reduced any external care support, so carers have to be in the home a lot more. And then of course, the issue of shielding means that even if they don't have to care more they can't go out and maintain social connections." – Programme manager*

It was expressed that at the start of lockdown restrictions in March 2020, service users experienced a sharp drop in support provided by charities and local authorities. Ranging from counselling to weekly support meetings, many of these services were delivered face-to-face and therefore affected by lockdown restrictions. It was felt that service users relied on these not only for support but for sociality, their absence resulting in increased feelings of loneliness.

Distance from family, imposed by the restrictions, was cited by volunteers from across organisations as a common factor that contributed to heightened service user loneliness. In particular, there were instances where newly born family members could not be introduced to the wider family; this further affected those who were digitally excluded, as they could not access virtual communication services. In contrast, volunteers and staff reported that the intensification of time spent with family for some service users had put a strain on the quality of those relationships or worsened already difficult circumstances. For instance, service users in abusive relationships were forced to spend most of their time with their abusers or to flee from them, which in both cases determined a worsening of their condition of isolation and loneliness. Service users who had caring responsibilities saw an increase in the time spent with the person they take care of due to shielding and lack of in person activities outside of their home, leaving them with none or scarce occasions to cultivate other relationships. Similarly, some service users were described as not used to living with their families for such a prolonged time due to their previous occupation, this required a number of adjustments that compounded other issues and the general consequences of the Covid-19 pandemic.

> *"We have a better understanding of what impact loneliness and isolation can have on people because Covid has pushed us." – Project lead*

5.1.2 Set up and delivery of funded activities

This section will present focus group participant experiences of the set up and delivery of services supported by the Fund. While participants could provide data on the delivery of activities, many joined the project at a later date. Furthermore, the grant application process was usually managed by a colleague in a different department to participants, therefore many did not have experience of this process.

The March 2020 lockdown caused an abrupt stop to many of the services being delivered across organisations. Reasons cited by programme managers and project leads included the face-to-face delivery element of services, staff having to go on furlough, and even a break in fundraising activities potentially affecting cash flow. As it became clearer that restrictions would be implemented over a longer period, the Fund was greatly welcomed.

Once the Fund money had been awarded, participants recounted the speed at which services had to be set up given the timeframe. Whereas existing services had to bring staff back from furlough and re-engage service users, new services also demanded sign off, training, recruitment of service users and volunteers, and the procurement of digital devices. Some organisations providing new services therefore had to proactively recruit new service users through social media, general advertising, and calling service users from other paused services.

Participants had mixed feelings about the move to deliver services by telephone and digital devices. While they cited that they provided support to a greater number of service users with more flexibility, at a time that this was necessary, it was also generally felt that the quality did not match that of face-to-face services. Furthermore, the digital training of staff and volunteers took less time and saved money, although one participant mentioned that their standards had to be lowered.

> *“A lot of the stuff we were doing with young people was face-to-face, because it had been proven that that approach works for children. When we had to move everything online, whilst they were able to do everything online, it meant that a lot of the more subtle things that we’d get out of face-to-face meeting were gone.” – Programme manager*

Volunteers provided further depth to why face-to-face delivery was preferred, explaining that it enables them to better gauge service user vulnerability, due to social cues and access to their environment. Furthermore, whereas telephone and digital services were usually accessed in service users’ homes, face-to-face enabled delivery to take place on a more neutral site e.g., a park or coffee shop. This was perceived to affect not only the conversations which could be had, due to the absence of family members, but increase the sociality of the service being delivered.

> *"Very difficult to judge in a voice how she is. She's very upbeat and chatty but you know that's not really what's happening. Were she face to face with her it would be easier to make those judgements." – Volunteer*

However participants also acknowledged the benefits of telephone and digital service delivery, especially as a necessity during the Covid-19 pandemic. This resulted in some participants opting for a blended approach in future, whereby they can continue to use the digital skills and processes that they have gained, while providing high-quality face-to-face services where needed.

5.1.3 Facilitators and barriers to delivering services

Facilitators

One key facilitator was the urgency underlying required changes to deliver services during the Covid-19 pandemic. Although participants expressed that their organisation had previously identified a need for digital working and service delivery, the necessity to adapt activities during the Covid-19 pandemic expedited this. This included a relaxation in administrative and bureaucratic barriers, which would normally delay the implementation of such wide-ranging changes in their organisation. In addition, it was perceived that the small size of one organisation enabled them to make quicker decisions to adapt services for digital delivery.

> *"A lot of our partners have said that they will continue to offer some services online, and that actually an online offer is something that had been in the backs of their minds for a long time and this has forced them to do it, forced them to develop it." – Programme manager*

It was generally viewed that face-to-face was the preferred method of delivery for the services, however digital delivery did facilitate some benefits. For befriending services in particular, remote delivery enabled organisations to reach a greater number of participants with the resources they had. Furthermore, staff and volunteers could be matched with service users across the country based on availability, rather than proximity.

It was expressed that providing services and working remotely increased efficiency. Whereas face-to-face delivery and meetings also included travel time, remote working enabled some to focus more on service delivery. As an example, the use of volunteers provided under corporate social responsibility was further pursued, not only because training could be delivered online but because volunteers were working from home and therefore more flexible.

> *"So many of our volunteers pre-Covid weren't able to do their face-to-face role that they'd done previously, so actually this new role allows them to do something from the comfort of their own home, but they still have an impact." – Project lead*

As illustrated in section 3.2, many activities delivered under the Fund were new and therefore had to recruit service users from the ground up. Participants across focus groups cited a number of proactive means to facilitate this, including investing in a recruitment drive before the Fund money had been received, advertising on social media, and making use of pre-existing contact lists from their other services which had been paused.

Barriers

One key barrier to delivering services under the Fund was timing, in various forms. As discussed, the quick set up time did have the benefit of expediting a move towards digital and remote delivery. However, participants had mixed feelings about the timeframe, especially at the start and end of the project.

> *"Having to deliver quite a big programme in three or four months, I don't think it's the best way to deliver or develop services. On the other hand, this has been a very unique time and things did need to get done quickly, so I think we have mixed feelings about the timeframe." – Programme manager*

Programme managers and project leads expressed that the quick set up resulted in a lack of lead time to prepare for the project's initiation. This included bringing staff back from furlough, the recruitment of volunteers and service users, (re)training new / existing volunteers and staff, gaining sign off, mobilisation and coordination, and the procurement of digital devices. For networked organisations, this included the need to review applications for brokered grants and send monies to local services added to this time pressure. In that context, some participants expressed that the timing of their first report update to DCMS of one month after initiation was too soon.

> "[what would have done differently] *Probably, taking a step back and taking an extra breath before going both feet in first." – Project lead*

It was generally appreciated that the Fund was set up when the Covid-19 pandemic was particularly unpredictable, in terms of the extent of time and related fluctuating restrictions. Nevertheless, participants felt that the stipulation for Fund money to be spent by the end of 2020 was not a suitable time to do so, especially given the Christmas holiday[14]. This resulted in activities being stopped at a time when service users were at their most vulnerable and at heightened risk of loneliness, as well as during a reduction in staff capacity. In addition, the nature of a 'hard stop' risked service users being cut off from services once again, with some participants feeling that there needed to be more focus on the legacy of the funded activities.

> *"We were particularly worried about the project ending just before Christmas. Not just because of our own capacities, but because of potentially removing support at Christmas for our service users." – Programme manager*

It was perceived that many service users were digitally excluded and found it difficult to access virtual activities. Although organisations adapted or designed services to make them more inclusive, it was felt that vulnerable service users were still not being reached. Some organisations also provided service users with digital devices, either funded by or separate from the Fund. However, unless planned for (i.e., the British Red Cross Generation Digital service, see section 3.2), instructing service users on how to use these remotely could be difficult. Examples of how organisations ameliorate this included an initial recruitment drive to recruit service users without email addresses, as well as adapting a service so digitally excluded service users could take part via post, by sending printed activity materials along with stamped letters to return work.

While participants, including volunteers, reported the benefits to those delivering services, programme managers and project leads also expressed concern around the wellbeing of staff and volunteers. These concerns were centred on the far-reaching impact of the pandemic, in that staff and volunteers were experiencing its effects alongside service users, as well as potential burnout compounded by sequential lockdowns. This was addressed by ensuring volunteers and staff could take breaks from delivering services, whereas another organisation arranged volunteer coffee mornings as an additional means of support.

> *"We've identified that volunteers also need support, so we're setting up a virtual coffee morning platform. They can then come together with volunteers from other areas, giving them the chance to sit and discuss, as*

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[14] As stated in section one, seven out of nine organisations were awarded with continuation funding. However, the original end data was Christmas 2020.

> *well as bring ideas to the table for how best to support service users." – Staff member*

Other staffing challenges mentioned throughout the focus groups included recruiting enough volunteers to keep up with service user demand, training, matching, and volunteer management. This included reviewing the way an organisation structured their volunteering, where instead of each volunteer being assigned a specific 'role manager' for one-to-one support, that support could be provided more centrally based on availability. In addition, volunteers for a befriending service would call service users in absence of any background information, while it was also expressed that volunteers themselves would have liked greater access to the overall impact data (i.e., number of service users reached) for their service.

> *"The role manager issue… we've got lots of people waiting for the service and lots of volunteers wanting to help out, but we just don't have the staff to help out the volunteers and ensure that match [with service users] is working. I think that has been one of the bigger challenges for us." – Project lead*

While at the same time acknowledging its importance, one of the barriers cited by programme managers and project leads was the evaluative requirements attached to the Fund money. It was expressed that the wellbeing and loneliness scales prescribed were not suitable for the organisation's needs or for service users, as they did not resonate with their experience or situation. For instance, one organisation already collected similar data in a different form, which resulted in them collecting data of the same theme twice. Other organisations found the questionnaire inappropriate for the population they usually target, and it was described as a cause of uneasiness and anxiety for their service users. It was also felt that the number of data collection points requested were excessive given the timeframe, resulting in potential burden for service users. This was compounded by the remote completion of questionnaires, which would normally be administered face-to-face, resulting in one participant having concerns around the service users' understanding of questions (particularly when English was not their first language) and the difficulties usually faced by both staff members and service users when sensitive questions are not asked in person.

5.2 Experiences of service users

This section will present the experience of service users relating to loneliness and to the funded activities, before discussing the barriers and the facilitators in accessing services.

The 36 individuals interviewed for this section had different ages (ranging between 22 and 90 years) and presented a variety of health conditions, working and economic conditions, and living conditions (some living alone, others with partners, children or other relatives). This variety of circumstances allows for the definition of a richer and more complex picture, from which similarities and differences in the perception and experience of the programmes can emerge.

5.2.1 Experiences of loneliness

Service users were asked about their experience of loneliness and how this had affected them and others during the Covid-19 pandemic. However, not all service users were able to discuss how the Covid-19 pandemic had affected others. They were not sure how others were coping with loneliness and isolation and in a few cases their opinion was mixed with reflections on their own experience.

Service users shared the opinion that human beings need to socialise and have physical contact, which had been made difficult by the Covid-19 pandemic. In addition, they reported that the experience of isolation and loneliness may have worsened as a result of other factors such as living alone, being in a caring role, shielding, and having a disability. It was also added that young people may have been affected more by isolation and loneliness during the Covid-19 pandemic. This was due to the effect on their mental health and growth in a delicate phase of their life. Other, more general factors perceived to affect loneliness included a sense of powerlessness, the feeling of uncertainty about the future, confusing new rules, how the media have approached the Covid-19 pandemic, and the presence of conspiracy theories on social media.

> *"What worries me and others more than anything is that it seems to be going on and on with no end in sight."* – (Service user)

Service users, especially elderly interviewees, were already experiencing some form of loneliness and isolation before the Covid-19 pandemic. This condition was exacerbated by the restrictions implemented during such period. For example, individuals living far from relatives and friends, who periodically used to meet, were unable to form a bubble with them. In other cases, participants found themselves in a new condition of loneliness and isolation due to the restrictions. This is the case, for instance, of a service user who was unable to form a bubble with their grandchildren because the children were part of a bubble with their other grandparents.

> *"To come from that, from a life with people around you, with children around you, with my grandchildren coming every day after school, their mummy would pick them up, to absolutely nothing."* – (Service user)

The disruption of routines was reported as one of the factors that worsened the feelings of loneliness and isolation. These routines included more socially oriented activities, such as meeting friends and family, taking part in church activities and volunteering, taking part in group activities and sports, visiting local shops, going to markets, and going to the pub on Sunday. The absence of social life was described as a cause of boredom, while the lack of physical proximity and contact was a source of frustration and discomfort, worsened by the inability to look at people's faces due to the use of masks.

Service users also expressed feelings of fear and anxiety connected to the risk of contracting Covid-19 (referring to both themselves and their loved ones), to the perception that the Covid-19 pandemic will still last for a long time, and to the impression that things have permanently changed in a negative way. The last concern was mentioned in relation to changes to the service user's local area (closure of shops and centres that may not be able to reopen after the end of the Covid-19 pandemic), but also in relation to personal relationships with friends and relatives. The main concern in this case was that friendships may have been weakened by the forced distance, while it was also expressed the fear of being unable to socialise again when this will be allowed.

> *"It's almost like this is life now, and I'm shutting down a little bit towards others. [...] The world is changing and I'm actually a little scared, which is normally not me. At some point I'm going to be back there, and it's not the disease that's frightening me. It's actually being back to socialising with people. It's kind of a scary thought. [...] I'm getting quite comfortable in being shut away from people. And that's bit of a worry."* – (Service user)

It was also expressed that service users felt unable to speak to others about their feelings and concerns. This was due to their friends and family also being in difficult situations, resulting in service users not wanting to burden them with their problems. This inability to share feelings with others was reported as increasing the sense of loneliness and isolation by service users.

Of those service users with caring responsibilities, a negative impact from the lack of support services and the need to shield together with the people in their care was reported. Consequently, the time they spent in caring roles increased, reducing their chances of having time for themselves. At the same time, others also reported that having health problems was one of the factors that made them lonelier and more isolated. This was due to the need that some had to shield, as well as difficulties with adapting to and following the current public health rules and new social norms. For example, service users with non-visible disabilities, such as some types of visual impairments, reported receiving aggressive remarks by members of the public for not having kept a safe distance. In addition, of those service users living with or who care for somebody with a degenerative disease, feelings of isolation and loneliness were compounded by losing a year during which the condition worsened.

Other factors that made service users' experience of loneliness and isolation worse included bereavement, moving to a different area immediately before or during the Covid-19 pandemic, and fear of or uneasiness with technology (reducing the ability to communicate with others). The impact of the Covid-19 pandemic was greater on some participants who reported a number of psychological issues, including anxiety, panic, sleeplessness, the feeling of being trapped, and suicidal thoughts.

It was explained by some service users that their experience with loneliness during the Covid-19 pandemic was not particularly negative, and they were able to cope with it and reduce its impact. A number of mitigating factors for loneliness and isolation were reported, including being in a bubble with others, having hobbies or working (in this case a good relationship with colleagues was seen as essential), having adapted to loneliness before the Covid-19 pandemic, and keeping in contact with other people via telephone or the Internet. In addition, service users expressed that the lockdown and the need to stay at home for longer periods allowed them to spend more time with their families, as well as improve their relationships with neighbours.

5.2.2 Experiences of service use during the Covid-19 pandemic

Experiences of services at the beginning of the Covid-19 pandemic

In general, service users reported that at the beginning of the Covid-19 pandemic they did not receive any specific service dedicated to coping with loneliness and isolation. Some service users received support from family members, friends, GP practices, religious organisations, local councils, charities, and volunteering groups. However, this support did not directly aim at addressing loneliness but was focused on supporting needs such as arranging medical appointments and buying groceries and medicines. Other service users reported that the service they received was a continuation of the service they were already receiving before the Covid-19 pandemic. Some of these services were initially disrupted due to social distancing restrictions and the first national lockdown. However, having already been in contact with support organisations before the Covid-19 pandemic seemed to have been an advantage for some, since they were able to look for different forms of support or to receive advice on the relevant organisations that may have been able to help them.

In some cases, the service was not initially planned or required by the service user. For example, one participant reported that the first call they received from a local authority was not connected to a specific service against loneliness, but since then they had received a call every week which was quite appreciated as a way to have a friendly chat with someone. In other cases, service users directly looked for available services at the beginning of the Covid-19 pandemic, either by independently searching for support organisations or by asking their GPs or Citizens Advice.

As discussed, family and friends were among those providing some kind of support to the service users we interviewed. In the case of support from family and friends, this was mainly provided over the phone, whereas support from charities and support organisations took the form of befriending calls, WhatsApp groups, Zoom group calls, online quizzes, social media initiatives, and checking-in calls. Some form of in-person support was also reported by service users, although less frequently. This was usually provided by social services, carers, or housing associations, and the service users described it as having different degrees of proximity: from people coming to their doors just to check that they were doing well, to buying groceries, to spending some time with the service user at their home.

The area where the service user lived also seemed to play a role. Whereas it was reported the absence of services and support due to the relative deprivation of their area or distance from large towns, others found the services offered locally good and appropriate for the new circumstances created by the Covid-19 pandemic. One respondent described how they were able to make a comparison because they had moved to a new, more deprived area before the Covid-19 pandemic began. The local authority of the area where they used to live contacted them to check if they were doing well and needed any support, while in the same period the local authority where they had moved did not directly offer any support and never contacted the service user.

Experiences of service delivery

One way service users were recruited by organisations for activities is that they knew or were in contact with the organisations before the Covid-19 pandemic. However, this also included cases where they were volunteers or planning to become volunteers, but the Covid-19 pandemic caused a considerable change in their conditions which forced them to look for the support of the funded programmes. Other service users were not sure how the organisations found them and assumed this happened thanks to friends, relatives, carers, GPs, or housing associations. Similarly, others reported that friends, relatives, and GPs, together with social services and Citizens Advice, had directed them to the funded organisations.

Most of the services offered were delivered remotely over the telephone or online. This type of service included chats with one or more people usually held every week or every month, wellbeing meetings, advising services, talking groups, companion and befriending calls, and various online activities such as classes, group meetings, singing sessions, and quizzes. Counselling sessions were also offered to support service users with anxiety and depression. Other services were instead delivered in person, and these included doorstep visits, buying groceries, providing meals, and delivering electronic devices (smartphones, tablets and pedometers). When asked how the service was adapted due to the Covid-19 pandemic, service users confirmed that the services were either offered over the phone and online, or delivered in compliance with social distancing rules. In cases where a service also included the presence of carers, the carers were regularly tested for Covid-19 and used the appropriate protective equipment.

The experience of the programmes varied due to the different conditions and needs of the service users. In general, services were perceived as a positive experience, and this was particularly true for those who did not have previous experiences with support services. In these cases, participants were happy to have received services that exceeded their expectations and to feel that someone cared about them. Reflections included that the services helped them feel better, connect with their families and friends, and address a wide range of challenges (from psychological issues to legal and financial ones). The people with whom they had spoken were understanding and supportive, including the experience of companionship and wellbeing calls was so positive that they would have liked to speak more often.

> *"Ah, I look so forward to that phone call." – (Service user)*

> *"They are a lifesaver. They made me feel like I should not give up and that there are people that can help me." – (Service user)*

An appreciation of telephone and online chat services was expressed, however it was felt that these services were not as good as talking to family and friends. In contrast, other service users specifically appreciated this aspect: talking to people who are not part of their family or circle of friends allowed some of them to vent in ways that would have not been otherwise possible. In other instances, service users found that talking to people different from family members and friends was refreshing and a way to dedicate some time to themselves and to keep their mind occupied.

> *"We do have a laugh and we joke about things [...] For someone who is totally on their own, it does lift the spirits." – (Service user)*

Service users reported that, in general, keeping in touch with others and knowing that they were also supported was a positive in itself. For example, it was comparable to getting together in a community centre with people from different areas of the country. Having access to companionship calls also helped another service user to discuss and address their fears and anxiety, and to process grief and shock deriving from losing someone due to Covid-19. Group calls were also described as a way to learn from others with similar issues, to learn how to address specific challenges, and to feel less isolated.

> *"I've found it good, calming, it just helps to listen to other people, how they deal with different situations and what they get up to." – (Service user)*

However, not all experiences were positive. One of the main issues reported by the service users interviewed regarded the devices they received, such as smartphones and pedometers. This included the devices not working properly or stopping working after a brief period of time. Additionally, the instructions to use these devices were not always clear or were missing. With regard to other services, such as group calls and wellbeing calls, these were described by some as too short or too rushed. It was reported that during group calls there was not enough time to discuss each subject properly, while some wellbeing calls were described as too short to be helpful. In other cases, the service users suggested as the main causes of dissatisfaction the age difference between them and the other participants to the group call and an absence of shared interests.

5.2.3 Barriers and facilitators to accessing services

Service users were asked to describe the barriers and facilitators they found to accessing the services. This question also prompted a variety of responses and in some cases what was described as a facilitator by some service users was instead mentioned as one of the barriers by others.

Facilitators

One of the facilitators mentioned by service users was the clarity and completeness of information to access services provided by the funded organisations. This was also usually associated with excellent communication and the organisations' promptness in responding to issues and users' requests. For example, it was mentioned that it took service users just a message or a call during a particularly difficult period to receive a call back and further support if needed (e.g., financial or legal support). Help was described as easy to be accessed and provided in a non-judgemental fashion. The registration and access to services was also seen as straightforward, and the perception of some users was that the funded organisations had successfully adapted to the new conditions dictated by the Covid-19 pandemic.

> *"When you ring them, they are very friendly people. You don't feel like you are in a hospital. They let you say what it is, what you're hoping to get out of this, and then they're on it."* – (Service user)

> *“Normally people might feel embarrassed… They didn't make me feel embarrassed at all. They made it very easy and welcoming for me to ask for help if I needed it.”* – (Service user)

Further facilitators were linked to how services were provided and how the scheduling of services was managed. Service users reported appreciating the social distancing and safety measures taken by those delivering the funded services (e.g., doorstep visits and use of protective equipment), and they also described as a facilitator that most activities linked to funded services were held remotely. This did not just help avoid unnecessary risks to the service users’ health, but it also allowed them to take care of their social life while spending more time with their families or doing other activities. Pertinently, those service users who valued flexibility, variety, and ease of management of remotely held activities preferred online and phone activities to in-person activities. Flexibility was also specifically mentioned as one of the facilitators with regard to the possibility of managing one’s time more easily. In this regard, it was also reported that specific services, such as wellbeing calls, were not rigidly scheduled; this was described as helpful because a stricter schedule would have made them feel under pressure and compelled to answer the phone even if they were unable or unhappy to do so.

Telephone and online activities were described as more accessible, especially by those who, owing to work or study experiences, were already used to attending remote meetings and to using laptops, smartphones, and tablets. As mentioned above, the funded service providers were also described by service users as ready to help with technical issues by checking with participants to group calls before connecting them to the call, or by calling them if they had not joined a meeting at the agreed time. This included the distribution of physical and electronic material to help studying offline.

Barriers

Among the barriers, participants mentioned technical issues with telephone and online services. Some lived in areas with poor Internet connectivity, while others were not used to online activities, had difficulties with using accessibility tools (such as screen readers), or were not able to access a service or use a device due to mental and physical health problems. All these factors limited their access to the funded services. In addition, some service users reported issues with the devices they received or were supposed to use. In this regard, they would have liked clearer and more detailed instructions, or the possibility to have someone doing the setup of their devices in person, which would have made it easier for them to explain the problems they were encountering and to ask for advice.

Timing and scheduling of the funded services was reported as a barrier. In these instances, service users would have liked more frequent communications and to be informed about other available services, as well as more options in terms of time. In contrast to what has been described in the section on facilitators, one service user mentioned that they would have preferred to receive the wellbeing calls at a fixed and scheduled time, since they need to prepare for a call due to their health condition.

Other barriers, mainly linked to group calls, were described as reducing the ability of service users to access the funded services. For example, taking part in group calls could be difficult if one was not used to them. Group calls may have had too much background noise, making communication very difficult (one service user reported having abandoned group calls due to this problem). Group calls may have included too many participants (six or more) or the conversation subjects may have been of little interest to a service user which would make their participation difficult if not impossible. Others reported feelings of anxiety connected to being in front of a webcam or on the phone with strangers. While other service users said that telephone and online activities were too remote to be of any help. For them, a more effective support against loneliness would require the physical presence of the participants.

6 Discussion

Evidence from the literature suggests that loneliness levels in Great Britain during the Covid-19 pandemic were higher than before the pandemic and displayed regional variation with parts of London showing the highest levels (ONS, 2020a; ONS, 2020b; Li and Wang, 2020; What Works Centre for Wellbeing, 2020; Bu et al., 2020a; Bu et al., 2020b). Evidence from recent studies also suggested that loneliness was both a major determinant of mental health issues such as anxiety and depression, but was also associated with pre-existing mental health conditions (ONS, 2020a; Chandola et al., 2020; Krendl and Perry, 2020; Robb et al., 2020; Manca et al., 2020; Shrira et al., 2020, cited in Manca et al., Lee et al., 2020; Loades et al., 2020). The overall findings from the evaluation suggest that the roll out of the Loneliness Covid-19 Fund was successful in addressing loneliness among users of the services and interventions that were provided. However, due to the absence of a comparative group, there is a possibility that external factors may have driven this change.

The Fund was also found to have had a positive impact on helping the beneficiary organisations to adapt their services to the new circumstances produced by the Covid-19 pandemic. Although our findings suggest that the Fund has been effective at both the organisational and the service user level, barriers to delivery from both have also been identified. These are discussed in conjunction with recommendations for future engagement, either for the Fund or for similar services, that aim to alleviate loneliness and enhance wellbeing.

6.1 Barriers and facilitators for organisations and services

The March 2020 lockdown caused an abrupt stop to many of the services being delivered across organisations including the face-to-face delivery of services, staff having to go on furlough, and even a break in fundraising activities potentially affecting cash flow. As it became clearer that restrictions would be implemented over a longer period, the Fund was seen very positively by both the organisations receiving the fund and the users of the services.

The urgency underlying required changes to deliver services during the Covid-19 pandemic in conjunction with the Fund had a positive impact on organisations and services. Although some organisations had already identified a need for digital working and service delivery, the necessity to adapt activities during the Covid-19 pandemic expedited this. Although face-to-face was the preferred method of delivery for services, the necessity of digital delivery during the lockdown did facilitate some benefits. For befriending services in particular, remote delivery enabled organisations to reach a greater number of service users with the resources they had. For example, staff and volunteers could be matched with service users across the country based on availability, rather than proximity, while providing services and working remotely increased efficiency. Whereas face-to-face delivery and meetings also included travel time, remote working enabled some to focus more on service delivery. The use of volunteers provided under corporate social responsibility was further perused, not only because training could be delivered online but volunteers were working from home and which provided both them and service users with more flexibility. Although telephone and digital delivery provided many benefits, face-to-face remained the gold standard for service delivery to vulnerable service users.

One key barrier was timing and duration of the Fund. However, it is acknowledged that DCMS could not know how long this pandemic was going to go on for and at the time the Christmas cut-off point may have seemed generous. While organisations welcomed the Fund at the time, more time was needed for set up, especially for new services.

6.2 Barriers and facilitators for service users

Before the Covid-19 pandemic, the *Community Life Survey (CLS)* showed around 6% of adults (16+) were always or often lonely (DCMS, 2020). This is substantially below the proportion seen in our sample, with nearly three in 10 (27%) service users reporting they often felt lonely at the baseline timepoint. These service users may already have been at greater risk of loneliness than the general population pre-pandemic, so part of this increased burden of social isolation may be due to their existing circumstances. For example, our sample included a majority (64%) of service users with a long-term disability, and the *CLS* shows people in the general population with a long-term illness or disability are much more likely to experience loneliness. Although those with a long-term illness or disability were less likely to experience increased loneliness during the Covid-19 pandemic compared to those without. Thirteen per cent of this group reported that they are often or always lonely, compared to 3% without any disability (DCMS, 2020). Though in our sample over one third (36%) of service users with a disability said they often felt lonely. This suggests that at least some of the heightened experience of loneliness is related to the restrictions on seeing people brought about by the pandemic, and this may be reinforcing social isolation which is already present in this group. On some users the psychological consequences of loneliness and the pandemic were found to be more serious than on others with service users reporting experiences of depression, panic, anxiety and suicidal ideation.

Evidence of experiences of loneliness from other studies in relation to sex (Bu et al., 2020b; Li and Wang, 2020; Robb et al., 2020; Groarke et al., 2020), age (Bu et al., 2020a; Groarke et al., 2020; Li and Wang, 2020; ONS, 2020a; Robb et al., 2020), and disability / long-term limiting conditions (Giebel et al., 2020; Garutti et al., 2020) also mirrored the evidence from the present evaluation. Women reported higher levels of loneliness compared with men. Age and ethnicity were also associated with risk of loneliness with younger adults, ethnic minorities and people from mixed ethnic backgrounds being at increased risk of loneliness. Living with a disability was also associated with higher levels of loneliness during the Covid-19 pandemic.

Evidence from previous studies suggests that in the UK, those who were loneliest at the outbreak of the pandemic became lonelier, whereas those who were least lonely before Covid-19 and lockdown were found to be less lonely during the national lockdown (e.g., What Works Centre for Wellbeing, 2020). Our findings support the evidence. Staff and volunteers expressed that service user loneliness had been exacerbated, rather than created, by the Covid-19 Pandemic. This was attributed to the varied existing situation of their service users, which included carers, single parents, refugees, young people, older people, and those leaving the armed services. Similar views were expressed by service users themselves as they expressed already experiencing loneliness which was exacerbated by the Covid-19 pandemic.

Others seemed to be unaffected because they were already used to living alone or because they lived with other people. The latter usually lived with their family or had a support bubble, had hobbies and jobs to keep them occupied, and were relatively healthier than others. The presence of mental and physical health problems, having lost a job, living in deprived or remote areas, being a carer, and not having a family close by or a support bubble were all factors that worsened the users' experience of loneliness.

The funded programmes were perceived and experienced in a positive way. Even when the programme was not perceived as having a big impact on users' life, they acknowledged the positive aspects (such as keeping themselves occupied, meeting new people or having new working devices). Several respondents emphasised the control and flexibility allowed by some of the programmes. The impression was that the programmes were user-driven, and this was usually appreciated.

The positive experience was also evidenced when looking at changes over time. Findings indicated that there had been a significant improvement over time in service users' reported levels of loneliness. Across all our measures of loneliness, the proportion of service users reporting that they often feel lonely, lack companionship, feel isolated from others, or feel left out, had fallen. Although this cannot be treated as an impact of the intervention per se since we did not have a comparison group, it suggests that this is not a worsening problem among this group of service users. It should be noted though that experiences of loneliness remain high relative to the population, for example at the second follow up timepoint 16% of service users were often feeling lonely, twice the rate reported by the *CLS* for the general population who felt loneliness often *and* always, which shows the heightened vulnerability of the users of the funded services (DCMS, 2020)

Adaptations to social support services such as community activities, befriending services, and local groups were possible using digital technologies and more traditional phone calls, though there were some barriers and there was a need to be flexible about delivery. Volunteer befriending services were suggested to alleviate loneliness both in the recipients of the service and in the volunteers themselves, a finding also supported by a study which found that befrienders themselves benefitted as well (Joosten-Hagye et al., 2020).

Furthermore, the services offered were not limited to those included in the funded programmes, but the programmes allowed for further support to be provided (legal advice, grants and funding advice, house repairing, buying cooking devices, etc.). The funded programmes allowed the organisations to get in touch with service users in a more granular way and to find and address other unmet needs. The main barriers were related to the duration of the programmes (e.g., started too late and ended too soon), the activities not being appropriate for a service user (e.g., due to specific health needs or preferences), and the electronic devices being difficult to use or not having instructions.

6.3 Recommendations for improvement

As discussed, overall both the Fund and the services delivered were perceived positively and data suggested that loneliness was reduced among service users following delivery of interventions. A number of reflections and recommendations were also discussed, some of which were common between project staff / volunteers and service users.

One of the main recommendations was related to the time that was allowed for projects to set everything up but also the duration of the fund and the timing of its original planned end. The Covid-19 pandemic is lasting longer than was anticipated when the funding was first allocated. Although it was necessary and positive at the time, staff felt that a longer and more sustainable approach, related to the evolution of the Covid-19 pandemic, to addressing service users' needs in this area was needed.

Recognising the fact that the Fund was an emergency measure to respond to an unprecedented situation, more time for set up at the project's inception would have allowed organisations to better address initial issues to benefit the service, without impacting the overall timeline of the Fund. For example, more time at the start of the project would have supported the set-up of logistics, staffing, training, recruitment, and sourcing of digital equipment.

Similarly, and considering that the Covid-19 pandemic has lasted longer than anticipated, for short term emergency funding the timing of when that funding ends should have been considered relevant to service user vulnerability and risk of loneliness, as well as when organisations may experience reduced capacity (e.g., Christmas). This was mirrored by service users, who felt that the funded activities should have continued for a longer period.

When evaluating various services delivered by multiple organisations that target many different types of service users, additional consultation was needed on reporting processes to establish suitability. Along these lines, the evaluation process was perceived as a burden for organisations many of which felt that required data may not apply to their target groups, so more consultation was needed prior to project initiation. However, due to the urgency at which the Fund needed to be set up, this was not necessarily possible.

Most service users either suggested improvements and recommendations for services not offered by the funded programs (social services, groceries delivery, NHS, etc.) or their main recommendations were related to the duration of the Fund (e.g., the same, or similar, activities should continue and also take place in person after the pandemic) and the frequency / intensity of the activities (e.g., group calls lasting longer, activities being delivered more often).

It needs to be noted that many services users may still not have been reached due to digital exclusion. Although the supply of digital devices was welcomed, issues around usability of such devices and user training were apparent. Finally, services / activities tailored for specific needs, such as languages other than English or people with co-morbidities, presented barriers for service users with these needs.

7 Conclusion

The findings from this project provide a positive picture on organisations and service users, giving the opportunity for organisations to develop or redesign numerous interventions to alleviate some of the loneliness burden of service users as a result of the lockdown. The Covid-19 pandemic is lasting longer than was anticipated when the funding was first allocated, and the future is still uncertain. An important consideration moving forward is how to maintain continuity of services and activities both while the Covid-19 pandemic is still going on but also once the lockdown is eased. Many of these services may have become vital for service users. Therefore, a greater focus on the sustainability of services once funding ends with a framework in place to ensure service users can still access support is an important factor of the legacy of the Fund.

Appendix 1:Topic guides

Focus group topic guide: programme managers and project leads

Aims of the interview:

Online focus groups will be conducted with Programme Managers and Project Leads of services supported by the Covid-19 Loneliness Fund, during December 2020 and January 2021. The aims of the focus groups are to explore:

How the implementation of programmes supported by the Covid-19 Loneliness Fund is going, what's working well and less well, and suggestions for improvement; and

Perceptions of how service users have experienced loneliness.

The topic guide:

This guide sets out a number of topic areas and broad themes to cover during the focus groups with the objective of **facilitating depth of discussion**. The richness of the insights will come from the interaction between participants. The guide therefore limits the discussion to the key issues so that there is scope for participants to discuss these issues as fully as possible within the timeframe.

The focus group discussion is conversational in style and will develop and expand on issues brought up by the participants. The discussion will be as **participant-led** as possible in the following ways:

Drawing on participants' own language (the language in the guide is for our reference only).

Allowing participants to spontaneously generate ideas, express views and provide the reasons underpinning these. Probes and prompts will only be used to stimulate and expand the discussion where appropriate.

The guide structures the discussion in different **phases** to take account of the **group dynamics** involved with forming a new online focus group and to ease participants into the discussion. The key issues are discussed midway through the interaction, following an introductory phase and before the final closing phase.

Ensuring that there is **a common frame of discussion.** The guide balances the need to allow participants to express views spontaneously while also ensuring there is a common frame of reference informing the discussion.

Duration:

The focus groups will last **approximately 90 minutes.**

1. Introduction to focus group (5 mins)

Aim: *to remind participants about the aims of the evaluation, explain how the focus group will be conducted, and how the data will be used.*

- Introduce:
    - Yourself;
    - Your colleague; and
    - Explain the role of you and your colleague;
    - NatCen Social Research – independent social research organisation.
    - Thank everyone for coming.

- Introduce the study:
    - Evaluation of the Covid-19 Loneliness Fund.
    - Loneliness is defined by DCMS as being 'A subjective, unwelcome feeling of lack or loss of companionship. It happens when we have a mismatch between the quantity and quality of social relationships that we have, and those that we want.'
    - Commissioned by the Department for Digital, Culture, Media and Sport (DCMS)
    - Role of NatCen – independent of DCMS and of participants' organisations.
    - Overall project aims:
        - The aim of the evaluation is to understand how the Fund is being delivered (including what's working well and less well) and the extent to which the programmes are achieving their planned outcomes.
        - The evaluation will also explore service users' experience of loneliness during the Covid-19 pandemic.
    - Six of the nine programmes funded have been selected for case study. We are conducting the case study through:
        - **Four focus groups in total**: one with **programme managers from organisations**, one from **project leads in organisations with local networks** (brokered services), **one with operational staff, and one with volunteers**.
        - **Fifty individual interviews** with service users from the six organisations.

- The discussion will last up to 90 minutes.

- Participation is voluntary:
    - Don't have to answer anything if you don't want to.
    - Can decide not to continue at any point without giving a reason.

- How we'll report findings:
    - Explain anonymity – we will not use your name or your organisation's name in any reports; but if you have a unique role – because of the small number of organisations funded by DCMS – it may be possible that you/your organisation are identifiable.
    - We will summarise what people have said across the interviews and focus groups. We won't tell your employer/organisation or DCMS what you as individuals have said.

- Group discussion ground rules (*consider posting these points in the group chat*):
    - Want to hear from everyone
    - No right or wrong answers
    - Respect others views and opinions; no need to agree
    - Confidentiality – helpful to treat what other people say as confidential and not to repeat outside the session
    - Might 'step in' to keep the discussion on track and on time
    - Technology – re-naming, muting, videos on/off

  - Quiet space – if possible, make sure you will not be disturbed, mobiles on silent, pets out of the room.

- We would like to audio record the discussion, so we have an accurate record of what is said:
  - Files stored securely in line with GDPR and deleted at the end of the project.
  - Nobody from your organisation or DCMS will have access to the recordings, only the research team at NatCen will have access.

- Information sheet and consent:
  - Check that participants have read and understood the study information sheet.
  - Any questions/concerns?
  - Permission to start recording (remind participants that we used a secure and encrypted software named Amolto).

START RECORDING

- ➢ ***If any participants have not returned consent forms before the focus group, capture the consent on the recording. Otherwise simply ask participants to confirm they are happy to proceed and then move on to 2. Introductions and background.***

- Confirm for the recording that you have explained:
  - What the focus group is for;
  - That taking part is voluntary;
  - That the group discussion is being recorded; and
  - That participant names will not be included in reports.
- Record verbal consent on the digital recorder:
  - Ask participants to confirm they are happy to proceed.

2. Introductions and background (5 mins)

***Aim**: A 'warm up' introduction for participants; and for them to provide an overview of their roles and responsibilities in relation to the Fund*

Introductions - Ask participants to take turns to briefly introduce themselves:

- Name and role
- Name of organisation and kinds of service users their organisation supports
- Which geographic area they cover.

3. Understanding the rationale and objectives (10-15 mins)

***Aims**: To explore participants' understanding of the Fund, what it aimed to address, and what it aimed to achieve*

- ➢ ***Explain to participants that we want to spend 10-15 minutes learning a bit more about their understanding of the Fund***
- ➢ ***Consider sharing screen with the summaries of the six organisations at this point so participants don't have to outline their organisation and activities.***

Understanding the programmes funded by the Covid-19 Loneliness Fund

- Main needs of target populations identified in the context of Covid-19
  - What impact has Covid-19 had on service users' loneliness
- Overview of activities they are responsible for delivering
  - What was the rationale behind designing the programme to address these needs
  - How have services been designed or redesigned to address service users' needs during the pandemic
  - What objectives do the programmes hope to achieve

4. Relationships with funders (PM only) (10-15 minutes)

***Aims**: To explore how the programme managers have been supported by DCMS to implement the programme*

- ***Explain to participants that we will work chronologically in order to understand each stage of the programme. Starting with the tender, going on to explore the set-up, and finally discussing ongoing support***

Understanding the tendering process

- What were participants' experience of the tendering process
    - Understanding of the Fund's objectives
    - What worked well or less well
    - To what extent did participants feel supported

Understanding the set-up process

- Once successful, what were participants' experience of set-up
    - Setting up the grant agreement and DSAs, agreeing a timeframe, receiving the money
    - Understanding evaluation requirements
    - What worked well and less well

Understanding ongoing support and relationships

- What are participants experiences of ongoing support
    - How have participants been supported throughout implementation e.g. number and method of contact
    - What does that support look like e.g. what issues have been supported
    - What has worked well and less well

5. Barriers and facilitators to implementation (10-15 minutes)

- What were the perceived administrative barriers to implementing the programme
    - The way that the Fund was allocated by DCMS/Organisation e.g. contract, timing (quick mobilisation of services; deadline the fund money had to be used by), , evaluation
    - The tendering process for brokered organisations
- What, if any, barriers were caused by the Covid-19 pandemic itself
    - Staffing, volunteering and training
    - Identification and recruitment of service users
    - Social distancing measures and need for virtual focus
    - Digital inclusion for virtual services

- What were the perceived facilitators to implementing the programme
    - The way that the Fund was allocated by DCMS e.g. grant agreement, timing (quick mobilisation of services; deadline the fund money had to be used by), evaluation.
    - The tendering process for brokered organisations
    - Pre-existing services prior to the pandemic e.g. service user contacts, piloted virtual programmes, ease of expansion/adaptation
    - Staffing, volunteering and training
    - Identification and recruitment of service users

6. Perceived programme outcomes: system, staff and users (10-15 minutes)

***Aims**: to discuss strategic programme managers and project leads' perceptions of impact on service-users and on their staff and volunteers*

- How have your organisation's systems and processes changed as a result of delivering the funded activities?
    - Changes that will be maintained after funding finishes
- How has the project impacted on staff / on volunteers?
- What were the perceived impacts on service users from participation in the funded activities?

7. Project development and sustainability (5-10 minutes)

- Activities and approaches that strategic staff might consider adopting in the longer term
- Activities / approaches that worked well during Covid-19 and might be transferable to other crisis situations

8. Perceptions of how service-users have experienced loneliness (5 minutes)

Aims: *to explore what perceptions managers have of how their service users have experienced loneliness since the outbreak of Covid-19.*

- ➢ ***Questions will only be administered if this is not emerged in 'Understanding the Rationale and Objectives'?***
- What is the perception (through staff and volunteers) of loneliness among service users during Covid-19 and what have been the triggers?
  - Social distancing, local lockdowns, national lockdowns, shielding – loneliness impact on different groups of people (service users)? – new loneliness / impacts on people previously experiencing loneliness (pre-pandemic)?
  - Covid-19 and how it has affected people's relationships
- What factors have **increased loneliness** in service users or helped to **prevent it** since Covid-19? What has made the difference?

9. Recommendations and suggestions for improvement (3 minutes)

Aim: *To gather insight into what participants think could be changed / added to improve the Covid-19 Loneliness Fund and / or its activities*

  - ➢ ***To end the discussion on a positive note, focus for a few minutes on what worked well and what participants feel will are valuable activities for the future – maybe ask participants for one positive recommendation***
- One example of best practice to prevent loneliness
- Recap of suggestions that emerged throughout the discussion (if applicable)
- Thinking back to how the programme was delivered, what would participants have done differently to improve it?
- Ask participants if there is anything they would like to add.

10. Closing the focus group (2 minutes)

- Reassure participants about anonymity in our reports (with the caveat mentioned above).
- Check if there was anything in the discussion that they would prefer wasn't quoted.
- Thank participants for their time.

END RECORDING

Focus group topic guide: operational staff and volunteers

Aims of the focus group:

Online focus groups will be conducted with operational staff and volunteers at services supported by the Covid-19 Loneliness Fund, during December 2020 and January 2021. The aims of the focus groups are to explore:

How the implementation of programmes supported by the Covid-19 Loneliness Fund is going, what's working well and less well, and suggestions for improvement; and

Perceptions of how service users have experienced loneliness.

The topic guide:

This guide sets out a number of topic areas and broad themes to cover during the focus groups with the objective of **facilitating depth of discussion**. The richness of the insights will come from the interaction between participants. The guide therefore limits the discussion to the key issues so that there is scope for participants to discuss these issues as fully as possible within the timeframe.

The focus group discussion is conversational in style and will develop and expand on issues brought up by the participants. The discussion will be as **participant-led** as possible in the following ways:

Drawing on participants' own language (the language in the guide is for our reference only).

Allowing participants to spontaneously generate ideas, express views and provide the reasons underpinning these. Probes and prompts will only be used to stimulate and expand the discussion where appropriate.

The guide structures the discussion in different **phases** to take account of the **group dynamics** involved with forming a new online focus group and to ease participants into the discussion. The key issues are discussed midway through the interaction, following an introductory phase and before the final closing phase.

Ensuring that there is **a common frame of discussion.** The guide balances the need to allow participants to express views spontaneously while also ensuring there is a common frame of reference informing the discussion.

Duration:

The focus groups will last **approximately 90 minutes.**

- Overall project aims:
    - The aim of the evaluation is to understand how the Fund is being delivered (including what's working well and less well) and the extent to which the programmes are achieving their planned outcomes.
    - The evaluation will also explore service users' experience of loneliness during the Covid-19 pandemic.
- Six of the nine programmes funded have been selected for case study. We are conducting the case study through:

    - **Four focus groups in total**: one with **programme managers from organisations**, one from **project leads in organisations with local networks** (brokered services), **one with operational staff, and one with volunteers**.
    - **Fifty individual interviews** with service users from the six organisations.

- The discussion will last up to 90 minutes.

- Participation is voluntary:
    - Don't have to answer anything if you don't want to.
    - Can decide not to continue at any point without giving a reason.

- How we'll report findings:
    - Explain anonymity – we will not use your name or your organisation's name in any reports; but if you have a unique role – because of the small number of organisations funded by DCMS – it may be possible that you/your organisation are identifiable.
    - We will summarise what people have said across the interviews and focus groups. We won't tell your employer/organisation or DCMS what you as individuals have said.

- Group discussion ground rules (*consider posting these points in the group chat*):
    - Want to hear from everyone
    - No right or wrong answers
    - Respect others views and opinions; no need to agree
    - Confidentiality – helpful to treat what other people say as confidential and not to repeat outside the session
    - Might 'step in' to keep the discussion on track and on time
    - Technology – re-naming, muting, videos on/off
    - Quiet space – if possible, make sure you will not be disturbed, mobiles on silent, pets out of the room.

- We would like to audio record the discussion, so we have an accurate record of what is said:
    - Files stored securely in line with GDPR and deleted at the end of the project.
    - Nobody from your organisation or DCMS will have access to the recordings, only the research team at NatCen will have access.

- Information sheet and consent:
    - Check that participants have read and understood the study information sheet.
    - Any questions/concerns?
    - Permission to start recording (remind participants that we used a secure and encrypted software named Amolto).

START RECORDING

- ➢ ***If any participants have not returned consent forms before the focus group, capture the consent on the recording. Otherwise simply ask participants to confirm they are happy to proceed and then move on to 2. Introductions and background.***

- Confirm for the recording that you have explained:
    - What the focus group is for;
    - That taking part is voluntary;
    - That the group discussion is being recorded; and

    - That participant names will not be included in reports.
- Record verbal consent on the digital recorder:
    - Ask participants to confirm they are happy to proceed.

2. Introductions and background (5 mins)

***Aim**: A 'warm up' introduction for participants; and for them to provide an overview of their roles and responsibilities in relation to the Fund*

- ➢ ***Consider sharing screen with the summaries of the six organisations at this point so participants don't have to outline their organisation.***

Introductions - Ask participants to take turns to briefly introduce themselves:

- Name and role
- Name of organisation and kinds of service users they work with
- Which geographic area they cover.

3. Experience of Covid-19 Loneliness Fund and project set up (10-15 minutes)

Aims: To explore participants' understanding of the Covid-19 Loneliness Fund and experience of initial set up of the project.

- ➢ ***Explain to participants that we want to spend 10 minutes learning more about the Fund and their understanding of the project and experience of getting started on it - as frontline staff / volunteers.***

- Awareness of the Fund and understanding of aims
    - When became aware and how - communications before, during or after the project start
- Timescales and how easy / hard it was to deliver within time – when started first activities with service users?
    - Opportunities to provide feedback to project leads / programme managers?
        - Improvement suggestions
        - Raising issues and risks
- Training received and confidence in delivering the service

4. Funded activities - delivery (15-20 minutes)

Aims: To explore participants' experience of delivery of the Loneliness Fund so far, including what's worked well and less well.

- Different types of activity
    - Describe the activities provided –
        - New activities or continuation of / enhancement of existing services?
        - Experience of taking on these activities - workloads
- Adapting the activities to make them Covid-19 secure
    - What kinds of changes were made / considerations given to physical and social distancing?
    - Facilitators and barriers to Covid-19 secure delivery of activities – from **service delivery perspective** (*will explore service users' perspective on Covid-19 secure services below in Section 5. but discussion may flow into this topic here)*
- Identifying service users
    - Existing / new service users?
    - How contacted and invited – communication methods, timings (all at the start or throughout the project), through other local / community organisations?
    - What made it easy for people to participate / what made it more difficult / who did they not manage to reach?
- Organisation of roles – who did what?
    - Activities only carried out by staff / only carried out by volunteers?
    - What worked well about roles and responsibilities / what could be improved?

    - Training, handover and communications between staff and volunteers
- Lessons learned
    - Thinking back to how the service was delivered, what would you like to have done differently to improve it? Participants may digress from the funded activity, please make sure to keep them on track and focus only on those activities supported by the Fund

5. Perceptions of how service users have experienced loneliness (10-15 minutes)

Aims: *to explore what perceptions staff and volunteers have of how their service users have experienced loneliness since the outbreak of Covid-19 and what factors have increased or prevented loneliness during this period.*

> ➢ ***Explain that this section is about service users' experience of loneliness more generally and during the Covid-19 pandemic, not specifically about their interaction with the funded activities, though it can be from feedback from and observations of service users during the activities.***

- Which service users have been lonely during Covid-19 and what have been the triggers?
    - Social distancing, local lockdowns, national lockdowns, shielding – loneliness impact on different groups of people (service users)? – new loneliness / impacts on people previously experiencing loneliness (pre-pandemic)?
    - Covid-19 and how it has affected the quality of people's relationships (rather than the number of relationships)
- What factors have increased loneliness in service users or helped to prevent it since Covid-19? What has made the difference?

6. Service users' experiences of and responses to the activities (10-15 minutes)

Aims: *To explore service users' experiences and perceptions of the activity they accessed, including on any adaptations to make activities Covid-19 secure*

- Feedback on the activities from service users
    - What were they positive about? Any negatives / complaints?
    - How was feedback gathered?
    - Things that made it easy for services users to access the activities / things that made it more difficult?
        - Particular feedback about users' experience of Covid-19 secure delivery, e.g. digital, online, phone, distanced

7. Recommendations and suggestions for improvement (5-10 minutes)

Aim: *To gather insight into what participants think could be changed / added to improve the Covid-19 Loneliness Fund and / or its activities*

> ➢ ***To end the discussion on a positive note, focus for a few minutes on what worked well and what participants feel are valuable activities for the future – maybe ask participants for one positive recommendation***

- Suggestions and recommendations for activities and approaches to support those experiencing loneliness in future (for example):
    - Activities / approaches they would like to see continuing
    - Activities / approaches that worked well during periods of lockdown / social distancing, so could be transferable to other crisis situations
    - Reaching service users who had not been supported before?
- Recap of suggestions that emerged throughout the discussion (if applicable)
- Ask participants if there is anything they would like to add.

9. Closing the focus group (2 minutes)

- Reassure participants about anonymity in our reports (with the caveat mentioned above).
- Check if there was anything in the discussion that they would prefer wasn't quoted.

- Thank participants for their time.

END RECORDING

Service user topic guide

Aims of the interview:

Online or telephone interviews will be conducted with service users of programmes supported by the Covid-19 Loneliness Fund, during January 2021. The aims of the interviews are to explore:

Participants' experience of loneliness during the Covid-19 pandemic; and

Participants' experience of their use of the programmes supported by the Fund.

The topic guide:

Topic guides help ensure consistency in data collection by setting out the key issues that should be explored with each participant. While the topic guide shapes the content of the interview, it should be used flexibly. This means that the order in which issues are covered and the time spent on different topics will vary from interview to interview. The responsive nature of qualitative research also enables interviewers to explore any unanticipated but relevant themes that arise during the discussion.

We believe topic guides work best when items are worded as short phrases rather than questions. This encourages the interviewer to formulate questions that are responsive to the situation and to use terms that are tailored to the participant. Decisions about what and how to follow up will be made by the researcher based on their knowledge of the research objectives.

Care for participant and for self as researcher:

The topic of loneliness during the Covid-19 pandemic could be sensitive for participants, particularly if they have experienced bereavement or social isolation or have had mental health symptoms during this time. Check that participant has received a copy of the aftercare leaflet and be alert to potential distress and ready to pause and stop the interview as necessary.

If the researcher needs support themselves after the interview, Alex Martin will be available for a debriefing conversation: alexander.martin@natcen.ac.uk

Duration:

The interview will last **approximately 45 minutes.**

1. Introduction to interview (5 mins)

Aim: *to remind participant about the aims of the evaluation and the research, explain how the interview will be conducted, and how the data will be used.*

- Introduce:
    - Yourself;
    - NatCen Social Research – independent social research organisation;
- Introduce the study:
    - Evaluation of the **Covid-19 Loneliness Fund** – the Fund has been providing money to organisations so they can give additional support to people during the Covid-19 pandemic.
    - When we talk about loneliness, we mean an unpleasant or unwelcome feeling of lack or loss of companionship or friends. It happens when we have fewer social relationships (check understanding) than we would like or the ones we have do not provide us with the quality of companionship (check understanding) that we would like
    - Evaluation has been commissioned by the Department for Digital, Culture, Media and Sport (DCMS).
    - Role of NatCen – independent of DCMS and of [**name of funded organisation**].
    - Overall aims of the evaluation:
        - To understand how the Covid-19 Loneliness Fund is working – the type of services offered, how you and others have experienced them, what's working well and less well, how services have changed during the pandemic, and how the services have helped to prevent loneliness.
        - To explore people's experience of loneliness during the Covid-19 pandemic.
    - Nine organisations were given funding to support people who might be lonely during the pandemic. We are looking at six of these organisations in more detail, as a **case study**, including [**name of funded organisation**]. We are doing this through:
        - **50 individual interviews:** with people like yourself who have accessed the services and support from one of the six organisations that were supported by the Fund
        - Also through **four focus groups:** with **managers, staff and volunteers** from the organisations. These are group discussions with the people running the services.

- The discussion will last up to 45 minutes.

- Participation is voluntary:
    - Don't have to answer anything if don't want to.
    - Can decide not to continue at any point without giving a reason.
    - The topics will be discussing might be upsetting – can take a break or stop altogether if it feels difficult to talk.
    - Check has received leaflet with contact details for further support [*after-care leaflet*].

- Confidentiality:
    - We will not tell DCMS, [**name of funded organisation**], or anyone else that you have taken part in the interview.

- How we'll report findings:
    - Explain anonymity – we will not use your name or [**name of funded organisation**]'s name in any reports. However, if we think that they or others are at risk of harm we then have a duty to alert the appropriate authorities.

  - We will summarise what people have said across the interviews. We won’t tell [**name of funded organisation**] or DCMS what you have said.
  - We might want to quote you (use some of your exact words) in the report but we will not include your name or anyone else’s name, or any place names that could identify you.

- We would like to audio record the discussion, so we have an accurate record of what is said:
  - Files stored securely in line with the General Data Protection Regulation (GDPR), a European Union law on data protection and privacy, and deleted at the end of the project.
  - Only the research team will have access.

- Disclosure:
  - Everything you tell us will be confidential.
  - If you tell me something which suggests you or someone else is at serious risk of harm, I will have to report it to the NatCen Disclosure board, who would decide if an authority should be informed.

- Information sheet and consent:
  - Check whether participant has received and read the information sheet;
  - Check whether the participant has received the aftercare leaflet;
  - Any questions/concerns?
  - Permission to start recording.

START RECORDING

  - ➢ ***Capture the consent on the recording.***
- Confirm for the recording that you have explained:
  - What the interview is for;
  - That taking part is voluntary;
  - That the discussion is being recorded; and
  - That participant names will not be included in reports.
- Ask participant to confirm their consent and that they are happy to proceed.

2. Introductions and background (5 mins)

Aim*: To break the ice and get to know participants. Please note that some of these will need to be tailored depending on who you are talking with.*

- About them:
  - A bit about where they live and about who is in their household (e.g., **which part of the country**; and **household composition** (living alone / single parent household / multi-adult household with / without children)
  - Day to day services (e.g., whether in paid work, seeking work, studying, caring, retired or other.

3. Experiences of loneliness during the pandemic (10 minutes)

Aim: *To introduce the topic of loneliness during the pandemic by first discussing loneliness among the general population; then to explore people's own experiences of loneliness.*

  - ➢ ***We are not making assumptions about the participants and loneliness – the participant may or may not be lonely and may or may not perceive the funded services in terms of loneliness prevention.***

- Loneliness and other problems during the Covid-19 pandemic – **for people generally**
  - What have **people generally** found hard / struggled with during the pandemic and lockdown – in your view
  - In what ways was being **lonely** a problem for **people in general** at that time;
- Loneliness for **participant him/herself** during the Covid-19 pandemic overall (from the start to now)
  - How has loneliness been experienced by yourself, if at all, during the pandemic? ('Can you tell me a little about')
  - Changes during the pandemic that made participant more lonely / less lonely, e.g.:
    - ▪ change in living and household arrangements
    - ▪ shielding / social distancing / physical distancing
    - ▪ lockdowns – national / local
    - ▪ changes to work or not / job loss / studying / working from home / not going out
  - How has the pandemic had an impact, if at all, on the quality of your relationships with others? (e.g., experience of satisfaction of social relationships; feelings around the quality of their social relationships; seeing more of / less of; contact with friends and family online)

4. Experiences during first months of the pandemic before the start of funded services (5 minutes)

Aim: *To discuss how people were coping during the pandemic before the funded programmes began*

  - ➢ ***Tailor this section to what participant has already said about whether living alone / shielding etc. Participants may digress to talk about other services (e.g. welfare), but please keep them on track***
  - Support and access to services during early months of Covid-19 – 'Thinking back to March and April and the first few months of Covid-19 and lockdown

up until June, can you tell me briefly about …What kinds of support or services you needed in terms on loneliness– if any (e.g. befriending services; virtual catch ups; phone calls from charities/organisations; supply of technology to enable communication).
  - Able to access the loneliness support or services needed? – in the first few months of Covid-19 (*not including Loneliness Fund support at this stage*)
  - Who was providing this help at the start (e.g., family, carers, neighbours, council, health workers, faith groups such as church, charities, volunteers)

5. Accessing services and support from the funded services (10 minutes)

Aim: *To explore people's experience of accessing and using the funded service and the types of services they used.*

  - ➢ ***Participants are likely to refer to the organisation, the programme, and the funded service in varying ways, for example using the name of a local group or specific service. Try to use their description throughout when referring to organisation / programme / service.***

- Describe first contact with [**name of funded organisation**]
  - How heard about the support or service and got involved (e.g. did they contact the organisation/ were they an existing service user/ did the organisation proactively find them?)
  - Tell me about which types of services or kinds of support were offered / which ones you took up
  - How accessed: (face to face / garden gate / telephone / online; individual / group)
  - Describe how you found (experienced) the services / support (e.g.: enjoyed / did not enjoy ; found useful / not so useful; helpful / unhelpful – and why).
- Adaptations to services - using the services safely during Covid-19
  - How did [**name of scheme or organisation or service**] keep you safe while they were providing support? (e.g., physical distancing, digital delivery – getting online, using tablets or mobiles

6. Barriers and facilitators (10 minutes)

Aim: *To find out what factors have made it easier or harder to access the funded services; and to explore what factors have increased or prevented loneliness of service users since the outbreak of Covid-19.*

  - ➢ ***You will need to adapt this part to the specific type of services accessed and the nature of the participant's specific needs for support.***
- Services offered and delivery style
  - How easy / how difficult to get signed up / involved in the service or support
  - Timings of services / fit with your responsibilities and schedule
  - Digital and online delivery during Covid-19 - How has this made it easier / harder for you, e.g.:
    - ▪ convenience of being at home / no need for transport / suitability or not of home for the services
    - ▪ level of technical skills / availability of digital training and support
    - ▪ physical factors with use of digital (sight / hearing / hands and dexterity / language / memory)
- How did you find the communications from [**name of organisation]** e.g. how did they keep in touch / could they ask questions/ how often did they keep in touch?
- In what way, if any, did the services [**name organisation**] offer meet your needs? (e.g. any specific needs for target group / did the organisation understand their situation)

7. Reflections (3 minutes)

- Overall reflections on the programme / organisation / scheme:
  - What has worked well

    - What has worked less well
    - How would have felt **if had no access** to the programme / organisation / scheme – particularly thinking about loneliness
- Recommendations for improvement:
    - Anything they would change about the services or stop doing
- Recommendations for continuation:
    - (‘To end on a positive note …’) Anything they feel has changed for the better / been done differently / helped prevent loneliness since Covid-19 – and that should continue if possible. (*from the programmes or more generally*)

8. Closing the interview (2 minutes)

- Final closing comments
    - Anything to add
    - Any questions
- Reassure participant about anonymity in our reports, in light of limits to anonymity – check if there was anything in the discussion that they would prefer wasn’t quoted.
- Check in with the participant how they found the interview and refer them to the aftercare leaflet.
- Thank participant for their time.

END RECORDING

Researcher debrief and support

If you need to debrief / have some support because of anything upsetting or difficult that arose during the interview (for the participant or yourself), Alex Martin will be available for a chat or a call: alexander.martin@natcen.ac.uk or 0207 549 7036.

Appendix 2 Information Sheets

All participants were sent information sheets prior to agreeing to take part in a focus group or interview. This section presents the separate information sheets that were provided to programme managers/project leads and operational staff/volunteers; a service user information sheet example; and a standard service user aftercare leaflet.

Focus group information sheet: programme managers and project leads

Evaluation of the Covid-19 Loneliness Fund

Participant Information Sheet: Programme Managers and Project Leads

Background

Under the Department for Digital, Culture, Media and Sport's (DCMS) Covid-19 Loneliness Fund, nine organisations have been awarded money to deliver programmes that support those at increased risk of loneliness during the pandemic. The organisation you work or volunteer for was awarded money from the Fund to support activities to address loneliness during the pandemic.

What is the evaluation about?

NatCen, an independent, not-for-profit organisation, has been commissioned by DCMS to conduct a process evaluation of the Covid-19 Loneliness Fund. This is an evaluation of processes, meaning that it aims to explore what works well and not so well in implementing the programmes supported by the fund. Therefore, please be assured that it is not the purpose of this evaluation to scrutinise any organisation or individual.

As part of the evaluation, NatCen would like to speak to strategic staff, operational staff and volunteers who have been involved in designing, leading and delivering the programme activities for each organisation. To do so, NatCen are conducting four focus groups with:

- Programme managers
- Programme leads
- Operational staff
- Volunteers

What is my involvement?

As you have been involved in one of the programmes supported by the Fund, we would like to invite you to a focus group to discuss your experience. In the focus group you will be joined by members of other organisations who have been involved with the fund, however we do not expect you to disclose any confidential or sensitive information. The focus group will take place via Microsoft Teams, the use of which we can provide support with, and they will last around 90 minutes. For any reason that joining the focus group on the internet becomes an issue, you may join via telephone if needed. The timing of the focus groups will be coordinated with the needs of other participants therefore, if you agree to take part, we will suggest times and dates. With your permission, the focus group will be audio recorded using a secure and encrypted software named Amolto, so that there is an accurate record of what will be discussed.

Key focus group topics will include:

- Understanding the rationale and objectives of the Fund;
- Explore relationships with Funders;
- Barriers and facilitators to implementation;
- Perceived programme outcomes: system, staff and users;
- Project development and sustainability;
- Perceptions of how service-users have experienced loneliness;
- Recommendations and suggestions for improvement.

Is the discussion confidential?

NatCen will carefully manage your personal data as part of our public task, which is our lawful basis for processing. All the information you provide will be held securely and in strict confidence in accordance with the General Data Protection Regulation (GDPR).

The information you provide will be used to write a report for DCMS. We will not identify you in the reports or presentations of the evaluation findings. Your personal details and the interview data collected will be deleted as soon as possible after the completion of the project, which is due to be completed by 2021.

Do I have to take part?

Your participation in the evaluation is entirely voluntary and if you agree to participate you are free to change your mind at any point prior to the focus group. Your participation or non-participation has no effect on your role. During the interview discussion you are also free to not answer any question you would prefer not to answer.

How can I take part?

Please respond to the email that this document was attached to with your availability. However, please note that we will be recruiting from a larger pool of potential participants, therefore participation is not guaranteed. We will ask you a short set of questions about you and your role, before inviting you to join the focus group. As well as answering any questions you have, this is to understand your role a little better – occasionally we have to choose between potential participants to ensure the evaluation covers a range of roles.

More information on the evaluation

If you would like to know more about how the information you provide will be processed, please see the privacy notice on our website here.

For more information, please contact the project team at:
loneliness_covid19@natcen.ac.uk
Focus group information sheet: Operational staff and volunteers

Evaluation of the Covid-19 Loneliness Fund

Participant Information Sheet: Programme Managers and Project Leads

Background

Under the Department for Digital, Culture, Media and Sport's (DCMS) Covid-19 Loneliness Fund, nine organisations have been awarded money to deliver programmes that support those at increased risk of loneliness during the pandemic. The organisation you work or volunteer for was awarded money from the Fund to support activities to address loneliness during the pandemic.

What is the evaluation about?

NatCen, an independent, not-for-profit organisation, has been commissioned by DCMS to conduct a process evaluation of the Covid-19 Loneliness Fund. This is an evaluation of processes, meaning that it aims to explore what works well and not so well in implementing the programmes supported by the fund. Therefore, please be assured that it is not the purpose of this evaluation to scrutinise any organisation or individual.

As part of the evaluation, NatCen would like to speak to strategic staff, operational staff and volunteers who have been involved in designing, leading and delivering the programme activities for each organisation. To do so, NatCen are conducting four focus groups with:

- Programme managers
- Programme leads
- Operational staff
- Volunteers

What is my involvement?

As you have been involved in one of the programmes supported by the Fund, we would like to invite you to a focus group to discuss your experience. In the focus group you will be joined by members of other organisations who have been involved with the fund, however we do not expect you to disclose any confidential or sensitive information. The focus group will take place via Microsoft Teams, the use of which we can provide support with, and they will last around 90 minutes. For any reason that joining the focus group on the internet becomes an issue, you may join via telephone if needed. The timing of the focus groups will be coordinated with the needs of other participants therefore, if you agree to take part, we will suggest times and dates. With your permission, the focus group will be audio recorded using a secure and encrypted software named Amolto, so that there is an accurate record of what will be discussed.

Key focus group topics will include:

- Experience of Covid-19 Loneliness Fund and project set up;
- The delivery of the funded activities;
- Perceptions of how service users have experienced loneliness;
- Service users' experiences of and responses to the activities;
- Recommendations and suggestions for improvement.

Is the discussion confidential?
NatCen will carefully manage your personal data as part of our public task, which is our lawful basis for processing. All the information you provide will be held securely and in strict confidence in accordance with the General Data Protection Regulation (GDPR).

The information you provide will be used to write a report for DCMS. We will not identify you in the reports or presentations of the evaluation findings. Your personal details and the interview data collected will be deleted as soon as possible after the completion of the project, which is due to be completed by 2021.

Do I have to take part?
Your participation in the evaluation is entirely voluntary and if you agree to participate you are free to change your mind at any point prior to the focus group. Your participation or non-participation has no effect on your role. During the interview discussion you are also free to not answer any question you would prefer not to answer.

How can I take part?
Please respond to the email that this document was attached to with your availability. However, please note that we will be recruiting from a larger pool of potential participants, therefore participation is not guaranteed. We will ask you a short set of questions about you and your role, before inviting you to join the focus group. As well as answering any questions you have, this is to understand your role a little better – occasionally we have to choose between potential participants to ensure the evaluation covers a range of roles.

More information on the evaluation
If you would like to know more about how the information you provide will be processed, please see the privacy notice on our website here.

For more information, please contact the project team at:
loneliness_covid19@natcen.ac.uk

Information sheet: service user interviews

A standard information sheet template was given to each organisation, whereby they had the opportunity to tailor specific content pertaining to the activities they delivered as service users understood them. The example below is an information sheet tailored by RNIB, with the tailored content highlighted in green.

Evaluation of the Covid-19 Loneliness Fund

Participant Information Sheet: Service users

Background

Under the Department for Digital, Culture, Media and Sport's (DCMS) Covid-19 Loneliness Fund, nine organisations have been awarded money to deliver programmes that support those at increased risk of loneliness during the pandemic. One of those organisations is RNIB, which used the funding to support individuals by delivering **wellbeing calls** and **Talk and Support groups**.

Wellbeing calls were launched as a response to the Coronavirus pandemic back in April, where RNIB reached out to people with sight loss to see if they needed support or advice during difficult times. You may have received an initial call in April/May time and then a follow up a month or two later.

Talk and Support is a befriending service for adults with sight loss. Typically, groups meet on a regular day of the week using a telephone or computer. Sessions can last up to a period of 12 weeks.

What is the evaluation about?

NatCen, an independent, not-for-profit organisation, has been commissioned by DCMS to conduct an evaluation of the Covid-19 Loneliness Fund. The evaluation aims to explore your experience of loneliness during the pandemic as well as your experience of using any of the services offered. Therefore, please be assured that it is not the purpose of this evaluation to look into and criticise any specific organisation or individual.

As part of the evaluation, NatCen would like to speak to those who have used one or more of the services supported by the Fund. It is understood that you may have experience of using one of the services provided by RNIB, therefore we would like to invite you to participate in the evaluation. We understand that the above services can be used for a range of reasons, and you may not have used them due to loneliness, but if you have done so we would like to speak to you about how you found them.

What is my involvement?

As you have experience of using one of the services provided by RNIB, we would like to invite you to talk about your experience with one of our researchers. The interviews will take place over the phone or using Microsoft Teams and they will last around 45 minutes. The research team can work with you to arrange an interview at a time and date convenient for you. With your permission, the interview will be audio recorded using secure and encrypted software named Amolto, so that there is a detailed and accurate record of what was discussed. The interview topics will include:

- Your experience of loneliness during the pandemic
- What has increased loneliness during the pandemic

- What has prevented loneliness during the pandemic
- Your experience of the services offered by RNIB

Is the discussion confidential?

Yes, what you discuss with our researchers is completely confidential. Neither DCMS or RNIB will be made aware of your participation. What you discuss will be brought together with information from other services users and analysed to produce a report for DCMS. All information in the report will be completely anonymous. For example, we may decide to use a quote from the interview, however there will be nothing within that quote or alongside it which could identify you. However, because of the small number of organisations funded by DCMS, it may be possible that organisations may be identifiable.

NatCen will carefully manage your personal data as part of our public task, which is our lawful basis for processing. All the information you provide will be held securely and in strict confidence in accordance with the General Data Protection Regulation (GDPR).

The information you provide will be used to write a report for DCMS. We will not identify you in the reports or presentations of the evaluation findings. Your personal details and the interview data collected will be deleted as soon as possible after the completion of the project, which is due to be completed by 2021.

Do I have to take part?

Your participation in the evaluation is entirely voluntary and if you agree to participate you are free to change your mind at any point prior to, during, or after the interview. Your participation or non-participation has no effect on your relationship with RNIB or DCMS. During the interview discussion you are also free to not answer any question you would prefer not to answer. If you would like to withdraw prior to or after the interview, please get in touch with the research team using the contact details below. If you would like to withdraw during the interview, please just let the researcher interview you know and they will ensure that the interview is stopped.

How can I take part?

Please consent for RNIB to share your contact details with NatCen. Once we receive them, one of our researchers may be in touch to invite you to interview. However, please note that we will be recruiting from a larger pool of potential participants, therefore participation is not guaranteed. When we contact you, we will ask you a short set of questions before inviting you to an interview. As well as answering any questions you have, this is to understand your experience of the services a little better – occasionally we have to choose between potential participants to ensure the evaluation covers a range of experiences

If you require any additional support to participate in the interview, please let the researcher know when booking the interview. For example, some participants may want a family member or friend to sit in on the interview for support, or if English is not your first language, to help with interpretation.

Should you decide to participate in an interview, we will also send you an aftercare leaflet which provides some additional information about services you can access. This is to ensure that you know where to find support following the interview if, for instance, anything discussed upsets you. However, you will not have to answer any questions you do not want to, can stop or pause the interview at any time, and let our researcher know if you are having any difficulties at all.

More information on the evaluation

If you would like to know more about how the information you provide will be processed, please see the privacy notice on our website here.
For more information please also contact the project team at:
Telephone: XXX XXXX XXXX
Email: loneliness_covid19@natcen.ac.uk

Appendix 3: Service user interviews: aftercare leaflet

All service users were provided with an aftercare leaflet at interview, which signposted them to a range of services should they need further support. A general aftercare leaflet was developed (please see below) and sent to organisations to add additional services that could be beneficial.

Evaluation of the Covid-19 Loneliness Fund: Aftercare Leaflet

You have been interviewed about your experiences using the services provided by [programme name], which were supported by the Covid-19 Loneliness Fund. We are very grateful for your participation, which will help us understand how this programme was delivered and your experience of using it. We hope that your experience of taking part was positive.

For some participants, discussing their experiences may raise uncomfortable or upsetting issues. In the event that you feel upset about any of the topics discussed, we want to ensure that you have the contact details of organisations who you can talk to if needed and who can help you. We provide a copy of this leaflet to all participants to ensure that everyone has the resources to seek help and support if needed.

Personal and emotional support

The organisations below can provide you with personal and emotional support:

- **Samaritans** – free and confidential emotional support if you need to talk

Helpline: 116 223 (24 hours)
Email: jo@samaritans.org
Website: https://www.samaritans.org/

- **Mind** – a mental health charity with a wealth of information on mental health conditions and services

Infoline: 0300 123 3393 (Mon-Fri 9am-6pm)
Website (national Mind): https://www.mind.org.uk/
Website (to find local Mind): https://www.mind.org.uk/information-support/local-minds/

- **Cruse – national bereavement charity who helps people experiencing grief**

Helpline: 0808 808 1677 (Mon & Fri 9am-5pm, Tues-Thurs 9am-8pm)
Website: https://www.cruse.org.uk/

- **Scope** – free, independent and impartial information and support for people with a physical impairment, learning disability or any other condition

Helpline: 0808 800 3333
Website: https://www.scope.org.uk

- **Independent age (for older people)** – befriending services

Helpline: 0800 319 6789
Website: https://www.independentage.org/

- **The Silver Line** – free confidential helpline providing information, friendship and advice to older people

Helpline: 0800 4 70 80 90 (24 hours)
Website: https://www.thesilverline.org.uk/

- **Age UK** – support and advice for older people

Advice line: 0800 678 1602 (everyday, 8am to 7pm)
Website: https://www.ageuk.org.uk/

- **SupportLine** – confidential emotional support to children, young adults and adults

Helpline: 01708 765200

Email: info@supportline.org.uk
Website: https://www.supportline.org.uk/

Financial support

The following organisations can provide you with information about financial issues:

- **The Trussell Trust** – nationwide network of food banks providing emergency food and support

Telephone: 01722 580 180
Website: https://www.trusselltrust.org

- **Universal Credit (UC) helpline** – advice on Universal Credit

Helpline: 0800 328 5644
Website: https://www.gov.uk/universal-credit/contact-universal-credit

- **Citizens Advice** – advice on debt, benefits, employment, housing, discrimination

Telephone: 03444 111 444
Website: https://www.citizensadvice.org.uk/

- **Shelter** – free information, support and advice to people facing homelessness or experiencing housing issues

Helpline: 0808 800 4444
Website: http://www.shelter.org.uk

NatCen Social Research is an independent social research institute. It designs, conducts, and analyses research studies in the fields of social and public policy. You can find out more about NatCen on www.natcen.ac.uk.

For any queries on this research please contact the NatCen research team at Loneliness_Covid19@natcen.ac.uk, or XXXX on XXX XXXX XXXX

Appendix 4: Briefing note and grant holders' monitoring data tables

This appendix presents an abridged version of a brief summary of the monitoring data, by grant holder, which was sent to DCMS in February 2021. This is followed by data tables on demographic characteristics of service users, loneliness and wellbeing, and tables on loneliness and wellbeing by demographic characteristics and disability.

Monitoring data briefing note

This note outlines the data that has been received from each grant holder and any limitations are also provided / discussed.

Table 1 (below) summarises the total number of cases in the dataset, detailing the numbers received from each grant holder.

Table 1: Summary table	
Carers Trust	419
EFL Trust	1,320
RNIB	146
Home Start	709
Alzheimer's Society	1,068
British Red Cross	2,494
SSAFA	195
Sense	455
Total	6,806

Carers' Trust

Carer's Trust collected data on all of the main requested areas for 419 of their service users.

However, its local branches collected the data and unique identifiers were not created for all individuals. This meant that at follow up timepoints, not all people could be matched with their baseline results. Only those who could be reliably matched to their baseline responses were included in the merged dataset.

As a result, of the 419 cases that were included at baseline, only a quarter (n=103) could be matched to respondents at the follow up. The full number of potential responses at follow up was 196.

English Football League (EFL) Trust

EFL Trust's data included 1,320 cases covering all the requested areas, except for demographic data which they have provided in aggregate. However, this means that sub-group analysis on specific demographics (e.g., age, sex, ethnicity) cannot be undertaken.

Two time-points of data were collected, although response fell substantially over time with, 1,018 responses at follow up timepoint 1 and 680 at timepoint 2.

RNIB

RNIB collected 146 responses at the baseline timepoint, falling to 73 at their second time point (50% response rate). While the majority of the requested variables were included, a number were omitted:

- Sexual orientation and ethnicity were not collected prior to August 2020, resulting in missing data for n=89 cases; and
- Respondents were also only asked about anxiety (in the wellbeing section) with no data collected in the other three areas.

SSAFA

SSAFA collected survey data from 195 respondents at baseline (covering all the variables in the primary dataset), and from 53 at a follow up timepoint.

BRC

BRC provided data for 2,494 service users, drawn from their administrative records. This indicated which services people received and also provided demographics information for some services.

However, survey information on perceptions of loneliness was collected from only a sub-sample of this group: those supported by the Refugee Services; Restoring Family Links and Anti-Trafficking (RSRFLAT); and, Connecting Communities services.[15] This means that for the loneliness data the sample size is reduced to 106 at baseline and 50 at the follow up timepoint.

While a limited amount of demographics data (on age and gender for Generation Digital service users) is present, in most cases the type of service received is the only recorded information. In these cases, this data is only useful to indicate how many people received that service.

Given the missing data for most of the other services, we will focus the analysis of demographics on the RSRFLAT and Connecting Communities services and will clarify in our reporting that the data does not represent everyone BRC has supported. This results in a sample of 1,612 people with demographics information. However, there is still some missing data including:

- Sexual orientation and disability status were collected only in the survey and so this information is only available for the 106 survey respondents; and,

- Ethnicity is only available for 58% of users and it was gathered through a combination of service user databases and survey results (with survey answers taking precedence). Ethnicity was covered by these sources the survey was not completed by all people and in BRC's database, country of origin was typically more useful, so ethnicity was not recorded in all cases.

Table 2 provides a summary of BRC's data.

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[15] Among Connecting Communities users, only 239 out of 359 service users were invited to participate in the survey.

Table 2: British Red Cross monitoring data

Service	Total in BRC data	Responded to survey
RSRFLAT	1,253	95
Connecting Communities (CC)	359	11
Total included in dataset for analysis by demographics:	1,612	106
Generation Digital volunteers	98	0
Co-production participants	31	n/a
Young people attending Zoom sessions	191	n/a
RSRFLAT and CC volunteers	41	n/a
Digital Classroom participants	513	n/a
Students receiving emotional support	8	n/a
Total received from BRC	2,494	106

Home-Start

Home-Start collected data on a total of 709 service users, with a strong coverage of all baseline variables.

Data was also collected at two follow up timepoints, with a low response at follow up 1 (n=134), and a strong response at follow up 2 (n=609).

In total 130 respondents were present at all three timepoints, and 609 at only timepoints 1 and 2.

Alzheimer’s Society

The Alzheimer’s Society collected responses from a total of 1,068 service users, with data collected at two follow up timepoints. Service users were not asked the UCLA 3 loneliness questions.[16]

Across the 1,068 service users, there was a high level of missing data. This was in part because service users were invited to participate in the follow up survey even if they had not completed the baseline timepoint survey. This has meant there are a number of cases with valid follow up data but missing demographic and baseline data with which to match. The total number of responses at the baseline timepoint were 792, and 724 at follow up 1, and 607 at follow up 2. There were 467 cases with data at all three timepoints.

Sense

Sense have collected demographic data through their internal administrative database for 455 service users, which includes the services they received from Sense and their demographic characteristics.

A limitation to this data is that much of this support is focussed on children, potentially from a very young age, and all the demographic information relates to the child.

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[16] How often people felt they were lacking companionship, feeling left out and feeling isolated from others.

However, there are some cases where the support may be more targeted towards the child's parents, and this is not captured in the data. This might be the case where, for example, the child is still at a very young age; and there are 55 service users age 0-2 in the data.

Sense's outcome measures include a different set of questions to the main dataset (listed below) and was collected for 65 people at 3 timepoints. It is also available at only the aggregate level, so subgroup analysis of responses is not possible (children were not asked to complete surveys, so data only covers a sub-sample of Sense service users).

Table 3: Sense Wellbeing Outcome Measures (agree/disagree scales)
My friendships are satisfying
I have enough people I feel comfortable asking for help at any time
I am happy with the friendships that I have
I am happy with the friendships I have made
I feel good about myself
I feel listened to
I enjoy being with other people
I have fun
I like taking part

Monitoring data

Characteristics of service users

Appendix table D:1 Characteristics of service users	
Gender	%
Male	39
Female	60
Non-binary	1
Prefer not to say	0.1
Prefer to self-describe	0.1
Base	*3,964*
Age	%
16-24	19
25-34	23
35-44	14
45-54	7
55-64	7
65-74	9
75+	21
Base	3,982
Sexual orientation	%

Heterosexual or Straight	89
Gay or Lesbian	1
Bisexual	2
Prefer not to say	6
Other	2
Base	2,315
Ethnicity	%
White ethnic groups	75
Mixed ethnic background	2
Ethnic minorities (excluding White minorities)	23
Base	2,995
Whether has a long-term disability:	%
Yes	64
No	30
Prefer not to say	6
Base	2,499

Loneliness

Appendix table D:2 Loneliness measures

How often do you feel lonely?			
	Baseline	Follow up 1	Follow up 2
	%	%	%
Hardly ever	23	25	23
Some of the time	51	57	61
Often	27	17	16
Base	*3,561*	*2,126*	*1,893*
How often do you lack companionship?			
	Baseline	Follow up 1	Follow up 2
	%	%	%
Hardly ever	27	36	30
Some of the time	43	43	50
Often	30	21	20
Base	*2,773*	*1,421*	*1,293*
How often do you feel out?			
	Baseline	Follow up 1	Follow up 2
	%	%	%
Hardly ever	32	43	40

Some of the time	40	40	45
Often	28	16	15
Base	*2,726*	*1,399*	*1,281*
How often do you feel isolated from others?			
	Baseline	Follow up 1	Follow up 2
	%	%	%
Hardly ever	24	31	25
Some of the time	39	45	50
Often	37	24	24
Base	*2,859*	*1,412*	*313*

Appendix table D:3 Changes in experiences of loneliness over time: Baseline to follow up two

		Some of the time to hardly ever %	Often %	*Base*	P
How often do you feel lonely?	Baseline	73	27	*1,748*	0.000
	Follow up 2	84	16		
How often do you lack companionship?	Baseline	68	32	*1,293*	0.000
	Follow up 2	80	20		
How often do you feel left out?	Baseline	70	30	*1,268*	0.000
	Follow up 2	85	15		
How often do you feel isolated from others?	Baseline	59	41	*1,290*	0.000
	Follow up 2	76	24		

Appendix table D:4 Changes in experiences of loneliness over time: Baseline to follow up one

		Some of the time to hardly ever %	Often %	*Base*	P
How often do you feel lonely?	Baseline	79	21	*1,861*	0.000
	Follow up 1	84	16		
How often do you lack companionship?	Baseline	75	25	*1,352*	0.000
	Follow up 1	80	20		
How often do you feel left out?	Baseline	78	22	*1,312*	0.000
	Follow up 1	85	15		
How often do you feel isolated from others?	Baseline	69	31	*1,390*	0.000
	Follow up 1	77	23		

Wellbeing

Appendix table D:5 Wellbeing

Overall, how satisfied are you with your life nowadays?

	Baseline	**Follow up 1**	**Follow up 2**
	%	%	%
Low	29	23	25
Medium	32	31	30
High	28	33	33
Very high	11	13	12
Base	*2,988*	*1,922*	*1,907*

Overall, to what extent do you feel that the things you do in your life are worthwhile?

	Baseline	**Follow up 1**	**Follow up 2**
	%	%	%
Low	24	19	19
Medium	27	25	25
High	32	38	37
Very high	17	18	19
Base	*2,973*	*1,910*	*1,864*

Overall, how happy did you feel yesterday?

	Baseline	**Follow up 1**	**Follow up 2**
	%	%	%
Low	31	24	27
Medium	27	26	25
High	28	34	33
Very high	14	16	16
Base	*2,984*	*1,914*	*1,870*

Overall, how anxious did you feel yesterday?

	Baseline	**Follow up 1**	**Follow up 2**
	%	%	%
Very low	20	22	19
Low	23	24	25
Medium	22	24	25
High	35	29	30
Base	*3,112*	*1,980*	*1,866*

Appendix table D:6 Changes in experiences of wellbeing over time: Baseline to follow up two

		Medium, high, or very high %	**Low %**	***Base***	**P**
How satisfied you are with life	Baseline	68	32		
	Follow up 2	76	24	*1,758*	0.000
How worthwhile the things you do in life are	Baseline	74	26		
	Follow up 2	82	18	*1,706*	0.000
How happy did you feel yesterday	Baseline	66	34		
	Follow up 2	75	25	*1,721*	0.000
Anxiety		**Very low, low or medium %**	**High %**		
How anxious did you feel yesterday	Baseline	64	36		
	Follow up 2	70	30	1,711	0.000

Appendix table D:7 Changes in experiences of wellbeing over time: Baseline to follow up one

		Medium, high, or very high %	**Low %**	***Base***	**P**
How satisfied you are with life	Baseline	76	24		
	Follow up 2	79	21	*1,732*	0.003
How worthwhile the things you do in life are	Baseline	81	19		
	Follow up 2	82	18	*1,712*	0.129
How happy did you feel yesterday	Baseline	74	26		
	Follow up 2	77	23	*1,723*	0.003
Anxiety		**Very low, low or medium %**	**High %**		
How anxious did you feel yesterday	Baseline	67	33		
	Follow up 2	71	29	*1,781*	0.001

Loneliness and wellbeing by demographic characteristics

Appendix table D:8 Loneliness at baseline – by gender

Baseline - How often do you feel lonely? (3 categories)			
	Male	**Female**	**Total**
	%	%	%
Hardly ever	26	12	16
Some of the time	53	52	52
Often	21	36	32
Base	*563*	*1590*	*2153*
P	0.000		
Baseline - How often do you feel that you lack companionship?			
	Male	**Female**	**Total**
	%	%	%
Hardly ever	24	11	14
Some of the time	48	46	46
Often	27	43	40
Base	*316*	*1129*	*1445*
P	0.000		
Baseline - How often do you feel left out?			
	Male	**Female**	**Total**
	%	%	%
Hardly ever	28	14	17
Some of the time	45	41	42
Often	28	45	42
Base	*315*	*1127*	*1442*
P	0.000		
Baseline - How often do you feel isolated from others?			
	Male	**Female**	**Total**
	%	%	%
Hardly ever	21	10	12
Some of the time	44	37	38
Often	35	54	49
Base	*347*	*1186*	*1533*
P	0.000		

Appendix table D:9 Wellbeing at baseline – by gender

Baseline - Overall, how satisfied are you with your life nowadays?

	Male	Female	Total
	%	%	%
Low	33	43	40
Medium	36	33	34
High	22	18	19
Very high	9	5	6
Base	*398*	*1181*	*1579*
P	0.000		

Baseline - Overall, to what extent do you feel that the things you do in your life are worthwhile?

	Male	Female	Total
	%	%	%
Low	27	36	34
Medium	33	28	30
High	28	24	25
Very high	13	11	12
Base	*397*	*1171*	*1568*
P	0.001		

Baseline - Overall, how happy did you feel yesterday?

	Male	Female	Total
	%	%	%
Low	31	45	42
Medium	33	28	29
High	25	18	20
Very high	11	9	9
Base	*397*	*1180*	*1577*
P	0.000		

Baseline - Overall, how anxious did you feel yesterday?

	Male	Female	Total
	%	%	%
Very low	20	14	16
Low	24	21	22
Medium	22	25	24
High	34	40	39
Base	*448*	*1265*	*1713*
P	0.025		

Appendix table D:10 Loneliness at baseline – by age

Baseline - How often do you feel lonely? (3 categories)								
	16-24	**25-34**	**35-44**	**45-54**	**55-64**	**65-74**	**75+**	**Total**
	%	%	%	%	%	%	%	%
Hardly ever	17	11	7	12	20	20	21	16
Some of the time	46	48	51	44	46	57	57	52
Often	37	41	42	44	35	23	23	33
Base	226	451	269	116	147	257	667	2133
P	0.000							
Baseline - How often do you feel that you lack companionship?								
	16-24	**25-34**	**35-44**	**45-54**	**55-64**	**65-74**	**75+**	**Total**
	%	%	%	%	%	%	%	%
Hardly ever	17	13	10	13	15	15	20	14
Some of the time	50	47	46	43	44	47	45	47
Often	33	40	44	45	41	38	35	39
Base	*227*	*454*	*268*	*112*	*117*	*125*	*137*	*1440*
P	0.000							
Baseline - How often do you feel left out?								
	16-24	**25-34**	**35-44**	**45-54**	**55-64**	**65-74**	**75+**	**Total**
	%	%	%	%	%	%	%	%
Hardly ever	18	18	11	11	13	18	32	17
Some of the time	41	41	45	40	47	44	34	42
Often	42	42	44	49	41	37	34	41
Base	*226*	*455*	*268*	*112*	*116*	*126*	*134*	*1437*
P	0.000							
Baseline - How often do you feel isolated from others?								
	16-24	**25-34**	**35-44**	**45-54**	**55-64**	**65-74**	**75+**	**Total**
	%	%	%	%	%	%	%	%
Hardly ever	14	11	11	10	14	10	18	12
Some of the time	40	36	37	35	37	51	39	38
Often	46	53	52	56	49	39	43	49
Base	*226*	*458*	*274*	*124*	*135*	*141*	*170*	*1528*
P	0.000							

Appendix table D:11 Wellbeing at baseline – by age

Baseline - Overall, how satisfied are you with your life nowadays?

	16-24	25-34	35-44	45-54	55-64	65-74	75+	Total
	%	%	%	%	%	%	%	%
Low	46	42	49	60	30	33	36	41
Medium	31	34	36	26	36	31	34	33
High	20	19	11	9	27	22	22	20
Very high	3	5	4	6	7	14	8	6
Base	*193*	*395*	*204*	*35*	*44*	*147*	*546*	*1564*
P	0.001							

Baseline - Overall, to what extent do you feel that the things you do in your life are worthwhile?

	16-24	25-34	35-44	45-54	55-64	65-74	75+	Total
	%	%	%	%	%	%	%	%
Low	42	37	40	37	23	26	29	34
Medium	27	32	29	26	34	26	28	29
High	22	20	23	26	32	30	29	25
Very high	9	12	8	11	11	18	13	12
Base	*192*	*390*	*203*	*35*	*44*	*147*	*542*	*1553*
P	0.001							

Baseline - Overall, how happy did you feel yesterday?

	16-24	25-34	35-44	45-54	55-64	65-74	75+	Total
	%	%	%	%	%	%	%	%
Low	47	48	49	51	30	35	37	42
Medium	28	27	28	34	32	24	28	28
High	17	18	17	6	27	24	24	20
Very high	8	7	6	9	11	17	11	9
Base	*193*	*395*	*204*	*35*	*44*	*146*	*544*	*1561*
P	0.001							

Baseline - Overall, how anxious did you feel yesterday?

	16-24	25-34	35-44	45-54	55-64	65-74	75+	Total
	%	%	%	%	%	%	%	%
Very low	13	11	9	13	18	27	19	16
Low	22	19	21	13	15	21	24	21
Medium	25	26	24	28	20	20	24	24
High	40	44	46	45	46	33	34	39
Base	*193*	*400*	*210*	*53*	*71*	*169*	*600*	*1696*
P	0.001							

Appendix table D:12 Loneliness at baseline – by sexual orientation

Baseline - How often do you feel lonely? (3 categories)

	Heterosexual or straight	**Gay, lesbian, bisexual, or other**	**Prefer not to say**	**Total**
	%	%	%	%
Hardly ever	16	15	11	16
Some of the time	52	52	48	52
Often	32	34	41	32
Base	*1952*	*95*	*125*	*2172*
P	0.101			

Baseline - How often do you feel that you lack companionship?

	Heterosexual or straight	**Gay, lesbian, bisexual, or other**	**Prefer not to say**	**Total**
	%	%	%	%
Hardly ever	15	8	13	14
Some of the time	45	58	48	46
Often	40	33	39	40
Base	*1268*	*60*	*106*	*1434*
P	0.586			

Baseline - How often do you feel left out?

	Heterosexual or straight	**Gay, lesbian, bisexual, or other**	**Prefer not to say**	**Total**
	%	%	%	%
Hardly ever	16.69	16.39	20.75	16.98
Some of the time	41.61	39.34	40.57	41.44
Often	41.69	44.26	38.68	41.58
Base	*1264*	*61*	*106*	*1431*
P	0.758			

Baseline - How often do you feel isolated from others?

	Heterosexual or straight	**Gay, lesbian, bisexual, or other**	**Prefer not to say**	**Total**
	%	%	%	%
Hardly ever	13	5	10	12
Some of the time	38	38	40	38
Often	49	57	50	49
Base	*1267*	*60*	*106*	*1433*
P	0.507			

Appendix table D:13 Wellbeing at baseline – by sexual orientation

Baseline - Overall, how satisfied are you with your life nowadays?

	Heterosexual or straight	Gay, lesbian, bisexual, or other	Prefer not to say	Total
	%	%	%	%
Low	40	39	39	40
Medium	34	38	35	34
High	20	21	18	20
Very high	7	2	7	6
Base	*1483*	*56*	*71*	*1610*
P	0.981			

Baseline - Overall, to what extent do you feel that the things you do in your life are worthwhile?

	Heterosexual or straight	Gay, lesbian, bisexual, or other	Prefer not to say	Total
	%	%	%	%
Low	33	34	39	33
Medium	29	34	27	29
High	26	14	21	25
Very high	12	18	13	12
Base	*1473*	*56*	*71*	*1600*
P	0.544			

Baseline - Overall, how happy did you feel yesterday?

	Heterosexual or straight	Gay, lesbian, bisexual, or other	Prefer not to say	Total
	%	%	%	%
Low	41	48	46	42
Medium	29	25	27	29
High	20	20	20	20
Very high	10	7	7	10
Base	*1481*	*56*	*71*	*1608*
P	0.398			

Baseline - Overall, how anxious did you feel yesterday?

	Heterosexual or straight	Gay, lesbian, bisexual, or other	Prefer not to say	Total
	%	%	%	%
Very low	15	14	14	15
Low	23	18	11	22
Medium	24	29	22	24
High	38	39	53	38
Base	*1523*	*56*	*76*	*1655*
P	0.030			

Appendix table D:14 Loneliness at baseline – by ethnicity

Baseline - How often do you feel lonely? (3 categories)

	White ethnic groups	Mixed ethnic background	Ethnic minorities (excluding White minorities)	Total
	%	%	%	%
Hardly ever	17	12	11	16
Some of the time	52	40	54	52
Often	31	48	35	32
Base	*1779*	*60*	*372*	*2211*
P	0.086			

Baseline - How often do you feel that you lack companionship?

	White ethnic groups	Mixed ethnic background	Ethnic minorities (excluding White minorities)	Total
	%	%	%	%
Hardly ever	16	11	10	14
Some of the time	45	42	52	47
Often	40	47	37	39
Base	*1038*	*57*	*345*	*1440*
P	0.347			

Baseline - How often do you feel left out?

	White ethnic groups	Mixed ethnic background	Ethnic minorities (excluding White minorities)	Total
	%	%	%	%
Hardly ever	19	11	10	17
Some of the time	39	42	49	42
Often	41	47	41	41
Base	*1037*	*57*	*343*	*1437*
P	0.623			

Baseline - How often do you feel isolated from others?

	White ethnic groups	Mixed ethnic background	Ethnic minorities (excluding White minorities)	Total
	%	%	%	%
Hardly ever	13	11	9	12
Some of the time	37	35	42	39
Often	49	54	48	49
Base	*1038*	*57*	*344*	*1439*
P	0.692			

Appendix table D:15 Wellbeing at baseline – by ethnicity

Baseline - Overall, how satisfied are you with your life nowadays?

	White ethnic groups	Mixed ethnic background	Ethnic minorities (excluding White minorities)	Total
	%	%	%	%
Low	39	49	45	40
Medium	34	23	36	34
High	21	21	13	20
Very high	7	6	6	6
Base	*1368*	*47*	*222*	*1637*
P	0.158			

Baseline - Overall, to what extent do you feel that the things you do in your life are worthwhile?

	White ethnic groups	Mixed ethnic background	Ethnic minorities (excluding White minorities)	Total
	%	%	%	%
Low	33	45	35	33
Medium	29	23	31	29
High	26	23	20	25
Very high	12	9	14	12
Base	*1359*	*47*	*220*	*1626*
P	0.183			

Baseline - Overall, how happy did you feel yesterday?

	White ethnic groups	Mixed ethnic background	Ethnic minorities (excluding White minorities)	Total
	%	%	%	%
Low	40	45	49	42
Medium	28	36	29	28
High	22	11	14	20
Very high	10	9	8	10
Base	*1365*	*47*	*223*	*1635*
P	0.041			

Baseline - Overall, how anxious did you feel yesterday?

	White ethnic groups	Mixed ethnic background	Ethnic minorities (excluding White minorities)	Total
	%	%	%	%
Very low	16	11	13	15
Low	23	13	22	22
Medium	24	45	20	24
High	37	32	44	38

Appendix table D:15 Wellbeing at baseline – by ethnicity

Base	1408	47	227	1682
P	0.084			

Appendix table D:16 Loneliness at baseline – by long-term limiting illness / disability

Baseline - How often do you feel lonely? (3 categories)			
		Long-term limiting illness/disability	
	Yes	**No**	**Total**
	%	%	%
Hardly ever	14	21	16
Some of the time	49	55	51
Often	36	24	33
Base	*1397*	*639*	*2036*
P	0.000		
Baseline - How often do you feel that you lack companionship?			
		Long-term limiting illness/disability	
	Yes	**No**	**Total**
	%	%	%
Hardly ever	12	18	14
Some of the time	43	50	46
Often	44	32	40
Base	*871*	*512*	*1383*
P	0.000		
Baseline - How often do you feel left out?			
		Long-term limiting illness/disability	
	Yes	**No**	**Total**
	%	%	%
Hardly ever	16	20	17
Some of the time	37	49	41
Often	48	31	42
Base	*872*	*508*	*1380*
P	0.000		
Baseline - How often do you feel isolated from others?			
		Long-term limiting illness/disability	
	Yes	**No**	**Total**
	%	%	%
Hardly ever	10	17	12
Some of the time	34	46	38
Often	56	38	49
Base	*961*	*510*	*1471*

Appendix table D:16 Loneliness at baseline – by long-term limiting illness / disability

P	0.000		

Appendix table D:17 Wellbeing at baseline – by long-term limiting illness / disability

Baseline - Overall, how satisfied are you with your life nowadays?			
	Long-term limiting illness/disability		
	Yes	**No**	**Total**
	%	%	%
Low	46	26	41
Medium	33	36	34
High	17	25	19
Very high	5	12	7
Base	*1092*	*401*	*1493*
P	0.000		
Baseline - Overall, to what extent do you feel that the things you do in your life are worthwhile?			
	Long-term limiting illness/disability		
	Yes	**No**	**Total**
	%	%	%
Low	40	19	34
Medium	29	30	29
High	21	31	24
Very high	10	20	13
Base	*1088*	*396*	*1484*
P	0.000		
Baseline - Overall, how happy did you feel yesterday?			
	Long-term limiting illness/disability		
	Yes	No	Total
	%	%	%
Low	47	29	42
Medium	27	32	28
High	18	24	20
Very high	8	15	10
Base	*1091*	*400*	*1491*
P	0.000		
Baseline - Overall, how anxious did you feel yesterday?			
	Long-term limiting illness/disability		
	Yes	No	Total
	%	%	%

Very low	15	18	16
Low	21	23	22
Medium	23	24	23
High	40	35	39
Base	*1231*	*399*	*1630*
P	0.052		

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